ปัจจัยคัดสรรที่สัมพันธ์กับปัญหาสุขภาพจิตของเด็กวัยเรียนที่มีปัญหาสุขภาพจิต
ณ อาเจะห์ อินโดนีเซีย

นายฟอซาน ซาปุตรา

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาพยาบาลศาสตรมหาบัณฑิต
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ปีการศึกษา 2558

SELECTED FACTORS RELATED TO MENTAL HEALTH PROBLEMS IN SCHOOL-AGED CHILDREN WITH MENTAL HEALTH PROBLEMS IN ACEH PROVINCE, INDONESIA

Mr. Fauzan Saputra

A Thesis Submitted in Partial Fulfillment of the Requirements
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Thesis Title	SELECTED FACTORS RELATED TO MENTAL HEALTH PROBLEMS IN SCHOOL-AGED CHILDREN WITH MENTAL HEALTH PROBLEMS IN ACEH PROVINCE, INDONESIA
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ฟอซาน ซาปุตรา : ปัจจัยคัดสรรที่สัมพันธ์กับปัญหาสุขภาพจิตของเด็กวัยเรียนที่มีปัญหาสุขภาพจิต ณ อาเจะห์ อินโดนีเซีย (SELECTED FACTORS RELATED TO MENTAL HEALTH PROBLEMS IN SCHOOL-AGED CHILDREN WITH MENTAL HEALTH PROBLEMS IN ACEH PROVINCE, INDONESIA) อ.ที่ปรึกษาวิทยานิพนธ์หลัก: รศ. ดร.จินตนา ยูนิพันธุ์, อ. ที่ปรึกษาวิทยานิพนธ์ร่วม: อ. ดร.สุนิศา สุขตระกูล, 143 หน้า.

อาเจะห์เป็นจังหวัดหนึ่งในอินโดนีเซียที่มีความชุกสูงสุดของปัญหาสุขภาพจิตในประชากรผู้ใหญ่ แต่ไม่ค่อยมีข้อมูลเกี่ยวกับปัญหาสุขภาพจิตในเด็กวัยเรียน ในขณะที่ปัญหาที่เกิดขึ้นเริ่มมีความน่าสนใจในอินโดนีเซีย การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อ 1) อธิบายปัญหาสุขภาพจิตในภาพรวมและรายด้านในเด็กวัยเรียน และ 2) ศึกษาความสัมพันธ์ของปัจจัยที่คัดสรร ได้แก่ เพศ อายุ ความสามารถทางการเรียน ความสามารถทางสังคม รายได้ครอบครัว สิ่งแวดล้อมครอบครัวมิติความสัมพันธ์ ความเครียดของด้านการเลี้ยงดูมารดา พฤติกรรมการเลี้ยงดูของมารดา และภาวะซึมเศร้าของมารดากับปัญหาทางสุขภาพจิตของเด็กวัยเรียนในจังหวัดอาเจะห์

เด็กวัยเรียนที่มีปัญหาสุขภาพจิตตามเกณฑ์ที่กำหนดจำนวน 143 คน คัดเลือกจาก 9 โรงเรียนประถมศึกษา ใน 3 ตำบล และมารดาของเด็กที่มีคุณสมบัติตามเกณฑ์ เครื่องมือที่ใช้ในการวิจัยประกอบด้วย แบบประเมินพฤติกรรม (SDQ) แบบสอบถามข้อมูลทั่วไป แบบสอบถามความสามารถทางสังคม (SCQ) แบบสอบถามความสัมพันธ์ในครอบครัวฉบับย่อ (BFRS) แบบประเมินความเครียดด้านการเลี้ยงดู (PSS) แบบรายงานของพ่อแม่เรื่องพฤติกรรมการเลี้ยงดู (PR) และแบบประเมินความซึมเศร้าของเบค (BDI-II) วิเคราะห์ข้อมูลด้วยสถิติเชิงพรรณนา ทดสอบความสัมพันธ์ระหว่างตัวแปรด้วยไคสแควร์และสเปียร์แมน

ผลการวิจัยพบว่า 1) มารดารายงานว่าเด็กมี อาการทางอารมณ์มากที่สุดร้อยละ 37.8 รองลงมาคือสมาธิสั้น ปัญหาพฤติกรรม และปัญหากับเพื่อน (ร้อยละ 27.3, 18.9 และ 16.1) ตามลำดับ และ 2) ความสามารถทางการเรียน สิ่งแวดล้อมครอบครัวมิติความสัมพันธ์ มีความสัมพันธ์ทางลบกับปัญหาสุขภาพจิตเด็ก ในขณะที่ความเครียดด้านการเลี้ยงดูของมารดา มีความสัมพันธ์ทางบวกกับปัญหาสุขภาพจิตระดับต่ำ ($r = -.177, -.176, .173$, $p < .05$ ตามลำดับ) เมื่อพิจารณาปัญหาสุขภาพจิตรายด้าน พบว่าอายุ มีความสัมพันธ์ทางลบระดับต่ำกับปัญหากับเพื่อน ($r = -.162$, $p < .05$) พฤติกรรมการเลี้ยงดูของมารดามีความสัมพันธ์ทางลบกับอาการทางอารมณ์ ($r = -.287$, $p < .05$) และมีความสัมพันธ์ทางบวกกับพฤติกรรมเกเร และสมาธิสั้นระดับต่ำ ($r = -.287$, $p < .05$) ในขณะเดียวกัน ภาวะซึมเศร้าของมารดามีความสัมพันธ์ทางบวกกับอาการทางอารมณ์ และสัมพันธ์ทางลบ และสมาธิสั้น ระดับต่ำ ($r = .236$, $r = -.158$, $p<.05$)

การค้นพบครั้งนี้ แสดงว่าพยาบาลจิตเวชและสุขภาพจิตที่เป็นเด็กควรให้ความสำคัญในการช่วยเหลือเด็กวัยเรียนที่มีปัญหาสุขภาพจิตเด็กอายุน้อยในด้านอาการทางอารมณ์และพฤติกรรมเกเรยิ่งกว่านั้น พยาบาลควรมุ่งส่งเสริมสิ่งแวดล้อมครอบครัวมิติความสัมพันธ์กับลดความเครียดของมารดา และภาวะซึมเศร้าของมารดา

สาขาวิชา พยาบาลศาสตร์ ลายมือชื่อนิสิต .....

ปีการศึกษา 2558 ลายมือชื่อ อ.ที่ปรึกษาหลัก .....

ลายมือชื่อ อ.ที่ปรึกษาร่วม .....

5677233636 : MAJOR NURSING SCIENCE
KEYWORDS: MENTAL HEALTH PROBLEMS / SCHOOL-AGED CHILDREN

FAUZAN SAPUTRA: SELECTED FACTORS RELATED TO MENTAL HEALTH PROBLEMS IN SCHOOL-AGED CHILDREN WITH MENTAL HEALTH PROBLEMS IN ACEH PROVINCE, INDONESIA. ADVISOR: ASSOC. PROF. JINTANA YUNIBHAND, Ph.D., CO-ADVISOR: SUNISA SUKTRAKUL, Ph.D., 143 pp.

Aceh is one of provinces in Indonesia which indicated highest prevalence of mental health problems in adult population, but little is known about mental health problems (MHP) in school-aged children, whereas the problems are being concerned in Indonesia. The purposes of the study were 1) to describe mental health problems and each dimensions in school-aged children and 2) to investigate relationship of selected factors, i.e. gender, age, academic competence, social competence, family income, family environment-relationship dimension, maternal parenting stress, maternal parenting behavior, and maternal depression with MHP in school-aged children with MHP in Aceh province, Indonesia.

A total 143 school-aged children with mental health problems from nine selected elementary schools in three sub-districts and their mothers were recruited based on inclusion criteria. The research instruments included SDQ, the Demographic questionnaire, Social Competence Questionnaire (SCQ), The Brief Family Relationship Scale (BFRS), Parental Stress Scale (PSS), Parent's Report on parenting behavior (PR), and Beck Depression Index II (BDI-II). Descriptive statistics and Spearman correlation were used to analyse descriptive data and to test the relationship among variables.

Findings revealed that: 1) mothers rated MHP in their children at an abnormal level (x= 17.66 SD = .978), and children experienced emotional symptoms (37.8 percent) more than other dimensions, then, hyperactivity, conduct problem, and peer problem (27.3, 18.9 and 16.1 percent), respectively. 2) Academic competence, family environment-relationship dimension had negative relationship, whereas, maternal parenting stress had positive relationship with MHP at low level ($r = -.177, -.176, r = .173, p < .05$) respectively. Considering each dimension, age had negative relationship with peer problem at a low level ($r = -.162, p < .05$). Maternal parenting behavior had negative relationship with emotional symptoms ($r = -.287, p < .05$) and had positive relationship with conduct problem and hyperactivity at a low level ($r = .162, r = 143, p < .05$) respectively. Meanwhile, maternal depression had positive relationship with emotional symptoms and negative relationship with hyperactivity at a low level ($r = .236, r = -.158, p < .05$) respectively.

These findings demonstrated that child psychiatric mental health nurses should give special attention to assist young school-aged children with MHP in the aspect of emotional symptoms, and conduct problem. Moreover, nurses should aim to improve family relationship and reduce maternal parenting stress and maternal depression.

Field of Study: Nursing Science
Academic Year: 2015

Student's Signature .....
Advisor's Signature .....
Co-Advisor's Signature .....

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INTRODUCTION

Background and significance of the study

A child is defined as a young human being below the age of puberty or below the legal age of majority (Oxford Dictionaries, 2014). Having encountered the stage of growth and development, on one hand, children will experience dramatic physical changes, but on the other hand, their inner world is still immature. This situation puts mental health of children as one of vulnerable aspects of their lives. Mental health, as other health aspects, plays important role for human being because it may influence individuals from the beginning of their lives. Fortinash and Holoday-Worret (2008) mentioned that mental health is how individual demonstrates the perceptions, thoughts, emotions and behaviors in type, quantity and quality. Meanwhile, mental disorder is diagnosed when the individual meets the criteria or specific indicators of psychiatric disorder.

In order to define mental health problem in children is not as easy as physical problem, some psychiatrist defines it as “mental illness” and “mental disorder”, but British Medical Association (BMA) tends to use “mental health problem” to reflect the difficulties and/or disabilities of children for having a personal relationship, psychological development, the function of playing and learning and in distress and maladaptive behavior (BMA, 2006). Furthermore, the BMA mentioned that mental health problems cover not only a broad spectrum of condition from diagnosable disorders but also the manifestation of behaviors. It is implied that mental health problem in children covers both of internalizing (emotional) and externalizing (behavioral) symptoms and it can be observed through their behavior, even some parents may not aware of the behavioral changes.

School-aged children are children with an age range from 6 to 12 and they are identified as students because they will experience the school environment for the first time (Hockenberry and Wilson, 2009). The study in school-aged children is important because Centers for Disease Control and Prevention (2014) mentioned that school age is one of period with significant changes of children, because they need to be more

independent from the family and they will have more friends to help and support their activities. In school-aged period, children will experience broader interaction with teachers and classmates, and teacher may be the first person who realize that something uncommon occurs in children (Yearwood, Pearson and Newland, 2012), because mostly the symptoms of mental health problems are easy to be observed in this period and the impact of the problems is not only affect the physical, emotional and cognitive aspects of school-aged children, but also other significant persons (Stuart, 2009).

Some studies indicated that school-aged children with mental health problem tend to continue into adolescence and adulthood, and it may predict later difficulties such as early substance use, smoking and bipolar disorder, even suicide and get involved in criminal activities such as traffic and drunk driving offenses, violence, damage property, drug-related crimes and pornography (Aebi et al, 2014; Biederman, 2008; Consoli et al, 2013; King, Iacono and McGue, 2004).

Interestingly, even both of mental health problems have significant effects, but parents may feel more anxious of behavioral problems than emotional problems in school-aged period because the impacts of behavioral problems directly affect parents and they tend to refer their children to seek professional help from health providers (Reddy and De Thomas, 2007). Parents may think that symptoms such as hyperactive behavior or conduct problem are perceived more dangerous and affect others than anxiety or depression. In other words, by helping school-aged children with mental health problems, we may help significant others, such as parents, grandparents, siblings, teachers and friends. Moreover, the number of mental health problems in this population becomes a global phenomenon and increased by year (Perou et al., 2013).

In addition, Perou et al. (2013) mentioned that in the United States, a total of 13% – 20% of children experienced mental health problems and surveillance during 1994–2011 has shown the prevalence of mental health problems in this population to be increased year by year, behavioral problem was reported frequently than emotional problems. In contrast, the data were taken from the 2007 National Survey of Children Health revealed that school-aged children in the USA were diagnosed with emotional problems higher than behavioral or conduct problems for 8% and 5.4% respectively (Ghandour et al, 2012). This finding proved that mental health problems in the child

population, especially in school-aged children, may have different type of mental health problems in different group of ages. Following the trend in the USA, the study of 51 Asian countries revealed that 10-20% of the child and adolescent's population in Asia also showed the general prevalence of mental health problems (Srinath, Kandasamy and Golhar, 2010). As one of countries in Asia, the situation of mental health problems in school-aged children in Indonesia is expected to follow the similar trend in the USA and other countries in Asia.

In 2011, Kementerian Pemberdayaan Perempuan dan Perlindungan Anak (Kementerian PP & PA, 2011) Republik Indonesia or ministry of women empowerment and child protection of Indonesia released a policy about children with mental health problems. In the policy, children with mental health problems is also included as one of specifications of children with special needs, defined as children with limitation of physical, mental, intellectual, social and emotional, that affect to the growth and development process of children significantly. Interestingly, even the Indonesian government mentioned that children with mental health problems as one of the important issues that needed to be solved, but the survey about this population has not been conducted yet in Indonesia (Kementerian PP & PA, 2011). Unfortunately, mental health problems in school-aged population are being concerned in Indonesia. Although there is no clear evidence to support mental health problems and their related factors among school-aged children in Indonesia, findings of Komisi Perlindungan Anak Indonesia (KPAI) or child protection agency may reflect these problems. KPAI found that many school-aged children in Indonesia involved in violence and conducts against the law as victims and abusers for 53% and 43%, respectively and increasing number of bullying that occurred at the school environment for 32% (Erlinda, 2014). Regarding of these gaps of knowledge, Kementerian PP and PA (2011) mentioned that, this situation makes the government of Indonesia is difficult to set the regulation and intervention to minimize and prevent mental health problems in school-aged children. However, WHO had estimated that 10% of child population are suffering from mental health problems at any one time (Mental Health Foundation, 2014), by using this estimation, the prevalence of school-aged children who experience mental health problems in Indonesia should be approximately 4.2 million persons, out of 42 million of Indonesian school-aged

children (Harnowo, 2013). As one of dynamics province in Indonesia, Aceh province is also experiencing the same situation about mental health problems.

Aceh is one province in Indonesia that has never stopped volatile. In the past, there was a vertical conflict between central government and some group of separatist. The conflict started from 1953; eight years after Indonesia declared its independence day. The conflict lasted until massive earthquakes and Tsunami hit Aceh province in 2004. Many of Acehnese became victims and remain in trauma because of prolonged conflict and natural disasters. Nowadays, Acehnese are involved in horizontal conflict between former combatants' circle of power. This situation makes Aceh is known for never ending conflict province in Indonesia (Wiratmadinata, 2014). As the consequences, many Acehnese have a risk for mental health problems.

Based on the data of Riset Kesehatan Dasar (Riskesdas) or basic health research survey, that was conducted by Pusat Penelitian dan Pengembangan Kesehatan (Puslitbankes) revealed that, Aceh province is the only one province in Sumatera Island, which showed a higher prevalence of adult population with mental health problems such as psychosis, anxiety and depression (Puslitbankes, 2013). Specifically, the study was conducted during January to May 2007 revealed that thousands of Acehnese were suffering from mental health problems for 5,389 cases of schizophrenia, depression and anxiety ("pelita", 2014). The number of mental health problems in adult is an important key to investigate mental health problems in school-aged children, because it can help us to evaluate risk factors for later mental health problems among these children (Copeland et al., 2010).

As adult mental health problems that can be reflected from mental health problems in school-aged children, Copeland et al. (2010) mentioned that there were two ways how mental health problems in school-aged children predict mental health problems in adult; 1) homotypic prediction, for the situations such as overanxious disorder predicted panic disorder, separation anxiety disorder predicted agoraphobia without panic and generalized anxiety disorder predicted agoraphobia without panic and 2) heterotypic prediction for the situation such as childhood oppositional defiant disorder predicted young adult depression and childhood depression predicted panic disorder without agoraphobia and generalized anxiety. Furthermore, depression as the

result of mental health problems in school-aged children also predicted suicide in adolescence and adulthood (Sourander et al, 2009). In short, mental health problems in adolescence and adulthood may derive from undetected and untreated mental health problems in school-aged period. Therefore, based on one million of school-aged population in Aceh (Badan Pusat Statistik Provinsi Aceh, 2014), there are 100,000 of school-aged children are estimated to experience mental health problems in Aceh. The number of mental health problems in school-aged children in Aceh may increase in the future, because both of vertical and horizontal conflicts are still occur in Aceh, and lots of adult population is suffering from mental health problems, and children, especially school-aged children may experience the same problems as adult. That is why, it becomes the responsibility of parents, teachers, and mental health worker, especially physicians and psychiatric nurses in Aceh province and Indonesia.

Based on the reports of Rumah Sakit Jiwa Aceh (RSJ Aceh) or psychiatric hospital of Aceh (2015), the total number of nurses who works in the hospital is 189 nurses, but mostly the educational nursing background is diploma nursing. Specifically, the number of child psychiatric nurse is not mentioned clearly, including the standard of nursing competencies for nurses, and the nursing services of In Patient Department (IPD) and Out Patient Department (OPD) are still unclear. This situation support the conclusion that, mental health problems in children population, especially school-aged children in Aceh province is still not considered as important as mental health problems in adult population. Therefore, the study about factors related to mental health problems in school-aged children should be promoted in Aceh province, in order to set the appropriate prevention and intervention to minimize the number of mental health problems in adult population.

The review of the literature on mental health problems in school-aged children confirms that mostly, there are three important factors influencing mental health problems in school-aged children with mental health problems: *1) children's factors* such as age (Bayer et al, 2011; Chabra, Chavez and Harris, 1999; Lesesne, Visser and White, 2003; Mendes, Crippa, Souza and Loureiro 2012), gender (Chabra, Chavez and Harris, 1999; Davis et al, 2010; Gothelf et al, 2006; Leadbeater, Kuperminc and Blatt, 1999; Lesesne, Visser and White, 2003; Rodriguez et al, 2011), social competence (Bornstein, Hanh and Haynes, 2010; Cole, Martin, Powers and Truglio,

1996; Larsson and Frisk, 1998; Rolf, 1972; Sallquist et al, 2009), academic competence (Cole, Martin, Peeke, Seroczynski and Fier, 1999; Cole, Martin, Powers and Truglio, 1996; Moilanen, Shaw and Maxwell, 2010), *2) parent factors*; maternal depression (Bordin et al, 2009; Darunee Ngamkum, 2013; Hancock et al, 2013; Lesesne, Visser and White, 2003; Lyons-Ruth, Easterbrooks and Cibelli, 1997; Mendes et al, 2013; Nantacha Sanguenkulchai, 2013; Whitaker, Orzol and Kahn, 2006), maternal parenting behavior (Alizadeh, Applequist and Coolidge, 2007; Aunola and Nurmi, 2005; Bayer et al, 2011; Ellis and Nigg, 2009; Moghaddam et al 2013; Yousefia, Far and Abdolahian, 2011), maternal parenting stress (Harvey, 2000; Williford, Calkins and Keane, 2007; Yousefia, Far and Abdolahian, 2011), and *3) family factors;* family income (Beiser et al, 2002; Bordin et al, 2009; Davis et al, 2010; Rodriguez et al, 2011) and family environment-relationship dimension (Nantacha Sanguenkulchai, 2013; Van Loon et al, 2013; Vatcharin Wuthironarith, 2013; Wang et al, 2014).

However, there was no research found, which investigated factors related to mental health problems in Indonesian school-aged children's population. The understanding of cultural differences is important for nurses, because the existing knowledge from other countries may be appropriate or inappropriate to apply in Indonesia context. Therefore, nursing research on the factors related to mental health problems in school-aged children with mental health problems in Indonesia is needed to fulfill the gap of knowledge. As presented previously, psychiatric nurses have a responsibility to clarify and explore factors related to mental health problems in school-aged children with mental health problems because it will be helpful to improve nursing practice and may increase the quality of services for school-aged children with mental health problems in Indonesia. The awareness and comprehension of nurses will be improved and they may conduct effort to care for this population and involved in policy initiation for school-aged children with mental health problems. The data are also valuable for further nursing research, especially for mental health problems of school-aged children in Indonesia.

Research questions

What are the incidences of mental health problems and its dimensions, such as emotional symptoms, conduct problems, hyperactivity, and peer problem, and factors related to mental health problems in school-aged children with mental health problems in Aceh province, Indonesia?

Purposes of the study

1. To study mental health problems and its dimensions, such as emotional symptoms, conduct problems, hyperactivity and peer problem in school-aged children in Aceh province, Indonesia.

2. To study the relationship between age, gender, social competence, academic competence, maternal depression, maternal parenting behavior, maternal parenting stress, family income, family environment-relationship dimension and mental health problems in school-aged children in Aceh province, Indonesia.

Research hypotheses and rationales

Based on literature review related to mental health problems in school-aged children with mental health problems, the factors of school-aged children, factors of parents, and factors of family were to be identified as significant factors. Factors of school-aged children such as age, gender, social competence and academic competence, as well as, maternal depression, and factors of parents such as maternal parenting behavior and maternal parenting stress, also factors of family such as family income and family environment-relationship dimension have been associated with mental health problems in school-aged children with mental health problems. There are research hypotheses and the rationales setting in nine statements as follows:

1) Age is presumed to have positive relationship with mental health problems in school-aged children with mental health problems.

Rationale: School-aged children are defined as children with age range starts from 6 to 12; children within this period may experience emotional problems due to height and weight changes, rapid or slow growth, and other important issues relating

development of children (Hockenberry and Wilson, 2009). In addition, as cognitive change, the perception of school-aged children will be influenced by several factors.

By increasing of age, the number of a friendship network of school-aged children will be increased and this situation makes children's perception will be determined based on peer's perception and popular culture among their friends, so that is why, it is very important for them to follow the trend of their friends to be more socially accepted (Eccles, 1999; Feiring and Lewis, 1991; Ozterich and Bowman, 2001). In this situation, school-aged children perceive that their friends' perception is very important and this may lead them to mental health problems when they cannot perform as their friends' expectation. Furthermore, Hay (2005) mentioned that school-aged children who show pro social behavior are perceived easier to be accepted than others with mental health problems. Once when children are labeled with mental health problems with their friends, they will be rejected in the group and receive negative treatment by peers (Hoza, 2008). For school-aged children with mental health problems, group acceptance is also important because when they are rejected by the group; their conditions may become worse. So, it was found that age of school-aged children associated with mental health problems. In other words, the older school-aged children have a greater risk for mental health problems (Bayer et al, 2011; Chabra, Chavez and Harris, 1999; Lesesne, Visser and White, 2003; Mendes, Crippa, Souza and Loureiro 2012).

Therefore, age of school-aged children is presumed to have positive relationship with mental health problems in school-aged children with mental health problem.

2) Gender is presumed to have relationship with mental health problems in school-aged children with mental health problems.

Rationale: Both of gender, male and female, are at the same risk of mental health problems in the school-aged children with mental health problems, even mostly the studies found that males have a greater risk for externalizing problems compared to females with internalizing problems (Davis et al, 2010; Gothelf et al, 2006; Leadbeater, Kuperminc and Blatt, 1999; Lesesne, Visser and White, 2003; Rodriguez et al, 2011). In contrast, study of Chabra, Chavez and Harris, (1999) found that male showed more internalizing problems than female, 67.3% and 32.7% respectively.

Thus, gender is presumed to have relationship with mental health problems in school-aged children with mental health problems.

3) Social competence is presumed to have negative relationship with mental health problem in school-aged children with mental health problems.

Rationale: The meaning of friends and the feeling of accepted by a group of friends is very important for school-aged children (Ball, Bindler, and Cowen, 2010). To be recognized and succeed as the member of the group, school-aged children should have a set of skills and behaviors when having interaction with others and this term is defined as social competence (Blumberg, Carle, O'Connor, Moore, and Lippman, 2008). Previous studies found that social competence associated with mental health problems in school-aged children with mental health problems. School-aged children with mental health problems tended to have lower social competence (Achenbach and Edelbrock, 1981; Cole, Martin, Powers and Truglio, 1996; Larsson and Frisk, 1998; Rolf, 1972; Sallquist et al, 2009).

Therefore, social competence is presumed to have negative relationship with mental health problems in school-aged children with mental health problems.

4) Academic competence is presumed to have negative relationship with mental health problems in school-aged children with mental health problems.

Rationale: Cognitive development in school-aged children may reflect academic competence; the abilities such as mathematics and language increase during this period (Hockenberry and Wilson, 2009). That is the reason why academic competence in school-aged children is mostly measured by the ability in both mathematics and language. The previous studies found that school-aged children with mental health problems tended to have lower academic competence (Cole, Martin, Peeke, Seroczynski and Fier, 1999; Cole, Martin, Powers and Truglio, 1996; Rolf, 1972). Study of Moilanen, Shaw and Maxwell (2010) found that externalizing behavior has a relationship with academic competence in school-aged children.

Therefore, academic competence is presumed to have negative relationship with mental health problems in school-aged children with mental health problems

5) Maternal depression is presumed to have positive relationship with mental health problems in school-aged children with mental health problems.

Rationale: One of the important aspects that needed to be detected earlier to enhance prevention effort is maternal mental health, because it related to mental health problems in children (Rishel et al., 2006). To be more specific, mother with depression has more association with mental health problems in school-aged children with mental health problems (Bordin et al, 2009; Darunee Ngamkum, 2013; Hancock et al, 2013; Lesesne, Visser and White, 2003; Lyons-Ruth, Easterbrooks and Cibelli, 1997; Mendes et al, 2013; Nantacha Sanguenkulchai, 2013; Olives et al, 2013; Whitaker, Orzol and Kahn, 2006). In addition, it will be important for mental health teams to identify depression in the mother because it may help to conduct prevention and early detection for school-aged children with mental health problems (Mendes et al, 2011).

Thus, maternal depression is presumed to have positive relationship with mental health problems in school-aged children with mental health problems.

6) Maternal parenting behavior is presumed to have positive relationship with mental health problems in school-aged children with mental health problems.

Rationale: Behavior of parents cannot be separated from their parenting style. Parenting behavior is defined as set behavior of parents that are performed toward their children, such as monitoring behavior, nurturance behavior, and discipline behavior (Statistics Canada, 2011). Mothers of children with mental health problems tended to be more authoritarian and use corporal punishment to discipline their children and performed inconsistent discipline and less respect for their autonomy (Alizadeh, Applequist and Coolidge, 2007; Aunola and Nurmi, 2005; Bayer et al, 2011; Ellis and Nigg, 2009, Moghaddam et al 2013; Yousefia, Far and Abdolahian, 2011).

Therefore, maternal parenting behavior is presumed to have positive relationship with mental health problems in school-aged children with mental health problems.

7) Maternal parenting stress is presumed to have positive relationship with mental health problems in school-aged children with mental health problems.

Rationale: Stress is consequences when people suffering from inconvenient situation or condition that may affect people's health physically and mentally (Maldonado, 2014). Parenting stress is the statement of parents to describe their feelings and

perceptions about the experience of being parents and child-parent relationship (Berry and Jones, 1995). In Addition, mothers of children with mental health problems will experience more parenting stress (Harvey, 2000; Williford, Calkins and Keane, 2007; Yousefia, Far and Abdolahian, 2011).

Thus, maternal parenting stress is presumed to have positive relationship with mental health problems in school-aged children with mental health problems.

8) Family income is presumed to have negative relationship with mental health problems in school-aged children with mental health problems.

Rationale: Some previous studies revealed that mental health problems have an association with family income, especially in low income family. Low family income was reported as one stressor in the family with mental health problems and it related to mental health problems in school-aged children (Beiser et al, 2002; Bordin et al, 2009; Davis et al, 2010; Rodriguez et al, 2011; Santoso, 2004).

Therefore, family income is presumed to have negative relationship with mental health problems in school-aged children with mental health problems.

9) Family environment-relationship dimension is presumed to have negative relationship with mental health problems in school-aged children with mental health problems.

Rationale: The environment is defined as surroundings or conditions in which person, animal, or plant lives or operates (Oxford Dictionaries, 2015). In a family environment, the focus on the environment is a social environment, or the way how the family member interacts with other family member in order to achieve and maintain desirable goals of the family (Moos and Moos, 1986). In addition, there are three dimensions of family environment, such as relationship dimension, personal growth dimension, and system dimension. Previous study revealed that family environment relationship dimension associated with mental health problems in school-aged children (Nantacha Sanguenkulchai, 2013; Van Loon et al, 2013; Vatcharin Wuthironarith, 2013; Wang et al, 2014).

Thus, family environment-relationship dimension is presumed to have negative relationship with mental health problems in school-aged children with mental health problems.

Hypotheses

The hypotheses for this study, including:

1. There is a positive relationship between age and mental health problem in school-aged children with mental health problems.

2. There is a relationship between gender and mental health problem in school-aged children with mental health problems.

3. There is a negative relationship between social competence and mental health problems in school-aged children with mental health problems.

4. There is a negative relationship between academic competence and mental health problems in school-aged children with mental health problems.

5. There is a positive relationship between maternal depression and mental health problem in school-aged children with mental health problems.

6. There is a positive relationship between maternal parenting behavior and mental health problem in school-aged children with mental health problems.

7. There is a positive relationship between maternal parenting stress and mental health problem in school-aged children with mental health problems.

8. There is a negative relationship between family income and mental health problems in school-aged children with mental health problems.

9. There is a negative relationship between family environment-relationship dimension and mental health problems in school-aged children.

Scope of the study

The target population of this study is school-aged children with mental health problems. In order to capture a full comprehension of phenomenon, the data will be gathered from the school-aged children with mental health problems and mothers of school-aged children with mental health problems in Aceh province, Indonesia. The dependent variable in this study is mental health problems and independent variables are selected factors related to school-aged children with mental health problems; age, gender, social competence, and academic competence, maternal depression, maternal parenting behavior, maternal parenting stress, family income and family environment-relationship dimension.

Operational definition

Mental health problems defined as set of behaviors or difficulties as perceived by mothers of school-aged children with mental health problems. It comprises of four dimensions as follow: emotional symptoms, conduct problem, hyperactivity, and peer problem. **Emotional symptoms** defined as a number of inner children's difficulties by often complains of headaches, stomachaches, or sickness, many worries or often seems worried, often unhappy, depressed or tearful, nervous or clingy in new situation, easily loses confidence, many fears, easily scared, and often loses temper, meanwhile **conduct problem** defined as behavioral difficulties of the children for having these following characteristics: generally less of well-behaved, usually does not do what adult request, often fights with other children or bullies them, often lies or cheats. **Hyperactivity** defined as attitude difficulties of children by showing these characteristics: restless, overactive, cannot stay still for long, constantly fidgeting or squirming, easily distracted, concentration wanders, does not think things out before acting, short attention span, does not see chores or homework through to the end and **peer problem** defined as several difficulties of children when having interaction with their friends by exhibiting: rather solitary, prefers to play alone, does not has at least one good friend, generally does not liked by other children, gets along better with adults than other children. For this research, mental health problems was measured by an Indonesian version of Strength and Difficulties Questionnaire (SDQ), calculated by total difficulties score of emotional symptoms, conduct problems, hyperactivity and peer relationship problems (Goodman, 1997).

Age defined as the chronological number of years living since birth of school-aged children with mental health problems. It was measured by the personal information sheet (student) that is developed by researcher.

Gender defined as sex characteristic, male or female, of school-aged children with mental health problems. It was measured by the personal information sheet (student) that is developed by researcher.

Social competence defined as the ability to develop and maintain friendship perceived by school-aged children with mental health problems. It characterized by following actions: to make friends, to make their classmate like them, to make more friends, understand how to get peers accept them and become popular among their

friends. It was measured by the Indonesian version of the social competence questionnaire [SCQ] (Harter, 1982/2012), translated into Bahasa Indonesia by a researcher.

Academic competence defined as the numerically quality of academic capability of school-aged children with mental health problems. It was measured by cumulative Grade Point Average (GPA) that is earned in last one year based on student's report book.

Maternal depression defined as uncomfortable feeling and mood perceived by mothers of school-aged children with mental health problems. It characterized by having depressed mood, feelings of guilt and worthlessness, feeling of helplessness, and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance of the mothers in Aceh province, Indonesia. It was measured by the Indonesian version of Beck Depression Index II (BDI-II) that was translated by Ginting et al. (2013).

Maternal parenting behavior defined as specific child rearing practice perceived by mothers of school-aged children with mental health problems. It comprises of five dimensions as follow: respect for autonomy, control through guilt and anxiety, consistency, child centeredness, and parental temper and detachment. It was measured by the Indonesian version of Parent's Report (PR) questionnaire (Cohen et al, 1977), translated into Bahasa Indonesia by a researcher.

Maternal parenting stress defined as inconvenient experience of being parent perceived by mothers of school-aged children with mental health problems, and it includes roles, relationship, affection, and responsibility. It was measured by the Indonesian version of the Parental Stress Scale [PSS] (Berry and Jones, 1995), translated into Bahasa Indonesia by a researcher.

Family income defined as the financial condition of the family perceived by mothers of school-aged children with mental health problems. It represented by the monthly family income of fathers and mothers of school-aged children with mental health problems. It based on minimum income in Indonesia that was set by Badan Pusat Statistik (BPS) or statistic center agency of Indonesia. It was measured by income question in personal information sheet that was developed by researcher.

Family environment-relationship dimension defined as the quality of family connection among family members perceived by mothers of school-aged children

with mental health problems. It covers cohesion, expressiveness, and conflict of family of school-aged children with mental health problems in Aceh province, Indonesia. It was measured by the Indonesian version of The Brief Family Relationship Scale [BFRS] (Fok et al, 2013), translated into Bahasa Indonesia by researcher.

Expected benefits

1. This study will provide a basic knowledge to explain the phenomenon of mental health problems of school-aged children in Aceh province, Indonesia.

2. This study may contribute to body of knowledge of nursing science in Indonesia. The findings will identify factors related to mental health problems in school-aged children with mental health problems in Aceh province, Indonesia. The knowledge may provide important information for nurses to develop appropriate nursing intervention in order to improve the quality of nursing services in Indonesia, especially in Aceh province.

3. Nurses may use the findings of this research and get involved with other health care providers, multidisciplinary teams, and policy maker in policy initiation process and guideline for school-aged children with mental health problems in Aceh province, Indonesia.

4. Nurses will be able to use the finding of this research to develop future research and nursing intervention for school-aged children with mental health problems in Aceh province, Indonesia.

5. Nurses may help to develop school-based intervention to promote mental health problems in Aceh province, Indonesia.

CHAPTER II
LITERATURE REVIEW

This section focuses on a comprehensive literature review of major concepts of the study. The literature review consists of three parts:

1. School-aged children development related to mental health.
2. Mental health problems in school-aged children in Indonesia
   - 2.1.Definition of mental health and mental health problems
   - 2.2.Risk factors of mental health problems
   - 2.3.Frequently identified mental health problems in school-aged children.
   - 2.4.The impact of mental health problems in school-aged children.
   - 2.5.Mental health service system in Indonesia
     - 2.5.1 Hospital based services
     - 2.5.2 Community based services
   - 2.6 The current situation of school-aged children with mental health problems and nursing services in Indonesia.
3. Factors related to mental health problems in school-aged children
   - 3.1 Age of children
   - 3.2 Gender of children
   - 3.3 Social competence of children
   - 3.4 Academic competence of children
   - 3.5 Maternal depression
   - 3.6 Maternal parenting behavior
   - 3.7 Maternal parenting stress
   - 3.8 Economic status
   - 3.9 Family environment-relationship dimension

1. School-aged children development related to mental health

Children age 6 to 12 is categorized as school-aged children, because children start to have school environment and broader scope of interaction, so this may impact to their development and social activity (Hockenberry and Wilson, 2009). During this period, children have to perform an appropriate attitude and behavior towards teachers and friends in order to achieve desired academic and social competence and be recognized and accepted in their peer group. As challenging task of school-aged children, children in this age tend to be vulnerable group of children for mental health problems. There are some developmental tasks of school-aged children that are need to be fulfilled in order to prevent mental health problems, especially for psychosocial and cognitive development.

Psychosocial development is important for school-aged children in order to achieve healthy personality. Erickson categorized school-aged children for Industry vs. Inferiority. A sense of industry is also known as a stage of accomplishment; school-aged children are motivated to develop and master new skills and participate in useful and meaningful social work. They tend to be engaged in individual working to complete tasks, and they may feel satisfaction when they are successfully manipulate and explore their environment and from their interaction with peers. When school-aged children achieve and perform new skills, they will be accepted in social life by their peers, and they tend to show desired social competence. In addition, school-aged children also need encouragement and stimulation, in order to maintain their social competence, including reinforcement in the form of grades, material rewards, additional privileges, and recognition (Hockenberry and Wilson, 2009).

In contrast, if the children cannot achieve their desired tasks, they may feel a failure and leads to the feeling of inferiority (Yearwood, Pearson and Newland, 2012). Actually, a sense of inferiority is not only occurring in children with mental health problems, but also in children without mental health problems. This is possible, because social skill is also a part of learning process, and they will not be able to master every skill they attempt, and they may experience feelings of inadequacy in some areas. But, the situation may become worse for school-aged children with mental health problems, because they cannot achieve some certain skills and it may related to reward structure. In school-aged children with mental health problems, the

reward structure is based on evidence of mastery, they tend to difficult to develop the skills, so they have more risk for inadequate and inferior feelings. Having experienced of inferiority, the children may encounter to mental health problems, especially behavioral problems, and this is including their academic skill.

The second important development for school-aged children is cognitive development. Piaget mentioned that, school-aged children experience concrete cognitive development (Yearwood, Pearson and Newland, 2012). During this period, children will have more logical and well-organized thinking. It will be easier for them to describe the concept by observing the real object. For example, children are easy to explain about a bear by giving them a bear doll instead of giving a description. This is the way how school-aged children perform their logical reasoning and concept formation, so they do not make judgments based on what they see, but based on the reason. Hockenberry and Wilson (2009) explained that, in school-aged period, children learn about the simple mathematics problems and the alphabet and its symbols called *word*. During this period, children improve their ability to read, one of important skills that they need to master in order to expand their knowledge by imagination and exploration of their environment.

Having had desired cognitive development, school-aged children may have an opportunity to achieve appropriate academic competence. School-aged children who are easy to perform their task and conduct their homework, especially for some difficult subject, such as mathematics, physics, and chemistry, may socially recognized. As of one encouragement and stimulation factors, children who get good grades in their report's book will achieve social acceptance from their friends. Having had academic recognition by peers, they may improve their relationship with their friends; their friends may ask them to join and help in learning group. But, when they cannot achieve desired academic competence, they will not socially recognized by their friends and they may put out of the group and receive peer rejection. In specific, school-aged children with mental health problems may experience difficulties to achieve the desired cognitive development; they may experience problems of academic and social competence. The attention from mother and especially teacher is needed, in order to help this group to improve their tasks as school-aged children for both social and academic competence.

As conclusion, in school-aged period, children are eager for the real achievement. They are socially achieved and academic recognized by their peers when they successfully master and perform the tasks by themselves, including achievement of good grades for some difficult subjects, and when they cannot complete the tasks, they may have the feeling of inferiority, and this situation may lead them for mental health problems.

2. Mental health problems in school-aged children

In order to define mental health problems in children, nurses should know that children are different based on their age and their developmental tasks. In school-aged children, they need to achieve an appropriate performance level of academic competence as well as social competence. Both of these competencies are important for school-aged children because they related to each other and may promote the success of developmental tasks for the children as students (Welsh, Parke, Widaman and O'Neil, 2001). Considering the number of school-aged children with mental health problems around the world, it is very important to know factors related to mental health problems, because the study of Fryers and Brugha (2013) found that mental health problems in childhood may appear and become worse in adulthood if the program of detection, prevention, and health promotion are not initiated.

Having known the situation, it is important to differentiate the definition of mental health, mental illness and mental health problems, because those of terms are different and the comprehension about the meaning of terms may increase the understanding of the psychiatric nurse's scope of responsibility, such as detecting, preventing, and promoting mental health as a part of nursing intervention in school-aged children with mental health problems in Aceh province, Indonesia.

2.1 Definition of mental health and mental health problems in school-aged children

Mental health or psychological aspect is another dimension of human being as important as a physical dimension. It may affect not only the physical aspect of human health's dimension, but also social and spiritual aspects in order to maintain

the balance of healthy life. Mental health is the successful effort of human to achieve appropriate mental functions such as valuable activities, meaningful relationship with others, adaptation and coping ability to the stresses that usually occur in life (Mohr, 2009). People will exhibit better performance of mental health when they feel comfortable in activities in their social group and satisfy with the achievements. People with good mental health condition will be reflected by rational thinking in making decision, effective communication with others, effective learning of new experiences, and resilience ability after unpleased situations. In contrast, people with unhappiness feeling regarding their achievements in life are difficult to start and maintain relationship with others; they tend to have negative adaptation and put them at the risk of mental health problems. Mental health problems are not diagnosed; it is the way to describe people with unsuccessful development tasks. In order to be successful in the school age period, children also need to fulfill some of developmental tasks.

Based on theories of developmental tasks, school-aged children need to fulfill their desirable activities in order to achieve the concept of successful in mental health definition. School-aged children need to perform some of activities based on developmental theories as follows (Kyle, 2008):

1. *Erikson theory*; including increased activities related to personal and peers such as learning activities to increase knowledge and outdoor activities with friends to increase social skill of them, but support is also important when they cannot successfully perform their activities.

2. *Piaget theory*; even older school-aged children think more abstract than younger school-aged children, but in general school-aged children still have concrete thinking about cognitive development, it means school-aged children need to achieve their concrete thinking ability by providing concrete object and learn the characteristics and relationships of the objects.

3. *Kohlberg theory*; school-aged children show conventional moral stage, in younger school-aged children, they treat behavior as right or wrong, and wrong behavior means punishment. They also tend to perform behaviors against the rules because they do not understand the reason behind the rules. In contrast, older school-

aged children are able to judge and act by intentions not its consequences, they understand and accept the concept of treating others as they would like to be treated.

4. *Freud theory*, school-aged children enter the latency stage, they focus on developing social and cognitive skills by making friends with the same sex friends and involving in same sex group activities.

In conclusion, there are four theories may explain about developmental tasks of school-aged children; Erikson, Piaget, Kolhberg and Freud theory. They are mentioned successful school-aged children if they can achieve all of the developmental tasks, but when the school-aged children are unable to perform their desired tasks based on their developmental stage, they start to indicate of mental health problems.

British Medical Association (2006) mentioned that mental health problems in school-aged children is the conditions when school-aged children tend to have difficulty in personal relationship, psychosocial development, learning, and appropriate behaviors. The definition refers to two broad dimensions of difficulties such as emotional problems (internalizing symptoms) and behavioral problems (externalizing symptoms). The term of internalizing symptoms reflects the problems in the children, such as anxiety and depression, and these problems may not affect others directly, meanwhile the term of externalizing symptoms reflects the problems outside the children, such as hyperactivity and conduct problems, and these problems may affect others directly, especially parents and grandparents, friends, teachers, neighbors, and in some cases, school-aged children exhibit conducts against the law.

2.2 Risk factors of mental health problems in school-aged children

There is no single cause may explain mental health problems in children, especially school-aged children, it usually presents as risk factors. Risk factors of mental health problem in school-aged children defined as conditions or situations that put school-aged children as a vulnerable group for mental health problems. Department for Education United Kingdom (2014) classified risk factors of mental health problems in school-aged children, including child factors, family factors, school factors, and community factors. All of these factors may not single incident, but it may affected by more than one situations from more than one factor, that have

occurred at the same time. Mendes et al (2013) found that school-aged children in a community sample with Depressive Disorder and Generalized Anxiety Disorder (GAD) had more risk for mental health problems when they had more exposure to risk factors compared to school-aged children with lower exposure of risk factors. Having known all of related factors; it gives psychiatric nurses an opportunity to understand the phenomenon of mental health problems in school-aged children.

Furthermore, Department for Education United Kingdom (2014) put several risk factors for mental health problems in school-aged children as follows:

1. Child factors, all of the risk factors that occur in school-aged children, the risk factors may directly or indirectly occur and generate mental health problems. The factors include genetic influences, age and gender of the child, low IQ and learning disabilities, specific developmental delay or Neuro-diversity, communication difficulties and social problem, difficult temperament, physical illness, academic failure, and low self-esteem.

2. Family factors, all of the risk factors that occur in families, and involving parents or siblings that may influence school-aged children for having mental health problems. The factors are such as parental stress, conflict and domestic violence, divorce, inconsistent, or unclear discipline, hostile or rejecting relationships, failure to adapt to changing needs of children, physical, sexual or emotional abuse, parental psychiatric illness, poor family, parental criminality, alcoholism, death and loss, or personality disorder.

3. School factors, all of the risk factors that occur in the school that involving peers and teachers that may affect children to have mental health problems. The factors include bullying, discrimination, breakdown in or lack of positive friendships, deviant peer influences, peer pressure, poor student-teacher relationship.

4. Community factors, all of the risk factors that occur in the community, but indirectly generate school-aged children to suffering from mental health problems. The factors are such as socioeconomic disadvantages, homelessness, disaster, accidents, war or other overwhelming events or discrimination.

Having considered the risk factors of mental health problems in school-aged children; it might be concluded that, there is an interaction among factors and no single factor may explain mental health problems in school-aged children. In the

present study, the researcher will focus on some frequently and repetitively investigated factors from previous studies, such as child factors (gender, age, social and academic competence), and parental and family factors (family income, family relationship, parental psychopathology, parenting behavior and parenting stress).

2.3 Frequently identified mental health problems in school-aged children

Unlike mental health problems in adults, mental health problems in children are more difficult to be detected if the parents are not aware about the behavioral changes of their children. The teacher is an important person that may aware about the misbehaviors that are shown by students in the classroom, and mostly the disruptive behaviors come from the student with mental health problems; this situation brings negative consequences, not only for the affected student, but also for teacher and friends, because the process in the classroom will be interrupted (CBC News, 2014). Having compared to teacher, study of Brown et al. (2006) found that parents failed to detect more than 50% cases of school-aged children with serious mental health problems. This study proves that the teacher is more objective to evaluate children with mental health problems than a parent. Screening of mental health problems in school is also important to differentiate students who really experience mental health problems, because study found that 15 students only showed poor behaviors, but they did not meet the criteria of mental health problems (Johnston, 2014).

Based on *the Classification of Child and Adolescent Mental Diagnoses in Elementary Care*, there are four groups of mental health problems that are frequently occur in school-aged children, they are including hyperactivity and attention problems, conduct and behavior problems, emotional symptoms, and peer problem (Center for Mental Health in Schools at UCLA, 2000).

1. Hyperactivity and Attention problems. The problem with attention during childhood period is one of the most common mental health problems that make parents refer their children to mental health professionals, and frequently reported attention problems in childhood is Attention Deficit-Hyperactivity Disorder or ADHD (Reddy and De Thomas, 2007). American Psychiatric Association (2000) mentioned that inattention behavior and/or together with hyperactivity-impulsivity in childhood is frequently exhibited and may result difficulties in academic, occupational, and

social situations. In the normal situation, younger school-aged children are expected to display such as actively playing games for long periods and impulsively doing something. In the older school-aged children, they engage in social activities and risky behaviors with their friends. In addition, there are different criteria of school-aged children that can be classified with mental health problems. In younger school-aged children, they display talkative, disruptive and interrupting behaviors, such as make annoying noises and bothering others. Meanwhile, in older school-aged children, they become more restless, interrupt and having trouble with other people.

2. Conduct and behavior problems. The most significant behaviors that frequently and repetitively showed in children with conduct problem are violating the basic rights of others and properties, and against societal norms or the law (American Psychiatric Association, 2000). When the children feel frustrated, normally they will exhibit these following behaviors, such as in younger school-aged children show temper tantrums and pounding their fists and screaming, and older school-aged children may hit objects, slam the door or curse the others, but these variations of behaviors do not meet the criteria for conduct problems. The children will classified with conduct problem if they show these following behaviors; in younger school-aged children, they display misbehaviors such as lying, stealing, fighting with peers, rude to both people and animals, engaging in bullying and destructive behaviors, performing inappropriate sexual activity, violating rules and experiencing academic difficulties. In older school-aged children, they may display misbehaviors more frequently and tend to get involved with illegal drug using, school suspending, running from home, violating rules and experiencing academic problems and difficulties with the law.

3. Emotional symptoms. The most reported emotional problems in school-aged children are anxiety, affect and mood problems. The experiences of anxiety in school-aged children are defined as fear and worried feeling about objects or situations that make they cannot live their life like other children. In order to respond to stress, younger school-aged children may experience motor responses of anxiety such as trembling voice, nail biting, and thumb sucking, and physiologic responses such as headache and abdominal pain. In older school-aged children, they may experience feeling afraid of separation from peers and unwilling to start new

experiences. Furthermore, these behaviors reflect that school-aged children experience anxiety, including restlessness, sweating, avoid attending or taking participation in school activities, declining in academic performances, and social competence. School-aged children may also experience sleep disturbances.

There are some differences between of affect and mood problems in children and adult (Brown cited in Center for Mental Health in Schools at UCLA, 1996/2000), such as 1) it may be more difficult to differentiate depression in children than adult because children have diminished vocabulary to explain their feeling and they tend to show the problems through their behaviors such as feeling of hate about themselves and around them, increasing irritability and aggression, experiencing problem with academic and friends, and displaying disruptive behaviors, 2) the characteristic of bipolar children described as irritability with prolonged and aggressive temperament rather than euphoria in bipolar adult but the symptoms are tend to be more chronic and continuous than the symptoms in adult. In the normal situation of the stressors, children may display sadness as one of depressive responses. In younger school-aged children, they may feel transient loss of self-esteem because of the failures and lose experiences. In older school-aged children, the expressions of sadness are similar, but they may also including thought of death because loss of significant persons. In addition, the younger school-aged children are categorized to have effect and mood problems if they have chronic fatigue, irritability, depressed mood, guilty feeling, and in older school-aged children, they exhibit retardation of psychomotor and hypersomnia, and delusion or hallucination.

4. Peer problem. Compared to adult, school-aged children have difficulty to maintain relationship with friends and this problem may also relate to poor performance at school. In younger school-aged children, they are not easy to make friends; this situation makes them to play solitary. Meanwhile, older school-aged children also experience difficulty to make new friends because lack information about popular dress, interests and activities. For school-aged children, the present of friends is important to increase their self-esteem, because the feeling of acceptance is one of key point for them to have successful social and interpersonal relationship. When they exhibit behaviors that are not expected, they tend to have social and interpersonal problems. Social withdrawal problem occurs when younger school-aged

children are socially isolated, rarely start interactions with friends, and prefer to choose solitary activities than group activities and older school-aged children show more difficulty in social situations, few of friends, experience eccentric hobbies and interests. Lack of information about latest popular fashion or good role model also makes older school-aged children experience interpersonal problems.

It may be concluded that, in school-aged period, mental health problems may varies between children, but they have the same opportunity to experience mental health problems; such as, inattention and/or hyperactivity, conduct and behavioral problems, emotional symptoms, such as anxiety, depression and peer problem.

2.4 The impact of mental health problems in school-aged children

Mental health is one of important key point for a human being to be successful in life; it may affect other aspects such as physical, social, and spiritual. Center for Disease Control and Prevention (2014) mentioned that mental health problems in children can continue into adulthood and bothering their ability in friendship capacity, this situation may lead to several problems, not only for themselves, but also other people at home, school and community setting. Comprehension about mental health problems in school-aged children and its impact may help significant persons of the children to prevent the negative consequences of mental health problems in school-aged period. Hucksmith, Spratt, Philip and McNaughton (2008) revealed that there are several negative impacts of mental health problems in school-aged children, including children themselves, family, school, friendship, and community.

The impact of mental health problems on school-aged children including bad feeling about their body image, judgmental situation of gender stereotyping for mental health problems such as female tend to have emotional problems and male for behavioral problems, feeling of overwhelming worry about their health and the impact of mental health problems, feeling of stress because of being abnormal and different from the others, experiencing judgmental situations for having poor physical health condition because of mental health problems, receiving discrimination treatments from others and self-stigmatization.

The impact of mental health problems is also affecting family, mostly with parents. Parents may get involved with conflict and start to blame each other by

having children with mental health problems, parents may feel stress because their lack of knowledge about what they have to do regarding the situation of their children, parents tend to have both emotional and physical abuse relationships with their children because the tendency of using harsh discipline and inconsistent discipline to control the behaviors of their children. Having children with mental health problems may put parents in awry position, because they tend to treat their children with special treatment, but this action brings two consequences such as guilty feeling because treating children differently and feeling of jealousy of a sibling because receiving different treatments. In contrast, children with mental health problems may feel isolated because their parents treat them differently from other kids; they may feel worried for having dependency to their parents and loss of self-identity.

The other significant impact of mental health problems in school-aged children is at school, because there are lots of expected roles that they have to perform as students in the school. Having had mental health problems, school-aged children may feel stressed about their social relation, especially about peer acceptance. They may experience peer pressure, being a victim of bullying and may result as having a poor peer relationship. Feeling of rejection and isolation make children avoid their friends, feeling estrangement and difficult to maintain friendships. This is one of traumatic situation for school-aged children with mental health problems because of having poor relationship with friends, they tend to withdraw from school and may become a bad role model in the community; they tend to against social norms and break the laws, and community will stigmatize them for having negative behaviors.

In conclusion, mental health problems in school-aged children may not only affect themselves, but also other significant persons, such as parent, sibling, teacher, and peers.

2.5 Mental health service system in Indonesia

Indonesia, as one of countries with the largest population in the world, starts to notice the importance of mental health problems that occur in community. Based on Riset Kesehatan Dasar (Riskesdas) or basic health research in year 2007, there was 11.7% of adult population in Indonesia suffering from anxiety and depression (Health

Ministry of Indonesia, 2009). The number of population with mental health problems increased because there were lots of natural disasters occurred and prolonged vertical conflict between central government and separatist group in some provinces of Indonesia. Specifically, the attention about this issue has increased after earthquakes and Tsunami's attacked in Aceh Province in 2004, this disaster has made survivors remain in trauma. The survey was cited by dr Diatri found that from three districts in Aceh; there was 78% of people had traumatic experience due to conflict and 65% of them displayed mental health problems (Minas, 2010). This issue became the forerunner of Community Mental Health Nursing (CMHN) program in Indonesia.

The prevalence of people with severe mental health problem was 1.7 per mile and most of patients arose from some provinces such as Yogyakarta, Aceh, South Sulawesi, Bali and Central Java, meanwhile the number of anxiety and depression was 6% (Badan Penelitian dan Pengembangan Kesehatan Kementerian RI, 2013). The application of CMHN and Model Praktek Keperawatan Profesional (MPKP) or professional nursing practice model in psychiatric nursing are believed to support mental health services in Indonesia, especially in community and hospital. Even it showed promising result but the there are many other important points that still need to be improved especially in hospital and community such as referral system, new case finding approach, proportion number of mental health providers, mental health services and other important issues such as discrimination and stigmatization in the community. In addition, the trend of mental health services in Indonesia still focus on adult population, little is known about mental health services in children and adolescents with mental health problem.

2.5.1 Hospital-based services

Psychiatric hospital plays important role in mental health services in Indonesia, because patient with mental health problem tend to be referred directly to the hospitals, despite in every sub-district area has primary health unit, this situation put psychiatric hospital is not only to supply tertiary service but also primary service (Hasjmy, 2009). Mental health providers in psychiatric hospitals may work more than their original roles because they also have to detect type of mental health problems, the service that supposed to be conducted in community hospital or primary care unit in sub-district. The problem that may exist is, most of the patients who are referred to

the hospital is patients with chronic phase or endanger other people in the community, so the community force the family to put the patient to the hospital.

Once the patient is referred to the psychiatric hospital, he or she will be delivered to Out Patient Department (OPD) and general physician will conduct initial assessment. After the assessment is finished, the patient will be referred to psychiatrist for more assessment and before the therapy is set, the patient should run additional supported examination such as psychology, laboratory, radiology, and brain mapping, including social worker examination. When the additional examinations are conducted, the psychiatrist will decide the patient may come back home, one day care, or should be hospitalized in psychiatric ward (rsjsoerojo, 2012).

Unlike OPD, psychiatric nurses in Indonesia try to differentiate their role in In Patient Department (IPD) by applying Model Praktek Keperawatan Profesional (MPKP) or professional nursing practice model by Sitorus (Akemat, Wardani and Widiastuti, 2009). Actually, the concept of Sitorus derived from nursing concept in general hospital and the team of psychiatric nurses conducted modification to make it easier to be applied in psychiatric setting.

Another new trend in psychiatric nursing services in Indonesia is Psychiatric Intensive Care Unit (PICU) and it will focus on patient with mental health problem in emergency or crisis psychiatry that needs intensive service. This service may be applied not only in psychiatric hospital but also psychiatric unit in general hospital (Akemat, Wardani and Widiastuti, 2009). This can be innovation for psychiatric service in Indonesia because this unit may accept the patient directly from community, primary health care unit or other wards in psychiatric hospital.

Meanwhile, patient with physical problems may also experience mental health problems. Some of physical problems that may affect patient psychological condition such as chronic disease (cancer, AIDS, etc.) and surgery, and people with those conditions may experience mental health problems. The most common mental health problems are anxiety, depression and even Post Traumatic Stress Disorder (PTSD). Furthermore, patients who had undergone cardiac surgery would experience some of mental health problems such as depressed features (32.4%), acute full in-hospital PTSD (17.6%), and in-hospital major depression (17.6%) as short-term consequences

and at 12 months study, the severity of depression and anxiety disorders including PTSD improved and returned to the preoperative level (Rothenhäusler HB, 2006).

The trend to integrate psychiatric nursing services into general hospital starts to attract attention in Indonesia, even the role of psychiatric nursing in general hospital do not developed very well (Keliat, 2013). Keliat added that in Indonesia, one study found that 98.1% of patients with cancer are suffering from depression, this finding supports the implementation of psychiatric nursing care in general hospital, because the trend of mental health problem in patient with physical problem is increasing. The integrated program for this issue is called *psychiatric and mental liaison nursing.* Keliat suggested five of these mental health problems that frequently occur in patient with physical problem, such as anxiety, body image disturbances, situational low self-esteem, discouragement, and powerlessness, and to overcome the problem. Keliat and team conducted training in some of general hospitals in Indonesia and it is called Consultation Liaison Mental Health Nursing (CLMHN).

Besides, the increasing number of elderly and drugs users in Indonesia make these issues are easily to get attention from the central government. In Indonesia, the proportion of older adult in 2010 was 24 million or 9.77% from total population and it may be increase become 28.8 million or 11.34% from total population in 2020 (Viora, 2013). Elderly with chronic diseases such as diabetes, stroke, heart disease, cancer and Parkinson's disease may co-occurrence with depression and usually under recognized and undertreated for mental health problem (National Institute of Mental Health, 2010).

The number of drugs users in Indonesia is increasing year by year. Generally, based on data of Badan Narkotika National (BNN) or national narcotics agency, from year 2007 to 2011 in Indonesia, it is about 1.5% from total population in Indonesia was drug abuser and specifically, there was 37.5% of people who were involved in drug criminal offence were drug abuser and the trend showed that the prevalence continue to rise in the near future (Indriany, 2012). Akemat, Wardhani and Widiastuti (2009) mentioned that the services for drug abusers including OPD/IPD, detoxification, psychotherapy, hypnotherapy, maintenance therapy of Methadone, voluntary and counseling therapy and Care, Support and Treatment (CST). The

minimal required nursing educational background to work in these services is bachelor nurse with psychiatric experiences for a better quality of nursing services.

Specifically, Indriany (2012) added that, of the total cases of drugs in Indonesia, 561 cases or 0.3% of drug abuse and drug-related criminals were involving school-aged children. There are some situations put school-aged children in drugs problem in Indonesia; 1) as an abuser, there is an increasing trend for school-aged children to inhale glue, especially for "Lem Cap Kambing" or Goat Branded Glue; 2) as a user and victim, drug dealer uses strategy to increase drug user in school-aged children by putting drugs inside the candy and give it free to the children, and 3) as a courier, drug dealer uses a child to deliver drug in order to minimize police suspicion.

2.5.2 Community based services

Stigmatization and discrimination for patient with mental health problem is still one of big problems that occur in our community. In United Kingdom, 66% of people with mental health problems preferred to keep their condition from others because afraid of stigma and discrimination, 70% people with psychiatric problem suffering from discrimination in some area such as 47% in the workplace, 44% from general practitioners, 32% from other health professionals, and surprisingly, more than a half of respondents said that their family and friends (56% and 52% respectively) ignored them for 6 years (Wright and Ponte, 2001). Kusumowardani (2006) found that there is relationship of patient with schizophrenia's perception on their family attitude with the frequency of relapse in psychiatric hospital of Surakarta, East Java Indonesia. It is clear that both of stigmatization and discrimination affect patients with mental health problems.

The other problem in the community is the pressure to put the patients at home and never let them outside. The family chooses to apply *pasung*, or restrain, because they have no idea how to take care patient with mental health problems. Since this becomes big issue in Indonesia, *Indonesia free of pasung* was declared in 2005 in Aceh province to help patient in *pasung* (Keliat, 2013). In addition, having understood this situation, Keliat and team develop one program with community as the foundation, and the program called Community Mental Health Nursing (CMHN) and the pilot project was applied in Aceh province started in 2005.

It may be concluded that, in Indonesia, mostly psychiatric nursing interventions are still focus on adult population, and the interventions towards children population are still limited and being unclear.

2.6 The current situation of school-aged children with mental health problems and nursing services in Indonesia.

Children and adolescents with mental health problem is the newest issue in psychiatric services in Indonesia. That is why, this services is not available in every psychiatric hospital in Indonesia, even one of the oldest psychiatric hospital in Jakarta, Dr. Soerharto Heerdjan hospital, launched child and adolescent's psychiatry unit in 2013. Some of other psychiatric hospitals such as DR. Amino Gondohutomo hospital Semarang, Menur hospital Surabaya, Prof. Dr. Soerojo Magelang, and psychiatric hospital of West Java also provide the services for child and adolescent with mental health problems, and it includes OPD and IPD services. Having provided with this new service, Indonesia still face other problems for this population; *firstly*, there is no psychiatric nursing standard services for children and adolescents with mental health problems, especially for school-aged children with severe mental health problems that may need hospitalization, so until now the standard still adopt the adult standard.

Secondly, the educational background nurses who work in this unit mostly are diploma nurse so they have limitation of knowledge and experience. In fact, the desired nursing background to work in children with mental health problems is psychiatric nursing for minimum requirement. *Thirdly*, the prevalence of children and adolescents who are suffering from mental health problems is difficult to find in any literature. Specifically, Indonesia still has no data about mental health problem in children and adolescents but following the estimated number of WHO (10% of total population) so, the population of children with special needs in Indonesia is about 4,2 million compared to 42 million children without mental health problems, but only 1,5 million children from that population are officially counted (Harnowo, 2013). *Lastly*, Indonesia still does not has psychiatric hospital for children and adolescents with mental health problems, this situation brings consequences, such as families with no experience and knowledge have to take care their children by themselves, or take their

children to schools for children with special needs, but no nursing background staffs are working in those schools.

In Indonesia, compared to adult with mental health problems, mental health problems in school-aged children still have many challenges. Isfandari and Suhardi (1997) found that 244 from total 2396 children or 10.2 % of school-aged children had emotional problems in several islands of Indonesia. They revealed that some problems are still occurring in Indonesian regarding mental health problems in school-aged children. *Firstly*, the survey of mental health problems in school-aged children is not frequently conducted in a wider population, and usually focuses on psychiatric hospital. Having had this situation, it is more difficult for the Indonesian government to set the prevention policy or intervention to minimize the number of school-aged children with mental health problems or its impact to themselves or other significant persons. *Secondly*, both of parents and teachers may not aware of children's mental health problems, even they may sense the behavioral changes of children, but they have limitation in early detection of mental health problems. *Thirdly*, people with mental health problems are still experiencing stigmatization and discrimination; this makes family tend to ignore their family member with mental health problems. *Fourthly*, the number of child psychiatrist who can diagnose children with mental health problems is still limited and less of psychiatric nurses who have experience in taking care of children, especially school-aged children with mental health problems, as well as the application of standardized assessment in order to identify mental health problems.

Psychiatric nursing is one of nursing specification in Indonesia. In order to conduct the professional roles, Indonesian National Nurses Association (INNA) has set the nursing competencies based on educational background. Unfortunately, in Indonesia there are many levels of nursing education; senior high school of nursing, diploma nursing, bachelor nursing, graduate and post graduate nursing. So, the standard of competencies is different depend on level of education, and a clear statement about competencies is needed to be explained in implementation. In psychiatric nursing area, the competencies for bachelor nurse only cover nursing care to manage patients with stress and suicide tendency, and for psychiatric nurse, it only mentioned about nursing care for patient with mental health problems and child abuse

in the community. The scope of psychiatric nursing competencies is still limited. Besides, the application of nursing competencies is still under expectation of the Indonesian government. Actually, more than a half of psychiatric nurses who work in the hospital, university, public health center, and community have master level of education, even mostly they are still concentrated at university, but the number of child psychiatric nurse remains unclear, and some of psychiatric problems is still under pediatric nursing area, such as autism and Attention Deficit Hyperactivity Disorder (ADHD) [Ditjen Dikti Kemdikbud, 2010; Kristyaningsih, Utami, and Wardani, 2015; INNA, 2005]. The similar situation also occurs in Aceh province.

In conclusion, psychiatric nursing care for school-aged children with mental health problems in Indonesia is still limited, because of some existed problems, such as lack of survey about mental health problems in school-aged children in wider population, psychiatric nursing care for children population is still difficult to find in every psychiatric hospital, low level of nursing educational background for nurses who work in psychiatric hospital, most of psychiatric nurses are working at university instead of psychiatric hospital, and the psychiatric nursing competencies in children population are still limited and still adopting adult standard of nursing care.

3. Factors related to mental health problems in school-aged children with mental health problems

Mental health problems in children are the new issue in psychiatric nursing services in Indonesia. There are not many services and psychiatric hospital specifically address this group of population. In addition, the published articles about mental health problems are also difficult to find in the Indonesian literature, especially in school-aged child population. Study of Wiguna et al (2010) mentioned that most children who referred to psychiatry's child and adolescent polyclinic in Ciptomangunkusumo hospital in Jakarta were suffering from peer problem and emotional problem, for 54.8% and 42.2% respectively. In addition, 65.9% of them were school-aged children and male gender was reported for 60.2%. Another study that conducted in Malang, East Java Province, Indonesia revealed that parenting stress, parental lack of supervision, parental inconsistent discipline, temperamental parent and excessive physical punishment lead children to hyperactive behavior

(Lestari, 2006). This study puts family factors such as parenting behavior and parenting stress as one of the risk factors and they have relationship with mental health problems, especially hyperactive behavior in school-aged children.

The investigation about the other factors is important to present the new insight for mental health problems in school-aged children in Indonesia. Previous studies found that mostly factors related to mental health problems in school-aged children were not only in parent, but also children and family. The factors related to mental health problems in school-aged children with mental health problems are important for psychiatric nurses in Indonesia to gain knowledge and comprehension about the new issue in psychiatric nursing as well as to set the appropriate intervention to prevent the increasing number of school-aged children with mental health problems and to minimize the severity and the impact of mental health problems in student for themselves, family, friends, school, and community.

In this study, the related factors of mental health problems in school-aged children with mental health problems will be selected from study literature that associated with mental health problems in school-aged children. The independent variables are representing factors from three important aspects of school-aged children, including children factors such as age, gender, social competence, and academic competence; parental factors such as maternal depression, maternal parenting behavior, and maternal parenting stress; and family factors, such as economic status and family environment-relationship dimension.

3.1 Age of children

Age is one of important personal factors that associate with mental health problems in school-aged children. Along with increased age, the cognitive development of school-aged children is dramatically changed. Based on Piaget theory, younger school-aged children have logical thinking compared to older school-aged children. Having had different cognitive development, school-aged children have different perception about role model. On one hand, younger school-aged children put popular culture from the media as their influences, on the other hands, older school-aged children perceive that the perception of other children is important and it will change their thought (Ozterich and Bowman, 2001). At this point, the perception of

others is one of the crucial factors that may increase the risk of mental health problems in school-aged children. Compared to younger school-aged children, older school-aged children tend to be easier to get labeled from their peers regarding their behaviors, especially related to mental health problems (Hay, 2005). Study of Hoza (2008) revealed that when the children were labeled as ADHD, they will be rejected and received negative treatment from their peers. Having understood this situation, older school-aged children have more risk for mental health problems compared to younger school-aged children. In conclusion, the risk of mental health problems in school-aged children is increased by increasing of age.

The study of Lesesne, Visser and White (2003) found that older school-aged children have more risk for mental health problems for behavioral problem (ADHD), and the study in Brazil found that older school-aged children also experienced more mental health problems, especially for emotional problems, such as Depressive Disorder and Generalized Anxiety Disorder (Mendes, Crippa, Souza and Loureiro, 2013). This result was strengthened by study of Chabra, Chavez and Harris (1999), they mentioned that more than 50% of school-aged children that were hospitalized is older school-aged children with emotional problems (depression). But, the longitudinal study in Australia found that both of emotional problems and behavioral problems might also display in young age of children, especially in younger school-aged children (Bayer et al, 2011).

As one of personal factors that may influence mental health problems in school-aged children, age of children is defined as the chronological number of years living since birth of school-aged children with mental health problems that live in Aceh province, Indonesia. In this study, age of children will be measured by Personal Information Sheet, developed by the researcher.

3.2 Gender of children

There are many considerations that are involved gender as one of the risk factors in school-aged children with mental health problems. Wicks-Nelson and Israel (2006) mentioned that the differences of sex hormones between male and female as well as sex chromosomes may relate to specific mental health problems. In addition, the maturity process of female is considered to be faster than male, put male in the

higher risk of suicide in young adolescence. However, there are many reports that mentioned that male school-aged children have more risk for behavioral problems compared to female school-aged children who have a possibility for emotional problems. But, that is still not clear, what makes specific gender tend to have specific mental health problems. Dogra, Gupta, and Leighton (2009) explained that it could be a genetic factor or even a social expectation where the female students are expected to internalize their problems meanwhile male students are expected to express their problems by exhibited specific behaviors.

Many studies in school-aged with mental health problems found that, gender is one of more frequent variables that were studied in order to determine the risk factors for mental health problems. Studies in different countries revealed that male school-aged children tend to have externalizing symptoms or behavior problems, the problems that were frequently reported such as ADHD and Conduct Disorder; on the other hands, female school-aged children prevalently showed internalizing symptoms or emotional problems such as depression and anxiety (Davis et al, 2010; Leadbeater, Kuperminc and Blatt, 1999; Lesesne, Visser and White, 2003; Rodriguez et al, 2011). Even externalizing behaviors are more frequent in male school-aged children, but once when those behavioral problems displayed in the female, they tended to have a poorer clinical outcome than male (Gothelf et al, 2006). In contrast, study of Chabra, Chavez, and Harris, (1999) revealed other interested findings. They found that many of male school-aged children, who were hospitalized in a psychiatric hospital in California, exhibited more emotional problems than females. The result of the study also found that male students who displayed depression tended to have more risk of suicide and tend to be hospitalized. The study of Islam, Khan, Ahsan and Saifuddin (2010) recommended that is better to create intervention to minimize risk factors of mental health problems based on the gender, because gender disparities is significantly related to mental health problems.

As another personal factor, gender of school-aged children with mental health problems is also important to study because a specific mental health problem may occur in a specific gender of school-aged children. In this study, gender of children is defined as sex characteristic, male or female, of school-aged children with mental health problems who live in Aceh province, Indonesia. Gender of school-aged

children will be measured by Personal Information Sheet, developed by the researcher.

3.3 Social competence of children

Social competence is the perception of self and others about the effectiveness of interaction (Rose-Krasnor, 1997). It may reflect some of behaviors that are characterized by transactional, dependent context, orientation of performance, and specific to the goal of the relationship. Arnold and Lindner-Muller (2012) perceived social competence as an important goal of education in family and school. Both parents and teachers have a responsibility to teach and give a role model for school-aged children, about how to behave with friends and perform pro-social behaviors. Compared to younger school-aged children, older school-aged children treat the relationship with friends as one of important aspect that may influence their self-esteem, because in the older school-aged children, the number of friendship network will be increased significantly, especially in girls; female school-aged children were reported to have more friends than male school-aged children, with specific types of competence (Feiring and Lewis, 1991). A normal school-aged child are believed to display a higher social competence, on the contrary, school-aged children with mental health problems may exhibit lower social competence.

As one of the expected aspect that needed to be performed at school, social competence is found to be related to mental health problems. Study of Bornstein, Hahn and Haynes (2010) revealed that school-aged children exhibited more externalizing problems and internalizing problem if they have lower social competence when they were toddlers. The studies of the relationship between social competence and mental health problems in school-aged children revealed different results. Study of Achenbach and Edelbrock (1981) found that social competence related to behavioral problems in school-aged children, they tended to have lower social competence. In contrast, if the school-aged children have internalizing symptoms, they exhibited higher social competence (Rolf, 1972). Different with those studies, study of Sallquist et al (2009) found that school-aged children with emotional problems displayed lower social competence. Furthermore, emotional problem, especially depression in school-aged children with mental health problems was also

found to be predicted by social competence (Cole, Martin, Powers, and Truglio, 1996; Rolf, 1972).

Based on those previous studies, we can conclude that social competence frequently related to mental health problems for both emotional and behavioral problems. In this study, social competence of children reflects the social skill that is defined as perception about the social capacity of school-aged children with mental health problems when having interaction with others, especially friends, who live in Aceh province, Indonesia. Social competence will be measured by Social Competence Questionnaire developed by Harter (1982/2014).

3.4 Academic competence of children

During school-aged period, children are expected to perform some of important capacity. Beside social competence, academic competence is another criterion aspect of successful school-aged children. Academic competence is usually reflected by the maturity of cognitive development (Hockenberry and Wilson, 2009). There are positive and negative consequences, whether or not school-aged children can perform appropriate academic competence (Huffman, Mehlinger and Kerivan, 2000). The positive impact of appropriate academic competence such as increase the probability of children to become productive citizens in adulthood; they tend to be more independent, social confidence, and earning higher salary. On the other hands, if the school-aged children cannot perform desired academic competence, they tend to have a more impaired academic achievement, such as grade retention, low scores of scholastic performance and need special education. Many studies had revealed that there was a relationship between mental health problems in school-aged children with academic competence.

Study of Rolf (1972) found that academic competence related to externalizing symptoms of mental health problem in school-aged children with mental health problems. Study of Moilanen, Shaw and Maxwell (2010) strengthen the relationship of academic competence and mental health problems in school-aged children. They found that mental health problems in school-aged children related to lower academic competence; meanwhile Cole, Martin, Peeke, Seroczynski and Fier (1999) revealed that academic competence in school-aged children with mental health problems

related to internalizing symptoms such as depression and anxiety. Interestingly, the other study indicated that mental health problems in school-aged children only related to social competence, but it was not directly related to academic competence (Cole, Martin, Powers and Truglio, 1996).

As another aspect of school achievement, academic competence is considered as one of the important factors that related to mental health problems in school-aged children with mental health problems. In this study, academic competence of children is defined as the numerically quality of academic achievement of last one year that is mentioned in school report stated by cumulative GPA of school-aged children with mental health problems who live in Aceh province, Indonesia. Academic competence will be measured by GPA score that will be obtained from student report book.

3.5 Maternal depression

Mental health condition of the parents is one of the important issues in family of school-aged children with mental health problems. If the parents are reported to be suffering from mental health problems, the children who stay with them should receive special treatment in order to minimize the impact of the parents' condition to their children. Department of Community Services, Centre for Parenting and Research (2008) mentioned that children who have parents with mental health problems have risk for many consequences, such as maltreatment, risk of later mental health problems such as social and behavioral problems, and the children may feel stressed because they need to treat their parents with mental health problems. Compared to father, maternal mental health is most frequently found as one of the risk factors for school-aged children with mental health problems.

Study of Olives et al (2013) found that parental mental health strongly related to child mental health. The study of three generations in a family with mental health problems also found the similar result; mental health problems both in grandmother and mother are the significant risk factors for mental health problems in children (Hancock et al, 2013). Maternal depression is frequently reported related to mental health problems in school-aged children. Krishnan and Nestler cited in Perese (2008/2012) mentioned that depression is not only one of psychiatric illnesses, but also involving several feelings such as sadness or unhappiness, unstable mood,

diminish of pleasure, sleep, appetite, and cognitive, motor, social, and sexual function. Some studies mentioned that a mother with depression is significantly related to internalizing and externalizing problems of later childhood (Bordin et al, 2009; Department of Community Services Centre for Parenting and Research, 2008). Furthermore, maternal depression might individually relate to behavioral problems (Darunee Ngamkum, 2013; Lesesne, Visser and White, 2003; Nantacha Sanguenkulchai, 2013; Whitaker, Orzol, and Kahn, 2006) and emotional problems (Lyons-Ruth, Easterbrooks and Cibelli, 1997; Mendes et al, 2013).

The comprehension about maternal depression is important in order to prevent mental health problems in school-aged children, because both of these risk factors are associated with each other (Rishel et al, 2006). So, in this study, maternal depression is defined as the symptoms of mothers who are experiencing the feeling of sadness or emptiness, feeling hopeless, irritable, anxious, or angry etc. in Aceh province, Indonesia. Maternal depression will be measured by Indonesian version of Beck Depression Index-II (BDI-II), translated by Ginting et al. (2013).

3.6 Maternal parenting behavior

Parenting behavior is a set behavior of parent in child-parent interaction in child rearing practices (Cohen et al, 1977). Based on this definition, it is stated that parents will adopt specific behaviors to maintain appropriate relationships with their children in order to achieve good parenting practice. In addition, parenting behavior covers at least three behaviors of parents such as monitoring behavior, nurturance behavior, and discipline behavior (Statistics Canada, 2011). In addition, there are five factors of parenting behavior that was suggested by Cohen et al. (1977), they are included, respect for autonomy, consistency, control through guilt and anxiety, child-centeredness, and parental temper and detachment. *Respect for autonomy* is the behavior of parents to support their child to be independent, this is may include an equal consideration of the independence degree or controlling their child activities. *Consistency* defined as the perception of parents to commit to the rules. *Control through guilt and anxiety* is the way how parents control their child's behaviors by applying guilty feeling. *Child centeredness* is the parental attempt to focus on their

child by sufficient concern and warmth. *Parental temper and detachment* describes the behavior of parents to withdraw from their child when they feel angry.

Several studies found that mothers tend to show negative parenting behavior when they have school-aged children with mental health problems, especially ADHD (Alizadeh, Applequist and Coolidge, 2007; Aunola and Nurmi, 2005; Ellis and Nigg, 2009; Yousefia, Far and Abdolahian, 2011). Mothers tended to perform authoritarian parenting behaviors such us harsh parenting and using corporal punishment with less of affection, inconsistent discipline and less respect for children's autonomy. In addition, if the mother suffering from mental health problems, the parenting behaviors that are displayed by them is worse than normal mother. In the study of mother with depression, mothers tended to display permissive and inconsistent discipline, and mothers may continue negative interaction with their school-aged children resulted negative parenting attitude such as unresponsive and ineffective parenting behaviors (Oyserman, Mowbray, Meares and Firminger, 2000).

In this study, the maternal parenting behavior is defined as specific actions of mothers that are performed in raising their school-aged children with mental health problems who live in Aceh province, Indonesia. Maternal parenting behavior will be measured by Parent's Report questionnaire (Cohen et al., 2013).

3.7 Maternal parenting stress

Parenting stress is a normal experience of parent in raising a child, when the demand of desired parenting roles is not achieved and the resources are not available for parent to become a successful parent (Deater-Deckard, Chen and El Mallah, 2013). In addition, they mentioned that parenting stress is may derive from three domains such as parent, child, and parent-child relationship's domain. The factors of parenting stress in parent domain are including parental age, parental gender, parental mental health, personality characteristics, and social cognitions such as attitudes and self-concept. In a child's domain, factors such as serious illness or disability, mental health problems, and difficult temperament of children may provoke a parent to have parenting stress. In addition, parents who experience parenting stress may have a poor relationship with their children. As one factor of provoking parenting stress, many

studies were reported that mental health problems in school-aged children related to parenting stress.

Most studies found that parenting stress in the mother was frequently reported with mental health problems in children and the most common form of mental health problem is behavioral problem or ADHD (Harvey, 2000; Williford, Calkins and Keane, 2007; Yousefia, Far and Abdolahian, 2011). Compared to parenting stress in father, mother was reported to has more parenting stress because mother spend more time with the children and to fulfill the traditional expectation of woman gender to treat the children, but she will be more overprotective than father (Stephens, 2009).

In this study, maternal parenting stress is defined as the perception of mothers about an inconvenient experience of being parent, and relationship with their school-aged children with mental health problems who live in Aceh province, Indonesia. Maternal parenting stress will be measured by Parental Stress Scale (Berry and Jones, 1995).

3.8 Family income

Family income is defined as a financial situation of the person or family in the community based on monthly income (Kartono, 2006). Defining low family income depends on per capita income of the country and a minimum income of the labor. Badan Pusat Statistik (BPS) or statistic center agency of Indonesia mentioned that there are 14 criteria of people in Indonesia that are categorized as poverty, the criteria such as 1) building area of residence is less than 8 m^2, 2) floor of residence made by ground/bamboo/cheap wood, 3) wall of residence is made by bamboo/poor quality wood, 4) residence does not has toilet, 5) residence does not has electricity, 6) drinking water sources only from river or rain, 7) fuel for cooking from firewood/charcoal/kerosene, 8) meat/milk/chicken consumption is once a week, 9) family can buy only one clothes within one year, 10) family can buy food only for two times in one day, 11) family cannot pay for medicine in the community hospital, 12) family income is less than 600,000 rupiah per month, 13) education level of parents is elementary school or even not completed for elementary school, and 14) family does not have saving (Bappenas, 2010). If the family fulfills at least one of the

criteria above, it is categorized as poor family. In conclusion, family with monthly income less than600,000 rupiah is categorized as family with low income.

Studies in different countries revealed that low family income strongly related to mental health problems in school-aged children with mental health problems, even some studies found that the association might occur also in early childhood (Beiser et al, 2002; Davis et al, 2010; Rodriguez et al, 2011). Study of Bordin et al. (2009) mentioned that children with mental health problems from the poor family tended to experience severe physical punishment and this situation aggravated their mental health problems.

In this study, family income is defined as the monthly financial condition of fathers and mothers of school-aged children with mental health problems in Aceh province, Indonesia based on minimum income in Indonesia that was set by BPS.

3.9 Family environment-relationship dimension

Family plays important roles to achieve the appropriate development of the children, and one way to ensure the needs of children are fulfilled is by effective family functioning (O'Shea et al, 2001). They mentioned that family should set consistent discipline based on family rules and limits fairly, allocate resources for children as earn, save, and spend money efficiently, and share the family process based on family tradition and values appropriately. In addition, effective communication, trust, and togetherness determine the successful family functioning. As one of important achievements, social skill of the children depends on their relationships with their families, especially parents.

Zastrowand Kirst-Ashman (2013) defined the family environment as all of family circumstances and social conditions that already exist in the family. The entire factors in the family cannot be separated; indeed they are related each other, such as family conflict, poor parent-child communication, family disorganization, and mental illness in the family (Brooks, 2001). Family environment consists of three dimensions, such as relationship, personal growth, and system maintenance (Moos and Moos, 1986). Furthermore, each dimension has different subscales and three subscales for relationship dimension, they are *cohesion*, defined as the degree of family member's commitment, help, and support for one another; *expressiveness*

defined as the way of family members to express their feelings; and *conflict*, defined as the way of family members express anger and conflict openly in the family. Personal growth dimension consist of five subscales, including *independence*, defined as the way of family members is encouraged to be assertive, self-sufficient, and make decision independently; *achievement orientation*, defined as number of activities such as school and work that focus on achievement; *intellectual-cultural orientation*, defined as the interest of family member for activities in politics, intellectual, and culture; *active-recreational orientation*, defined as the number of family member participation in social and recreational activities; and *moral-religious emphasis*, defined as the concern of family member for ethical and religious issues and values. System maintenance dimension consists of two subscales, such as *organization*, defined as the importance of clear organization and structure to plan family activities and responsibilities; and *control*, defined as how much family in making rules and procedures to run family life.

Study of Wang et al. (2014) revealed that family environment is the important factor for families of children with mental health problems, especially in the way to interpret the information within the family. In addition, in family with maternal depression, it tended to show less family cohesion and expressiveness, and more family conflict (Van Loon et al, 2013). In Thailand, family environment-relationship dimension related to mental health problems in school-aged children and adolescents, both of emotional problem and behavioral problem (Nantacha Sanguenkulchai, 2013; Vatcharin Wuthironarith, 2013).

In this study, family environment-relationship dimension is defined as the perception about the quality of family connection that cover cohesion, expressiveness, and conflict of family of school-aged children with mental health problems in Aceh province, Indonesia. Family relationship will be measured by The Brief Family Relationship Scale (Fok et al., 2013).

Therefore, age, gender, social competence, academic competence, maternal depression, maternal parenting behavior, maternal parenting stress, family income, and family environment-relationship dimension related to mental health problems in school-aged children as illustrated in figure 1.

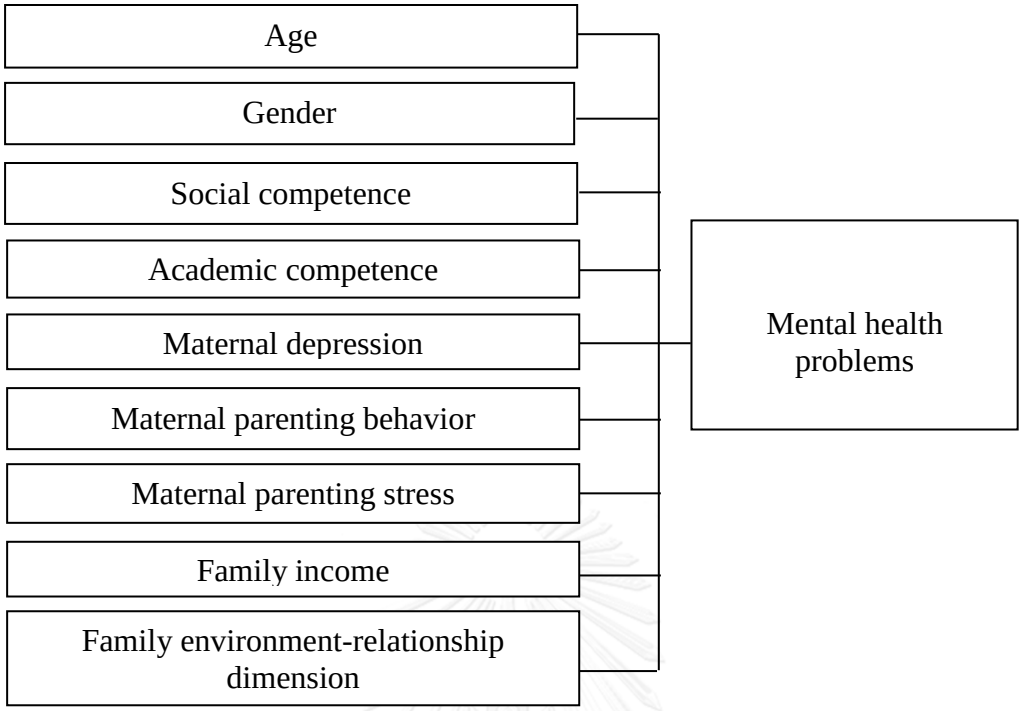

Figure 1 Conceptual Framework

CHAPTER III
METHODOLOGY

This chapter focuses on research design, population, sampling technique and section method, instrument construction, data collection, subject protection, and data analysis. A cross-sectional design was applied to determine selected factors that correlate to mental health problems in school-aged children with mental health problem in Aceh Province, Indonesia.

Population and sample

The population of the study was school-aged children with mental health problems in Aceh province, Indonesia. However, the data should not only obtain from the children, but from their mothers as well. It is considered to be significant, since selected factors not cover only children and school performance factors but also parent and family factor.

Sample size calculation

The sample size was estimated though Thorndike's formula (1978). This formula size the sample based on total numbers of independents variables.

The Thorndike Formula: $N \geq (10k) + 50$

Where, N = sample size.

K = total of independent variables

In this study has 9 (nine) independent variables, so

$N \geq (10k) + 50$

$N \geq 10\ (9) + 50$

$N \geq 140$

The estimated respondents' size was expected to be adequate to determine the selected related factors of mental health problems in school-aged children with mental health problems. A minimum of 140 respondents expected to involve in this study. In order to anticipate undesired situation and condition, an extra 10% of sample size was added. Therefore, the number of sample size was 154 children, respectively.

Sample selection procedure

A multistage randomized sampling technique was carried on this study in order to optimize the representation of the school-aged children with mental health problems in Aceh Province, Indonesia. For the first step, three districts in Aceh Province consist of North Aceh, Lhokseumawe and Bireuen were selected to represent Aceh Province's mental health problems figure. The selection were conducted under consideration that those three districts statistically shown to be the top three highest prevalence on adult with mental health problems (Puslitbangkes RI, 2013) and there were many study which suggest that adult's mental health problems related to it that precipitated during childhood period. The samples of each district were selected though a simple random sampling at first. Then, three elementary schools obtained randomly to represent the districts figure. Conducting this sampling frame was essential to ensure that the entire elementary school in those three selected sub districts were representative to capture selected factors that were related to mental health problems in school-aged children with mental health problems in Aceh province, Indonesia (Figure 2).

Step 1. Three districts of Aceh Province, Indonesia were selected based on their number of prevalence of mental health problems in adulthood.

Step 2. One sub district was randomly chosen from each selected district.

Step 3. Three elementary schools were selected by a simple random sampling from each sub district.

Step 4. At each school, respondents were randomly selected based on inclusion criteria and the number of samples was equally divided into nine selected elementary schools; 17 students and 18 students with mental health problems based on mothers' rated of SDQ from 12 classrooms of each school were selected and became the representatives of the study.

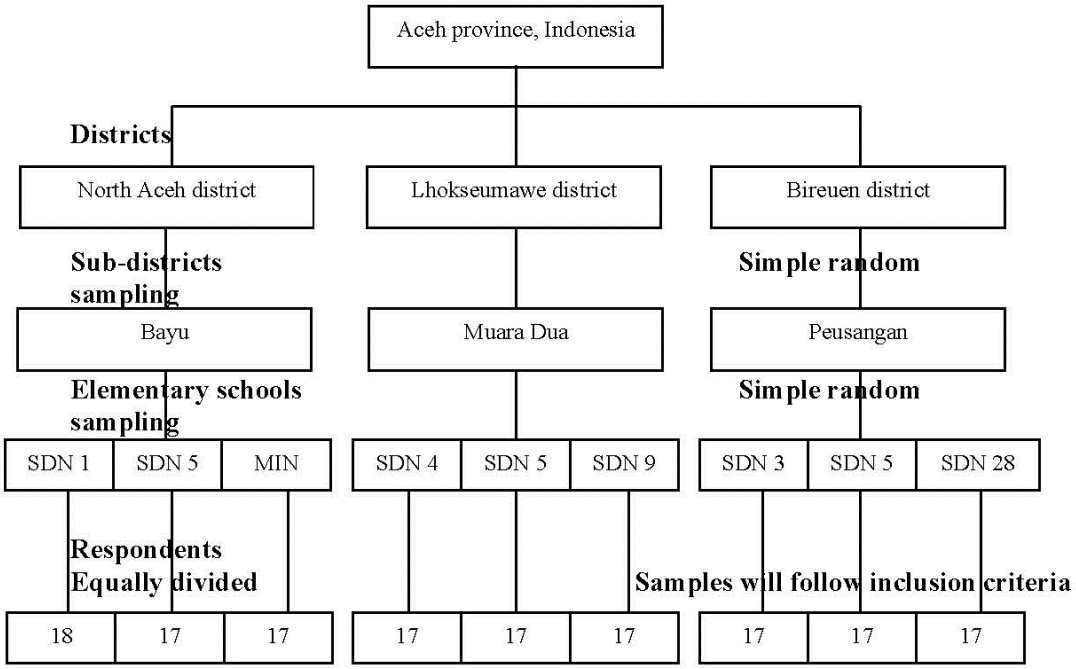

Figure 2. The sampling selection with multi-stage simple random sampling

Data Gathering

The sample in the study was not only school-aged children with mental health problems in the elementary school in Aceh province of Indonesia, but also their teachers and mothers. Data were collected in the community setting (elementary school) by fulfilling questionnaires for students, mothers, and teachers. In order to include 154 respondents in this study, nine elementary schools in Aceh province were selected randomly. Of each elementary school, the researcher selected the respondents with simple random sampling method based on inclusion criteria, mainly for school-aged children.

The selected elementary schools consisted of; In North Aceh District, the selected three elementary schools; SD No. 1 Syamtalira Bayu, SD No. 5 Syamtalira Bayu and MIN Punteut (Sub-District of Bayu). In Bireuen district, Peusangan sub-district was selected and it was represented by three elementary schools. They were SDN 3 Percontohan Peusangan, SDN 5 Peusangan and SDN 28 Peusangan. The third district was Lhokseumawe and the three selected elementary schools were SDN 4 Muara Dua, SDN 5 Muara Dua and SDN 9 Muara Dua (sub-district of Muara Dua).

The following inclusion criteria in this study were set for the student and their mothers. *Firstly*, student selection; children, both male and female, age 6-12; children were under supervision of counseling teacher for having emotional and behavioral problems. *Secondly*, mother selection; mothers of school-aged children with mental health problems were based on SDQ score, and mothers have good reading and writing ability and willingness to participate in the study.

Demographic characteristics of the study sample

A total nine counseling teachers from nine elementary schools were asked to differentiate school-aged children with mental health problems. Meanwhile, of 218 school-aged children met the inclusion criteria, 154 school-aged children were selected by simple random sampling, but only 143 school-aged children with mental health problems and their mothers were obtained because the data showed that 11 outlier data had extreme values and in order to minimize bias, they needed to be excluded. The distribution of sample in this study was not normal. The summary of demographic characteristics of the participants is shown in table 1.

Table 1 Demographic characteristics of the respondents (n= 143)

Characteristics	Number	Percentage
School-aged children		
Gender		
Male	110	76.9
Female	33	23.1
Age		
6-9 years old	52	36.4
10-12 years old	91	63.6
School Achievement (GPA)		
< 2.00	5	3.5
2.00-2.99	87	60.8
≥ 3.00	51	35.7
Number of sibling(s)		
None	18	12.6
1 sibling	41	28.7
More than 2 siblings	84	58.7

Table 1. Demographic characteristics of the Participants (n= 143) (cont.)

Characteristics	Number	Percentage
Mothers		
Age		
20-30 years old	49	27.2
31-40 years old	64	44.8
More than 40 years old	40	28
Education		
No school or Elementary	56	39.2
Junior to Senior High School	70	49
Bachelor or more	17	11.8
Marital status		
Married	115	80.4
Widow	24	16.8
Divorced	4	2.8
Occupation		
Housewife	96	67.1
Government office	21	14.7
Private sector	26	18.2
Family Income		
<Rp.600,000	84	58.7
Rp.600,000-Rp.2,000,000	48	33.6
>Rp.2,000,000	11	7.7

In table 1, it was found that a total of 143 participants who were school-aged children with mental health problems were included in this analysis. The findings shown that the majority of respondents was male (76.9%), age 10-12 years old (63.6%), and has grade point average 2.00 or moderate academic competence (60.8%). They have been living with more than two siblings (58.7%).

Whereas, in the group of mother, finding shown that the majority of mothers were aged between 30 and 40 years old (44.8%) and have married (80.4%). Most of mothers graduated from junior high school to senior high school or have middle educational background (49%). In addition, more than a half number of mothers were unemployed (67.1%) and more than a half number of families have income lower than Rp.600,000 per month or low family income (58.7%).

Research instruments

In order to collect data for the research purposes, the following instruments were delivered and to be fulfilled by different subjects, they were mothers, and children. School-aged children with mental health problems fulfilled SCQ and their mothers questioned based on personal information sheet, SDQ, BFRS, PSS, PR, and BDI-II.

Table 2 List of variables, instruments and desired respondents of the study.

Name of variables	Instruments	Respondent
Mental health problems in school-aged children.	SDQ translated by Wiguna and Hestyanti (Goodman, 2014).	Mother
Age and Gender of school-aged children	Personal Information Sheet	Student report book
Social competence of school-aged children	Social Competence Questionnaire/SCQ (Harter, 1982/2014).	Children
Academic competence of school-aged children	GPA in the student's report.	Student report book
Maternal depression	Beck Depression Index II (BDI-II), that translated by Ginting et al. (2013).	Mother
Maternal parenting behavior	Parent's Report (PR) questionnaire (Cohen et al., 1977).	Mother
Maternal parenting stress	Parental Stress Scale (Berry and Jones, 1995).	Mother
Family income	Personal Information Sheet.	Mother
Family environment-relationship dimension	The Brief Family Relationship Scale (Fok et al., 2013).	Mother

Personal information sheet was developed by researcher, two instruments (SDQ and BDI-II) were already have its Indonesian version, meanwhile SCQ, BFRS, PSS, and PR were translated from English into Indonesia language through the back translation process. The detail about validity, reliability, and translation process are presented.

1. Personal Information Sheet.

The first part of questionnaires requires the participants to fulfill demographic data in personal information sheet. This demographic questionnaire was divided into two forms, one for children and one for their mothers. Mother form of personal information sheet consist of questions about (1) age, (2) level of education, (3) marital status, (4) occupation, (5) number of children and (7) family income. This form included the measurement for family income which was measured by family income question; <Rp.600,000 for low family income, Rp.600,000-Rp.2,000,000 for moderate family income and > Rp.2,000,000 for high family income.

To measure academic competence, the researcher asked counseling teachers to provide student's report book and fulfill personal information sheet of children. This form provided measurement for academic competence by cumulative GPA; 4.00-3.00 (range of score is 75-100) for high academic competence, 2.99-2.00 (range of score is 60-74) for moderate academic competence, and < 2.00 (range of score is 0-59) for low academic competence.

2. SDQ

There are many instruments that can be used to examine mental health problems in school-aged children. Some of instruments have their own version for self-assessment, parent and teacher's assessment form. SDQ is the one of the instruments that is frequently used to capture the phenomena of mental health problems in children age range from 3 to 16 years old (Goodman, 1997). The SDQ is used not only to conduct the screening in predicting the presence of a psychiatric disorder, but it is also used in clinical assessment, outcome evaluation, and in large epidemiological studies. Study of Goodman, Renfrew and Mullick (2000) found that SDQ precisely identified more than 80% of children who had a clinical diagnosis in London and Dhaka, the study recommended to use SDQ as an assessment tool before referring children with mental health problems to child mental health services.

Compared to other instruments, studies found that SDQ as accurate as other instruments in detecting children with mental health problems. Study of Goodman (1997) revealed that SDQ as well as Rutter questionnaire because it focuses on both strengths and difficulties, including some of the frequent dimension of children's behaviors such as inattention, peer-relationship, and pro-social behavior. SDQ also

pronounced to be a better instrument than Child Behavior Checklist (CBCL) in detecting inattention and hyperactivity (Goodman and Scott, 1999). This instrument is also valuable in measuring outcome as well as the Nation Outcome Scales for Children and Adolescents (HoNOSCA). The study showed that a significant decline of total difficulties scores as rated by parents, teachers, and children (Mathai, Anderson, Bourne, 2003). The other beneficence of using SDQ is that this instrument is available in many language translations.

Indonesian version of SDQ was translated by Wiguna and Hestyanti (Goodman, 2014) has an acceptable reliability. Study that conducted by Oktaviana and Wimbarti (2014) revealed that SDQ had an acceptable reliability coefficient of Cronbach's alpha and it showed α=.773 in detecting school-aged children with behavioral problems in Sleman and Yogyakarta, Indonesia. They used the Indonesian version of the SDQ teacher rating. Having applied this instrument in Indonesia gives change for psychiatric nurses in Indonesia to use SDQ to conduct a screening for school-aged children with mental health problems.

SDQ consists of five dimensions, they were emotional symptoms (5 items), conduct problems (5 items), hyperactivity/inattention (5 items), peer relationship problems (5 items), and pro-social behaviors (5 items). Total item numbers of SDQ is 25 with provided answer options: "Not True", "Somewhat True", and "Certainly True". In order to get classified school-aged children with mental health problems, the researcher only added four subscale, which were emotional symptom scale, conduct problems scale, hyperactivity scale and peer relationship problems and calculated as total difficulties (Verhulst and Ende, 2006). Wille et al. (2008) calculated four dimensions of SDQ to categorize children and adolescents (7-17 years old) with mental health problems in study the risk and protective factors. This method of interpretation is not only common in school-aged child population (Hancock et al., 2013; Olives et al., 2013) but also in toddler and pre-school child population (Davis et al., 2010). As initial screening, teachers were asked to fulfill SDQ. Teacher rating score of SDQ showed higher internal consistency (.82) and test-retest reliability (.84) than parent rating score for .80 and .76 respectively (Stone et al., 2010). However, the researcher asked a mother to fulfill SDQ to confirm the score of SDQ whit it from teacher and compare it with other variables. The score interpretation was decided as

normal, borderline, or abnormal. For teacher rated score were normal for score 0-11, borderline for score 12-15 and abnormal for score 16-40, and scores for mother are 0-13, 14-16 and 17-40, respectively. A child with an abnormal score was indicated as children who have mental health problems. In this study, Indonesian version of SDQ instrument was used to measure mental health problems in school aged children and it was fulfilled by counseling teachers and mothers.

3. SCQ

Harter (1982) developed one instrument to measure several domains of school-aged children to evaluate their achievement based on their development. The instrument is Self- Perception profile for Children. There are six domains that can be measured by this instrument such as scholastic competence, social competence, athletic competence, physical appearance, behavioral conduct, and global self-worth. Each of subscale can be evaluated separately. There are two instruments that were developed to measure children profile such as "What I am Like" to measure children profile based on their perception and "Teacher's Rating Scale of Child's Actual Behavior" to measure teacher's perception of the student's profile. The total number of questions is 36 questions including six of subscales for social competence questionnaire and 15 questions for teacher version. The type of question is contradictive statement, for example "some kids find it hard to make friends BUT other kids find it pretty easy to make friends". The provided options of answer are "really true for me" and "sort of true for me" with the range of score from 1-4 Likert scale based on the statement.

In this study, the researcher only adapted Social Competence Questionnaire (SCQ), and it consists of six contradictive questions with the provided options of answer are "Really true for me" and "Sort of true for me". In order to increase the comprehension of the participants, Harper (2012) allowed the other researchers to use this instrument freely but she suggested maintaining its original format. The form called "structured alternative form" is giving the opportunity for respondents to choose which statement is true for them from two statements on the same line with the same available answers. For example, is "some kids find it hard to make friends BUT other kids find it pretty easy to make friends" Has chosen any contradictive statements, respondents are encouraged to choose the answer whether "Really True

for me" or "Sort of True for me". The score given is 1 to 4; which 1 indicates the lowest perceived competence and 4 indicates the highest perceived competence. The low score indicates low social competence. Harter mentioned that social competence subscale has an acceptable instrument for Cronbach's alpha ranged from .75 to .84.

4. BDI-II

BDI-II is one of the instruments that frequently used to measure depression. Many studies found that the BDI-II has good validity and reliability; the internal consistency reported ranged from .84-.90 and retest reliability ranged from .73-.96 and a high correlation with BDI-I (Kuhner et al., 2007; Wang and Gorenstein, 2013). The Indonesian version was also reported to have a good reliability in internal consistency and Cronbach's alpha for .80 and .90 respectively (Ginting et al, 2013). The Indonesian version of the BDI-II also suggested cutoff point 17 for mild depression. This study focuses on the mother because based on previous studies, mostly mentioned that maternal depression related to mental health problems in school-aged children with mental health problems (Bordin et al, 2009; Darunee Ngamkum, 2013; Hancock et al, 2013; Lesesne, Visser and White, 2003; Lyons-Ruth, Easterbrooks and Cibelli, 1997; Mendes et al, 2013; Nantacha Sanguenkulchai, 2013; Olives et al, 2013; Whitaker, Orzol and Kahn, 2014).

BDI-II consists of 21 groups of statements with three options of answers based on the topic for each group of statements. Ginting et al. (2013) suggested the range of score for Indonesia population as follow: 0-13 = normal, 14-17 = mild depression, 18-28 = moderate depression and 29-63 = severe depression. In this study, researcher used an Indonesian version of the BDI-II because it showed good reliability and suitable for Indonesian culture, and the questionnaire was fulfilled by mother of school-aged children with mental health problems in Aceh province, Indonesia.

5. PR questionnaire

Cohen et al. (1977) developed PR questionnaire to measure parenting behavior of parents in fostering their child, based on their previous studies with a range of samples age from toddler to adolescent. PR questionnaire was reported to have acceptable reliability with Cronbach's alpha ranged from .67 to .90 (Cohen et al., 1977). This consists of five behavioral dimensions such as respect for autonomy (4 items), control through guilt and anxiety (4 items), consistency (4 items), child

centeredness (4 items), and parental temper and detachment (4 items) for total 20 questions. The provided options of answer are Likert Scale rated 0 = never to 6 = always. The highest score is interpreted that parent show the pointed behaviors.

In this study, the researcher only focused on parenting behavior of mothers because they are usually performed inconsistent discipline and less respect for children's autonomy in parenting behaviors and both of those factors related to mental health problems in school-aged children (Alizadeh, Applequist and Coolidge, 2007; Moghaddam et al 2013;Yousefia, Far and Abdolahian, 2011).

6. PSS

Berry and Jones (1995) developed PSS to measure the parenting stress level, whether or not the parents have children with or without mental health problems. This instrument can be used for both fathers and mothers to identify their stress during their experience in raising the child. PSS consists of both of positive parenting experience and negative parenting experience. The positive parenting experiences include emotional benefits; self-enrichment, and personal development, meanwhile negative parenting experience includes these following components such as demands on resources, opportunity costs and restrictions.

This self-report scale of parenthood experience contains 18 items to measure parental relationships towards the children with an expression of agree and disagree five-point scale, start from 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, and 5 = strongly agree. Eight items of positive statement have reserved score, so the possible score ranges from 18 to 90, whereas a higher score indicates the greater parenting stress of fathers and/or mothers. The parental stress scale demonstrated satisfactory levels of internal reliability for .83 and test-retest reliability for .81, and this instrument is believed as a good instrument to measure the parenting scale for parents of children with mental health problems.

This study measured the maternal parenting stress of school-aged children with mental health problems, because some studies found that mothers perceived more stress in raising a child with behavioral problems than fathers, because their expected roles to take more responsibility in raising children and spent more time at home than fathers (Harvey, 2000; Williford, Calkins and Keane, 2007; Yousefia, Far and Abdolahian, 2011). In addition, the differences of parenting behavior may affect

parenting stress of fathers and mother. Turner (2011) mentioned whenever the child gets a problem, father tend to have less immediate support and teach adaptive problem-solving skills than mother that is directly intervene the problem. By conducting this behavior, mother is believed to have more parenting stress than father, because she wants to get involve into her child's problem until the problem is solved.

7. BFRS

The instrument of BFRS was developed by Fok et al. (2013), adopted from the Family Environment Scale (FES) relationship dimension by Moos and Moos (1994). This short version of questionnaires can be used to measure family functioning based on three aspects of family relationship, such as cohesion (7 items), expressiveness (3 items), and conflict (6 items). BFRS showed good reliability for Cronbach's alpha .88 and it can be used not only in Western background population and an American Indian population, but also south and East Asian population.

In this study, family environment-relationship dimension will be measured in mothers because study of Van Loon et al.(2013) revealed that mother with mental health problems, depression, tend to show a bad level of relationship, such as less level of cohesion and expressiveness and more conflict. Mothers will be asked to fulfill BFRS with total 16 questions and answer's options such as Not at all = 0, somewhat = 1, and A lot = 2. The lower score of BFRS can be interpreted as poor level of family environment-relationship dimension.

Translation process

The process of translation of instruments that were used in this study was conducted by Back-Translation technique, where the following instruments such as SCQ, BFRS, PSS, and PR questionnaire were translated from English version to Bahasa Indonesia by bilingual translators who were good both in English and Bahasa Indonesia. The translators were expected to have appropriate English proficiency score, such as Test of English as a Foreign Language (TOEFL) score for ≥ 550 or International English Language Testing System (IELTS) score for ≥ 6. The translation process was described as follow:

Step 1: two translators translated English version of instruments to Bahasa Indonesia, separately.

Step 2: the researcher invited the translators to discuss and compare two versions of translated instruments in order to get the better version of Bahasa Indonesia.

Step 3: the other two translators were asked to translate the first Bahasa Indonesia version of the instruments into English version.

Step 4: the researcher compared the original English version of the instruments with the English translated version of the instruments. The researcher found some different words but still have similar meaning between the original and translated instruments. The final version of Bahasa Indonesia instruments was produced. The final Bahasa Indonesia version of instruments was tested for validity and reliability.

Psychometric testing

Validity and reliability of instruments

In this study**,** there were four instruments that still need to be translated into Bahasa Indonesia and checked for both validity and reliability testing, such as SCQ, PR questionnaire, PSS and BFRS. For validity testing, the researcher performed Content Validity Testing (CVI) and asked five experts consist of three psychiatric nurses, and two pediatric nurses. Experts were asked to rate each item by rating scale; 1 (not relevant) to 4 (relevant) including comment and possible revision. The experts were agree if they put score 3 and 4. List of the experts in this study are presented in Appendix D. CVI score .80 is more desirable based on formula (Polit and Beck, 2008): CVI= number of agreed items/total number of items

Table 3 Content Validity Index of research instruments

Instruments	Scale-CVI/Ave	Item-CVI
1. SCQ (6 items)	1	1.00
2. PR questionnaire (20 items)	.90	.86-1.00
3. PSS (18 items)	.92	.86-1.00
4. BFRS (16 items)	.96	.86-1.00

Having reviewed by the experts, all of four instruments showed acceptable score of CVI, because their scores is higher than .80. The results of content validity index were summarized in Table 3.Table 3 showed that majority experts agreed with the instruments of SCQ, PR, PSS, and BFRS. Most of them suggested the more appropriate and understandable translated words to increase the comprehension of Indonesian population.

The reliability testing of the instruments was performed in each 30 mothers and school-aged children with similar characteristics and meet inclusion criteria of the study. The participants were informed about their rights to decide, whether or not they wanted to participate in this pilot study. The result of the pilot study showed that the time spent on completion of the questionnaires took about 45 minutes. The findings showed that all of the tested instruments had acceptable reliability because the acceptable level of alpha Cronbach for the instruments is at least .70 (Burns and Groove, 2009). The reliabilities of the instruments were summarized in table 4.

Table 4 Reliabilities of the pilot study (n=30) and current study (n=154).

Variable	Instrument	Item	Cronbach's alpha (n=30)	Cronbach's alpha (n=154)
Social competence	SCQ	6	.809	.969
Maternal parenting behavior	PR	20	.777	.841
Maternal parenting stress	PSS	18	.711	.982
Family Environment-Relationship Dimension	BFRS	16	.852	.928

Summary of instruments

The instruments that were used in this study are presented in Appendix G. two instruments were already have Bahasa Indonesia version, such as SDQ (Goodman, 2014) and BDI-II (Ginting et al., 2013). Four instruments were translated into Bahasa Indonesia by using Back-Translation technique, such as SCQ (Harter, 1982/2014), PR questionnaire (Cohen et al., 1977), PSS (Berry and Jones, 1995), and BFRS (Fok et al., 2013). Personal information sheet was developed by the researcher. All of the translated instruments showed satisfactory validity and reliability.

Protection of human subjects

Ethical permission is one of the important parts of the research that put human as a sample, and in order to convince that the participants are safe and the process is not endangered their lives, the researcher has to get ethical permission before start collecting data. This study was conducted in Aceh province, Indonesia, so the ethical permission was gathered from the Institutional Review Board (IRB) of Indonesia. The institution is called Komite Nasional Etik Penelitian Kesehatan (KNEPK) or National Ethical committee of health research, and nursing faculty of Universitas Sumatera Utara, No. 551/VII/SP/2015. The written informed consent for both mothers and children finished before data collection was started in Indonesia. The informed consent form explained the purposes of the study, benefits, risks, and the questionnaires that needed to be completed by participants.

Before the children and mothers fulfilled the questionnaires, they were informed about their rights in the study, such as refused to participate in the research and withdraw from the study at any time without penalty, if they did not want to answer the questionnaires. In order to ensure confidentiality, the name of participants was not being entered in the database; instead, the code number was used to represent the participants of the study. Having participated in this study, the participants were not asked for any payment and also there was no harm for their participation. However, after completing the questionnaire, the gift was presented to the participants as appreciation for their participation in the study.

Data collection

Having approved by the Institutional Review Board (IRB) from Komite Nasional Etik Penelitian Kesehatan (KNEPK) or National Ethical committee of health research in Indonesia at nursing faculty, Universitas Sumatera Utara, the governmental university in North Sumatera province, the data were collected from the participants. The following process described the data collection procedures for this current study.

1. The researcher trained research assistants for data collection. Two bachelor nurses who have experiences in child and adolescent were the research assistants, because the researcher had difficulties to find nurses with mental health and psychiatric background. Research assistants were trained about questionnaire administration by researcher. In addition, they were also trained for inform assent and consent by using the participant information sheet. At the beginning, research assistants were asked to observe researcher in administering the questionnaires, the researcher also performed how to answer questions from the participants until they understand the information. Before let the research assistant did the procedure by themselves, researcher observed them and gave them suggestion to improve their comprehension in using the questionnaires, conducting inform assent and consent procedures. After they could perform the appropriate procedure, the researcher let them know and allow them to be research assistants in process of data collection.

2. The researcher sent an official letter to the Dinas Pendidikan, Pemuda, dan Olahraga or education, youth, and sports office in these three districts such as North Aceh district, Lhokseumawe district, and Bireuen district to ask for written permission. After that, the permission letters were delivered to the selected elementary schools. Having gathered the permission from the principals, the researcher met the teacher and informed about the purposes and the importance of the study. In addition, the discussion about questionnaires, data collection methods, and ethical consideration were conducted in order to enhance the comprehension of counseling teachers and mothers about the process of the study.

3. First of all, the researcher asked counseling teachers to screen school-aged children under their supervision, some of criteria such as children with no friend, or tended to play alone, children who had problems with peer or teacher, and children

who could not stand still for long time, or children who disturbed the learning process in the class. Teachers were also asked to provide the researcher for student's report book. A 17-18 students were selected by teachers for at least one week. Of 218 school-aged children with mental health problems, 154 school-aged children with mental health problems were selected but, 143 students were maintained in the study. The total time needed to collect data from all of participants was about two months (started from the third week of July and finished in the second week of September 2015).

4. In order to ask mother participation in the study, the researcher and teacher discussed the most appropriate way to approach mother based on the local situation. Based on the discussion, there were three methods applied, such as inviting mother to school, visiting mother directly to their homes, and asking teacher to help researcher to collect data from mothers. They were asked to fulfill following instruments; Personal Information Sheet, SDQ, BDI-II, PSS, PR questionnaire, and BFRS to measure family income, mental health problems in their children, maternal depression, maternal parenting stress, maternal parenting behavior, and family relationship.

5. The researcher also prepared informed consent and a paper that explain about the purposes of the study and the contribution that they can make if they participated in the study. The researcher emphasized on confidentiality of the information that was being collected. The researcher also asked for mother's permission to collect data from their children at school.

6. In the first method, mothers of children from six elementary schools needed at least two hours to fulfill six instruments, some of mothers had difficulties to understand the instruments' instructions and some questions in the questionnaires. The researcher and research assistants helped them to understand instructions and explained unfamiliar words. But, some mothers came late, so this situation made data collection process delayed. In the second method, the researcher and research assistants visited two locations in each district of Lhokseumawe (Muara Dua) and Bireuen (Peusangan) for 3-5 mothers a day. Some problems that occurred in this process including; some mothers were busy with their activities at homes, and some mothers were not at home, so the researcher and research assistants had to go back

later. For the third method, teacher of one area in North Aceh district (Bayu Sub-District) was asked to delivered questionnaires to mothers. Some mothers needed more than three days to fulfill the questionnaires, and some of them called the researcher by provided phone number, whenever they had some questions about the instruments.

7. During maternal data collection process, the researcher asked the teacher to collect all of selected students with abnormal scores of SDQ in one class to fulfill the questionnaire of SCQ to measure their social competence after informed consent were collected from them. For this process, the researcher and research assistants had at least one hour to explain about the questionnaire, because some children had problems to understand about instructions and the questionnaire's items. To overcome this situation, the researcher and research assistants accompanied them step by step, and explained unfamiliar words, and some students needed to be guided personally.

8. After completing the questionnaires, the researcher examined the questionnaire whether or not they were complete and asks participants to fulfill the questionnaires again if there was any missing data. Having appreciated for cooperation, the researcher gave each mother a gift for their participation in the study.

Data analysis

Data were analyzed by descriptive and inferential statistics as follow:

1. Descriptive statistics were applied in order to describe the demographic characteristics of the participants and to describe mental health problems in school-aged children.

2. The bivariate correlation analysis was used to examine the relationships between the selected variables and mental health problems and each dimensions, after normality test was performed to determine which association test was more appropriate based on the data distribution.

Normality testing

In the current study, there were six variables that needed to be investigated for normal distribution such as mental health problems, social competence, family environment-relationship dimension, maternal parenting stress, maternal parenting behavior, and maternal depression. The test of normal distribution was conducted by using descriptive statistics, such as mean, standard deviation, skewness, and kurtosis.

Mental health problems of school-aged children

The total score of mental health problems was ranged from 16 to 23 (the possible range = 16 to 40) with a mean of 17.66 (SD = .978). The mental health problems score has a positive skewness value (1.451), thus indicating that most of the participants had score of mental health problems lower than the mean score. The kurtosis value of mental health problems was a positive value (1.570), thus suggesting that mental health problems scores were shaped like a leptokurtic.

Social competence

The finding revealed that school-aged children with mental health problems had total score of social competence ranged from 6 to 24 (the possible range = 6 to 24) with the mean score of 12.85 (SD = 6.271). The social competence scores had a positive skewness value (.560), thus indicating that most of the participants had score of social competence lower than the mean score. The kurtosis value of social competence was a positive value (-.1.423), thus suggesting that social competence scores were shaped like a platykurtic.

Family environment-relationship dimension

The total score of family environment-relationship dimension was ranged from 5 to 32 (the possible range = 0 to 32) with the mean score of 18.99 (SD = 7.400). The family environment-relationship dimension scores had a negative skewness value (-.342), thus indicating that most of the participants had score of family environment-relationship dimension higher than the mean score. The kurtosis value of family environment-relationship dimension was a negative value (-.993), thus suggesting that family environment-relationship dimension scores were shaped like a platykurtic (flattened curve).

Maternal parenting stress

The total score of maternal parenting stress of school-aged children with mental health problems was ranged from 18 to 82 (the possible range = 18 to 90) with a mean of 52.52 (SD = 19.90). The maternal parenting stress scores had a slight negative skewness value (-.190), thus indicating that most of the participants had score of maternal parenting stress higher than the mean score. The kurtosis value of maternal parenting stress was a negative value (-1.604), thus suggesting that maternal parenting stress scores were shaped like a platykurtic (flattened curve).

Maternal parenting behavior

The finding revealed that mothers of school-aged children with mental health problems had total score of maternal parenting behavior ranged from 38 to 96 (the possible range 0 to 120) with a mean of 69.36 (SD = 10.238). The maternal parenting behavior scores had a slight positive skewness value (-.810), thus indicating that most of the participants had score of maternal parenting behavior higher than the mean score. The kurtosis value of social competence was a positive value (.738), thus suggesting that maternal parenting behavior scores were shaped like a leptokurtic.

Maternal depression

The total score of maternal depression of school-aged children with mental health problems was ranged from 0 to 28 (the possible range = 0 to 63) with a mean of 17.17 (SD = 7.278). The maternal depression scores had a negative skewness value (-.448), thus indicating that most of the participants had score of maternal depression higher than the mean score. The kurtosis value of maternal depression was a negative value (-.265), thus suggesting that maternal depression scores were shaped like a platykurtic (flattened curve). Details about normality testing are shown in table 5.

3. Of 154 participants, 143 participants were maintained in this study, in order to minimize bias in analysis. Based on normality testing, all of the tested variables show non normal distribution of the samples, so the association test would be conducted by non-parametric testing. The relationship between gender, age, academic competence, social competence, economic status, family environment-relationship dimension, maternal parenting stress, maternal parenting behavior, maternal depression with mental health problems and each dimension were tested by Spearman Correlation.

Table 5 Possible range, actual range, Mean, SD, Skewness, kurtosis, standard error, and the interpretation mental health problems, social competence, family environment, maternal parenting stress, maternal parenting behavior, and maternal depression (n= 143).

Variable	Possible range	Actual range	Mean	SD	Skewness (SE)	Kurtosis (SE)
MHP	17-40	17-21	17.66	.978	1.541 (.203)	.761 (.403)
SC	6-24	6-24	12.85	6.271	.560 (.203)	-1.423 (.403)
FERD	0-32	5-32	18.99	7.400	-.342 (.203)	-.993 (.403)
MPS	18-90	18-82	52.52	19.910	-.190 (.203)	-1.604 (.403)
MPB	0-120	38-96	69.36	10.238	-.810 (.203)	.738 (.403)
MD	0-63	0-28	17.17	7.278	-.448 (.203)	-.265 (.403)

Note: MHP = Mental Health Problems, SC = Social Competence, FERD = Family Environment Relationship Dimension, MPS = Maternal Parenting Stress, MPB = Maternal Parenting Behavior, MD = Maternal Depression.

CHAPTER IV

RESULTS

This chapter presents the result of; 1) descriptive data of mental health problems in school-aged children with mental health problems in Aceh province, Indonesia, 2) relationship between gender, age, academic competence and social competence of children, economic status and family environment especially relationship dimension, maternal parenting stress, maternal parenting behavior, and maternal depression with mental health problems in school-aged children with mental health problems. Data collection was performed from July (third week) to September (second week) 2015 in nine selected elementary schools in Aceh province, Indonesia.

Descriptive data of mental health problems in school-aged children with mental health problems, in Aceh province, Indonesia.

The investigation about mental health problems in school-aged children in Aceh province, Indonesia was evaluated by SDQ score of mother, and it included each dimensions of SDQ, such as emotional symptoms, conduct problem, hyperactivity, and peer problem. Details about mental health problems in school-aged children, including each dimension are shown in table 6.

Table 6 Mental health problems characteristics rated by mothers (n=143)

Dimension	Number	Percentage
Emotional symptoms	54	37.8
Conduct problem	27	18.9
Hyperactivity	39	27.3
Peer problem	23	16.1

The majority of mothers in Aceh province rated their school-aged children with mental health problems for having emotional symptoms (37.8%), hyperactivity (27.3%), conduct problem (18.9%), and peer problem (16.1%).

Table 7 Frequency of variables compared to mental health problems (n=143).

Variables	Mental Health Problems (%)				
	Total	**Emotional**	**Conduct**	**Hyperactivity**	**Peer**
Gender					
Male	110 (76.9)	41 (28.7)	21 (14.7)	31 (21.7)	17 (11.9)
Female	33 (23.1)	13 (9.1)	6 (4.2)	9 (6.3)	5 (3.5)
Age					
6-9 years	52 (36.4)	22 (15.4)	13 (9.1)	14 (9.8)	3 (2.1)
10-12 years old	91 (63.3)	32 (22.4)	14 (9.8)	26 (18.2)	19 (13.3)
Academic competence					
Low	5 (3.5)	1 (0.7)	1 (0.7)	3 (2.1)	0 (0)
Moderate	87 (60.8)	36 (25.2)	15 (10.5)	26 (18.2)	10 (7.0)
High	17 (35.7)	17 (11.9)	11 (7.7)	11 (7.7)	12 (8.4)
Social competence					
Low	31 (21.7)	14 (9.8)	7 (4.9)	5 (3.5)	5 (3.5)
Moderate	81 (56.6)	25 (17.5)	13 (9.1)	28 (19.6)	15 (10.5)
High	31 (21.7)	15 (10.5)	7 (4.9)	7 (4.9)	2 (1.4)
Family Income					
Low	84 (58.7)	27 (18.9)	19 (13.3)	29 (20.3)	9 (6.3)
Moderate	48 (33.6)	24 (16.8)	6 (4.2)	9 (6.3)	9 (6.3)
High	11 (7.7)	3 (2.1)	2 (1.4)	2 (1.4)	4 (2.8)
Family Environment-Relationship Dimension					
Low	37 (25.9)	14 (9.8)	9 (6.3)	9 (6.3)	5 (3.5)
Moderate	69 (48.3)	27 (18.9)	12 (8.4)	20 (14)	10 (7.0)
High	37 (25.9)	13 (9.1)	6 (4.2)	11 (7.7)	7 (4.9)
Maternal Parenting Behavior					
Low	35 (24.5)	14 (9.8)	4 (2.8)	10 (7.0)	7 (4.9)
Moderate	76 (53.1)	26 (18.2)	18 (12.6)	23 (16.1)	9 (6.3)
High	32 (22.4)	14 (9.8)	5 (3.5)	7 (4.9)	6 (4.2)
Maternal Parenting Behavior					
Low	22 (15.4)	12 (8.4)	3 (2.1)	5 (3.5)	2 (1.4)
Moderate	102 (71.3)	40 (28.0)	19 (13.3)	27 (18.9)	16 (11.2)
High	19 (13.3)	2 (1.4)	5 (3.5)	8 (5.6)	4 (2.8)
Maternal Depression					
Low	15 (10.5)	3 (2.1)	1 (0.7)	8 (5.6)	3 (2.1)
Moderate	101 (70.6)	37 (25.9)	23 (16.1)	27 (18.9)	14 (9.8)
High	27 (18.9)	14 (9.8)	3 (2.1)	5 (3.5)	5 (3.5)

Based on table 7, the majority of school-aged children with mental health problems was male (76.9%), range of age was 10-12 years old (63.3%). Most of them had moderate level of academic competence (60.8%) and social competence (56.6%). They derived from low income family (58.7%) and they had moderate level of family relationship (48.3%). Meanwhile, their mothers showed moderate level of maternal parenting stress, maternal parenting behavior, and maternal depression (53.1%, 71.3% and 70.6%, respectively).

In details, the majority male and female school-aged children had emotional symptoms (28.7% and 9.1% respectively). Interestingly, study found that school-aged children with emotional symptoms were older school-aged children (22.4%), and they exhibited moderate level of academic competence (25.2%). Meanwhile, 19.6% school-aged children with hyperactivity showed moderate level of social competence. In addition, school-aged children with hyperactivity derived from low income family (20.3%). School-aged children with emotional symptoms had moderate level of relationship in their family (18.9%). Furthermore, mothers of school-aged children with emotional symptoms had moderate level of parenting stress, parenting behavior, and depression (18.2%, 28% and 25.9%, respectively).

Correlation between selected related factors with mental health problems

The bivariate Spearman correlation was used to investigate the relationship between gender, age, maternal depression, maternal parenting behaviors, maternal parenting stress and mental health problems among Acehnese school-aged children with mental health problems. Burns and Grove (2009) mentioned that, relationship is significant if *p* value < .05. The relationship magnitude was determined by the following criteria: r <.30 = weak or low relationship, .30 ≥ r ≥ .50 = moderate relationship and r > .50 = strong or high relationship.

As shown in table 8, there were three variables had relationship with mental health problems (total score). Academic competence had negative relationship with mental health problems at a low level (r = -.177, p < .05), family environment-relationship dimension had negative relationship with mental health problems at a low level (r = -.173, p < .05), and maternal parenting stress had positive relationship with mental health problems at a low level (r = .173, p < .05).

Table 8 Correlation coefficients of the variables compared to total score of mental health problems and each dimensions (n=143).

Variable	Total Difficulties Score		Emotional symptoms		Conduct problem		Hyperactivity		Peer problem	
	r	p-value	*r*	p-value	*r*	p-value	*r*	p-value	*r*	p-value
Gender	-.036	.671	.020	.808	.092	.275	.028	.736	-.067	.430
Age	.134	.056	.094	.133	.108	.099	-.010	.453	-.162	.026*
Academic competence	-.177	.017*	-.094	.133	-.052	.268	-.119	.078	.101	.114
Social Competence	-.110	.095	-.010	.095	.017	.421	.034	.344	-.116	.083
Family income	.024	.387	-.097	.124	.095	.131	.103	.111	-.005	.476
Family Relationship	-.175	.018*	-.013	.438	-.122	.074	.031	.356	.018	.414
Maternal parenting stress	.173	.020*	.052	.270	.113	.090	-.004	.479	-.093	.135
Maternal parenting behavior	.053	.263	-.287	.000*	.162	.027*	.143	.044*	.003	.488
Maternal depression	.023	.392	.236	.002*	-.019	.410	-.158	.030*	.020	.407

* Variables had significant relationship at level .05

+/- Variables had positive or negative relationship.

Furthermore, based on table 8; age had negative relationship with peer problem at a low level ($r = -.162$, $p < .05$). Meanwhile, Maternal parenting behavior had negative relationship with emotional symptoms ($r = -.287$, $p < .05$) and positive relationship with conduct problem and hyperactivity at a low level ($r = .162$, $p < .05$, $r = .143$, $p < .05$). Maternal depression had positive relationship with emotional symptoms ($r = .236$, $p < .05$) and negative relationship with hyperactivity at a low level ($r = -.158$, $p < .05$). In addition, gender, academic competence, social competence, economic status, family relationship, and maternal stress had no relationship with any dimensions of mental health problems.

CHAPTER V
DISCUSSION

This chapter focuses on the discussion of the study findings. It provides conclusion, discussion of participants' characteristics and study variables, testing hypothesis, limitations, implications for nursing, and recommendations for future research.

Conclusion

The purposes of this cross-sectional descriptive correlation study were to describe mental health problems in school-aged children and investigate relationship of selected factors such as gender, age, academic competence, and social competence of the children, family income and family environment especially relationship dimension, maternal parenting stress, maternal parenting behavior, and maternal depression with mental health problems in school-aged children with mental health problems in Aceh province, Indonesia. Recruitment process of 143 school-aged children with mental health problems at nine elementary schools from three districts and three selected sub-districts in province of Aceh was conducted by multi-stage random sampling. Data collection was performed from the third week of July until the second week of September 2015.

The research instrument was a questionnaire used to measure demographic data and both of independent variables and dependent variable. The questionnaire consisted of two parts; part one was for children, and part two for mothers. The children's questionnaire was Social Competence Questionnaire (SCQ). The mothers' questionnaire consisted of demographic questionnaire, Strengths and Difficulties Questionnaire (SDQ), Brief Family Relationship (BFR), Parenting Stress Scale (PSS), Parents' Report (PR), and Beck Depression Index-II (BDI-II). The validities and reliabilities of the instruments were examined. The association test among variables was tested by Spearman correlation.

A total of 143 school-aged children with mental health problems were selected in this study by their teachers. Most of them were male (76.9%), age 10-12 years old

(63.6%), and they have been lived with more than two siblings (58.7%). The majority of children had grade point average score 2.00 or moderate academic competence (60.8%). Whereas, the majority of maternal age of school-aged children with mental health problems was 30-40 years old (44.8%) and married (80.4%). Most of them had finished junior high school to senior high school or middle educational background (49%). In addition, more than a half mothers were unemployed (67.1%) and income per month less than Rp.600,000 or low economic status (58.7%).

The score of SDQ rated by mothers showed that, mothers of school-aged children with mental health problems in Aceh province had score of SDQ slightly higher that cutoff point (17) for total score of disabilities ($\overline{X}$ = 17.66 SD = .978). Mostly mothers rated their school-aged children with mental health problems for emotional symptoms (37.8%), hyperactivity (27.3%), conduct problem (18.9%), and peer problem (16.1%). In school-aged children with mental health problems, most of them showed moderate social competence (56.6%), and they had moderate family relationship with other family members (48.3%) and moderate parenting stress (53.1%). It was also confirmed that, the majority mothers with school-aged children with mental health problems also were suffering from moderate depression (70.6%).

Moreover, Spearman correlation was used to measure relationship among variables in school-aged children with mental health problems in Aceh province, Indonesia; gender did not have relationship with mental health problems. Gender also had no relationship with other dimensions of mental health problems. The other findings are found that age, social competence, family income, maternal depression, and maternal parenting behaviors have no relationship with mental health problems. In this study, there were three independent variables related to mental health problems, such as maternal parenting stress, academic competence and family environment-relationship dimension. Maternal parenting stress was positively related to mental health problems at a low level, academic competence and family environment-relationship dimension had negative relationship with mental health problems at a low level.

Specifically, there were three variables related to sub-dimensions of mental health problems, such as age negatively related to peer problems at a low level, meanwhile, maternal parenting behavior negatively related to emotional symptoms,

and positively related to conduct problem and hyperactivity at a low level. In addition, maternal depression had positive and negative relationship with emotional symptoms and hyperactivity at a low level, respectively.

Discussion

The purposes of this study were to describe mental health problems in school-aged children and investigate the relationship between gender, age, academic competence, social competence of children, family income and family environment especially relationship dimension, maternal parenting stress, maternal parenting behavior and maternal depression with mental health problems in school-aged children with mental health problems in Aceh province, Indonesia.

SDQ was applied in order to evaluate mental health problems in school-aged children, the study found that some situations of relationship; 1) there was one independent variable related to one dimension of mental health problems, but the total difficulties score showed no relationship with that independent variable; 2) there were some independent variables had no relationship with total score difficulties, but they had relationship with dimensions of mental health problems. This situation is possible, because each dimension of mental health problems that are measured by SDQ can be evaluated individually and the dimensions showed acceptable validity and reliability. In addition, each item of the dimensions correlated significantly and most highly with its respective dimension, so the independent variables may or may not related to total difficulties score, but they may be related to their dimensions separately (Goodman, 1997; Palmieri and Smith, 2007).

Findings of the research objectives and hypotheses testing

To describe mental health problems in school-aged children in Aceh province, Indonesia.

Based on mothers' score of SDQ, this study found that, the majority of school-aged children in Aceh province, Indonesia were suffering from emotional symptoms (37.8%), hyperactivity (28%), conduct problem (18.9%), and peer problem (15.4%) [Table 7]. This finding revealed that mothers rated their children for having emotional problems more than behavioral problems. Mother's rated-SDQ was supported by

study of Wiguna et al. (2010), they found that mostly mothers who took their children to psychiatry's child and adolescent polyclinic in Ciptomangunkusumo hospital in Jakarta were children with emotional problems by having peer problem and emotional symptoms as majority problems of their children (54.8% and 42.2% respectively).

As the major problem of school-aged children in Aceh province, an emotional symptom is mentioned as one of problems that may be difficult to be observed by parents. A parent is unaware of emotional symptoms because they cannot be observed directly from children's behaviors, and the problems remain undetected and untreated properly. Hockenberry and Wilson (2009) explained that in both school-aged children with or without mental health problems, it will be easier for them to feel worry or stress about their performances at school or their ability to achieve the desired developmental tasks, because they will be observed not only by their teachers, but also their friends. This situation puts school-aged children have more risk for emotional symptoms compare to any other condition of mental health problems.

In contrast, Reddy and De Thomas (2007) mentioned that hyperactivity is one of the most reported mental health problems in school-aged children and they will be referred by parent to seek mental health experts. Having known the situation, school-aged children may experience both of emotional problems and behavioral problems and parent should understand that, mental health problems in school-aged children have negative impacts, not only for themselves (body image disturbances, feeling of overwhelming worry, and self-stigmatization), but also for family (parental conflict and parental stress), school (bullying, feeling of rejection and isolation), friendship, and community (stigmatization and discrimination) [Hucksmith, Spratt, Philip, and McNaughton, 2008]. Parents should understand how to detect mental health problems in their children and refer to mental health professionals, especially when they find something uncommon or for having difficulties to control their children. the comprehension about factors related to mental health problems, may help them to identify which factors is possible for modification in order to minimize the severity or the impact of the problems in the family.

Research hypothesis 1: There is a positive relationship between age and mental health problem in school-aged children with mental health problems in Aceh province, Indonesia.

This study revealed that there was no positive relationship between age of children with mental health problems in school-aged children with mental health problems in Aceh province, Indonesia ($r = .134$, $p > .05$), but age negatively related to peer problem at a low level ($r = -.161$, $p < .05$).

The majority of students who involved in this study were older school-aged children with mental health problems, especially hyperactivity (14.7%). Study of Lesesne, Visser, and White (2003) revealed that older school-aged children exhibited more behavioral problem than emotional problem. In contrast, other studies found that older school-aged children tended to have emotional symptoms (Chabra, Chavez, and Harris, 1999; Mendes, Crippa, Souza and Loureiro, 2013; Wiguna et al., 2010). Furthermore, study of Bayer et al. (2011) found in their longitudinal study in Australia, they mentioned that both of emotional problems and behavioral problems might also display in younger school-aged children.

This finding neither supported the hypothesis in this study nor did previous studies relate to age and mental health problems (Lesesne, Visser and White, 2003). Even this study found that mostly school-aged children with mental health problems were older school-aged children (63.3%), but the association test showed that no relationship between age of children and mental health problems in school-aged children with mental health problems. Compared to younger school-aged children, older school-aged children put perception of others have more influence than popular culture from media. Ozterich and Bowman (2001) mentioned that, perception of other children is important for older school-aged children, because it will change their thought. Once, when they are labeled for having inappropriate behavior, especially with risk of mental health problems, this situation may make their mental health problems become worse, and labeling is easier in older school-aged children than younger school-aged children (Hay, 2005). In short, older school-aged children have more risk for mental health problems than the younger school-aged children.

This study also found negative relationship between age and peer problem. Based on this finding, this study revealed that, younger school-aged children with

mental health problems tended to have peer problem. It is a bit surprising, because Hoza (2008) mentioned that older school-aged children will have a problem with peer, because in this age, children put peer as one of important persons. It is easier for peers to label their friends, especially when their friends perform undesired and unaccepted behaviors with their group, whether or not they have mental health problems, peers tend to label and mock them and avoid to befriend with them. The explanation for the finding is younger children with mental health problems may experiencing more difficulties than their counterparts because they have to adapt with new environment, new persons and master new skills to support their performances at school. The finding of this study also is not supported by previous studies (Chabra, Chavez and Harris, 1999; Lesesne, Visser and White, 2003; Mendes, Crippa, Souza and Loureiro, 2013; Wiguna et al., 2010). But, study of Bayer et al. (2011) revealed that, Australian younger school-aged children were experiencing the same problems as older school-aged children. It may conclude that, both of younger and older school-aged children have the same opportunity to suffering from mental health problems, and it was not specifically related with age of school-aged children. But, it should be emphasized that younger school-aged children with mental health problems tended to have peer problem, and both of mother and teacher need to pay attention to this group in order to minimize the impact of mental health problems for themselves or other significant persons, such as teacher and peer.

Research hypothesis 2: There is a relationship between gender and mental health problem in school-aged children with mental health problems in Aceh province, Indonesia.

This study revealed that, there was no relationship between gender of children with mental health problems in school-aged children with mental health problems in Aceh province, Indonesia ($r = -.036$, $p > .05$).

Based on descriptive analysis, this study found that mostly school-aged children with emotional symptoms were male (28.7%). This study finding was not supported by previous studies that were conducted in western countries, because mostly they found that male tended to show more behavioral problems such as hyperactivity and conduct problem that emotional or peer problem (Davis et al., 2010; Leadbeater, Kuperminc and Blatt, 1999; Lesesne, Visser, and White, 2003; Rodriguez

et al., 2011). But, there were two studies appropriate with the finding; study of Chabra, Chavez, and Harris (1999) revealed that hospitalized school-aged children with emotional problem in California were male (67.3%), and study in Indonesia, Wiguna et al. (2010) also found that male exhibited more emotional problem than female (21.7% compared to 20.5%, respectively).

This finding did not support the hypothesis in this study. This finding was also not congruent with previous studies (Davis et al., 2010; Leadbeater, Kuperminc and Blatt, 1999). In the literature, there were many previous studies proved that mental health problems in school-aged children were not only occurred in specific gender, whether it male or female had the same opportunity to experience mental health problems. The study of Chabra, Chavez, and Harris (1999) and Wiguna et al. (2010) revealed that male gender of school-aged children tended to show more mental health problems than female gender. In contrast, studies of Davis et al., and Leadbeater, Kuperminc and Blatt (1999) found that female gender exhibited more mental health problems than male gender.

The differences of sex hormones between male and female as well as sex chromosomes brings consequences for them to have mental health problems based on their gender (Wicks-Nelson and Israel, 2006). This is the reason why, some male students tended to exhibit more behavioral problems than emotional problems and female students tended to show more emotional problems than behavioral problems. But, Dogra, Gupta, and Leighton (2009) mentioned that what makes specific gender to have a specific mental health problems remain unclear. They explained that it could be genetic factor, but also social expectation may contribute to this situation, where girls are expected to internalize their problems, meanwhile boys are expected to express their problems by exhibit specific behaviors. Furthermore, the result of this study supported the conclusion that, any gender of school-aged children may have the same opportunity to develop mental health problems, both of emotional problems and behavioral problems.

Research hypothesis 3: There is a negative relationship between social competence and mental health problem in school-aged children with mental health problems in Aceh province, Indonesia.

This study found that there was no negative relationship between social competence with mental health problems in school-aged children with mental health problems in Aceh province, Indonesia ($r = -.110$, $p > .05$).

The finding did not support the hypothesis and previous study related to social competence and mental health problems in school-aged children with mental health problems. Previous studies found many pattern of relationship; such as social competence related to both emotional and behavioral problems (Bornstein, Hahn, and Hayne, 2010), low social competence related to behavioral problems (Achenbach and Edelbrock, 1981), high social competence related to emotional problems (Rolf, 1972), and low social competence related to emotional problems (Sallquist et al., 2009). Furthermore, social competence also predicted emotional problems, especially depression, of school-aged children (Cole, Martin, Powers, and Truglio, 1996).

This study found, mostly school-aged children with mental health problems showed moderate social competence (55.8%). One of possible reasons is, the researcher met this group of children at their school, not in the clinical setting, so the social competence was still in moderate level. If the researcher meets them at the hospital, they may show low social competence, and the diagnosis of mental health problems will be more specific. It is because SDQ is only the initial assessment that the teacher may conduct to ensure that, whether or not, the children have a risk for specific mental health problems and the need to refer children to hospital. The second reason, they were assumed to respond the questionnaire for the ideal answer, and this might not reflect their original conduct. The other reason, the researcher and research assistants had limited time to build trust relationship with the children, so they might answer the questionnaire as fast as they can, in order to be perceived as a good student in front of researcher and research assistants.

Research hypothesis 4: There is a negative relationship between academic competence and mental health problem in school-aged children with mental health problems in Aceh province, Indonesia.

This study revealed that academic competence had a negative relationship on mental health problems in school-aged children with mental health problems in Aceh province, Indonesia at a low level ($r = -.177$, $p < .05$).

The present study revealed that school-aged children with hyperactivity tended to have moderate level of academic competence (15.4%). This finding supported the hypothesis and previous study about relationship between academic competence and mental health problems in school-aged children with mental health problems (Cole, Martin, Peeke and Seroczynski, 1999; Moilanen, Shaw and Maxwell, 2010; Rolf (1972). Interestingly, this study found that moderate academic competence related to mental health problems, because mostly school-aged children who participated have GPA score 2.00-2.99 or moderate level of academic competence. The reason why the level of academic competence was not similar with previous study is because the differences of evaluated subjects.

In western countries, most of the previous studies evaluated academic competence by GPA score from the following subjects, such as math, language, sports or social subjects. The other studies focus on specific subjects as writing, arithmetic, and reading, or including sports or English language. Meanwhile, this study was not focus only on selected subjects, but the researcher evaluated all of the subjects that students learn at their schools. The second possible reason is about measurement. This study measured academic competence by GPA in student's report book; meanwhile, other studies were using self-report, teacher rating or even friend rating to evaluate academic competence instead of GPA score. So, the differences perspective of evaluated subjects and measurements may present the differences level of academic competence. The other important issue is, some teachers may not objective in giving score by giving moderate score because of pity, so their GPA score might stay in moderate level, even in reality, they might have lower GPA score.

Research hypothesis 5: There is a positive relationship between maternal depression and mental health problem in school-aged children with mental health problems in Aceh province, Indonesia.

This study revealed that there was no positive relationship between maternal depression with mental health problems in school-aged children with mental health problems in Aceh province, Indonesia ($r = .023$, $p > .05$), but maternal depression positively related to emotional symptoms ($r = .236$, $p < .05$) and negatively related to peer problem at a low level ($r = -.158$, $p < .05$).

The finding of this study did not support the hypothesis, and it was not support the previous studies which found relationship between maternal depression and mental health problems in school-aged children with mental health problems (Bordin et al., 2009; Department of Community Services Centre for Parenting and Research, 2008). In specific, maternal depression had positive relationship with emotional symptoms and this finding supported by some of previous studies for the relationship between maternal depression and emotional problems (Darunee Ngamkum, 2013; Lesesne, Visser and White, 2003; Nantacha Sanguenkulchai, 2013; Whitaker, Orzol and Kahn, 2006), even other studies revealed that it also related to behavioral problems (Lyons-Ruth, Easterbrooks and Cibelli, 1997; Mendes et al., 2013).

In this study, the majority of mothers of school-aged children with mental health problems were suffering from moderate depression (47.4%). Study found that maternal depression tended to has permissive behavior, inconsistent discipline and negative interaction with the children and resulted negative parenting attitudes, such as unresponsive and ineffective parenting behaviors (Oyserman, Mowbray, Meares, and Firminger, 2000). But, the problem is that they were not diagnosed as mothers with depression by psychiatrist or psychologist, because the researcher met this group of mothers in community setting, not in clinical setting. So, the rating of depression was based on their perception, and there was an opportunity for bias when they were rating themselves, even they were accompanied by health professional or general nurses. It is very important to ensure depression in mother because both of maternal depression and mental health problems are related each other, and by knowing maternal depression, we may prevent mental health problems in school-aged children (Rishel et al., 2006).

The finding of this study might be initial data for health professionals to assume that mothers of children with mental health problems have a risk for depression, and it will be important for them to seek professional help from psychiatrist or psychologist for immediate assessment and checkup. In the future, it is necessary to replicate the same study in clinical setting to ensure that whether mother experiencing depression and early intervention can be conducted in order to minimize the impact of depression both for mother and children

Research hypothesis 6: There is a positive relationship between maternal parenting behavior and mental health problem in school-aged children with mental health problems in Aceh province, Indonesia.

This study found that there was no positive relationship between maternal parenting behavior with mental health problems in school-aged children with mental health problems in Aceh province, Indonesia ($r = .053$, $p > .05$), but maternal parenting behavior had positive relationship with conduct problem ($r = .162$, $p < .05$) and hyperactivity ($r = .143$, $p < .05$) at a low level, and negative relationship with emotional symptoms at a low level ($r = -.287$, $p < .05$).

This finding did not support the hypothesis in this study. This finding also was not congruent with previous studies (Alizadeh, Applequist and Coolidge, 2007; Aunola and Nurmi, 2005; Yousefia, Far and Abdolahian, 2011). The study found that, more than a half mothers of school-aged children with mental health problems in Aceh province Indonesia controlled their children through guilt and anxiety (55.2%). This finding was different from previous studies that were mostly conducted in Iran, they revealed that mothers tended to applying harsh parenting and using corporal punishment with less of affection and inconsistent discipline. Only “less respect for children’s autonomy” was supported by this study, because result found that only 4.9% mothers were using “respect for autonomy” as their specific parenting behavior.

The result of this study supported related study about mental health problems in Thailand; it found that parenting behavior did not have relationship with disruptive behavior and depression in Thai adolescents (Vatcharin Wuthironarith, 2013). One of possible reasons are the informants. In this study, parenting behavior was evaluated by mothers’ perception that may impact the accuracy of the result, moreover, mostly mothers who participated to fulfill the questionnaire were mothers with moderate

level of background education (50.6%), so they might experience misinterpretation of statements in the questionnaire or tended to choose ideal or appropriate answer instead of answer based on real situation, so the variation of answer was inevitable.

Interestingly, this study found that maternal parenting behavior positively related to both of conduct problem and hyperactivity. The findings possibly related to the way how mothers control their children behaviors. This can be explained that parents will adopt specific behavior to maintain appropriate relationship with their children, in order to achieve good parenting practice (Cohen et al., 1977). This may be the natural encouragement of mother to do protective behaviors towards their children with behavioral problems, especially when she finds something that may endanger her child or undesired situations from the environment. One of methods that mother may use is by controlling her child through guilt and anxiety. Furthermore, father involvement is also important. Ellis and Nigg (2009) mentioned that low paternal involvement related to behavioral problems, so it will be important to investigate the roles of father in order to evaluate many possible factors regarding behavioral problems in the children, especially for paternal parenting behavior factor.

This study also found that maternal parenting behavior had negative relationship with emotional symptoms. This finding is supported by study from Oyserman, Mowbray, Meares and Firminger (2000). They found that, mother with depression tended to exhibit permissive behavior, inconsistent discipline, and negative interaction with their children and resulted negative parenting attitudes, such as unresponsive and ineffective parenting behaviors. The mother in this study showed a tendency for having depression, so this finding explains why maternal parenting behavior had negative relationship with emotional symptoms.

Research hypothesis 7: There is a positive relationship between maternal parenting stress and mental health problem in school-aged children with mental health problems in Aceh province, Indonesia.

The study found that maternal parenting stress had positive relationship with mental health problems in school-aged children with mental health problems in Aceh province, Indonesia at a low level ($r = .173$, $p < .05$).

The finding of the study supported the hypothesis and previous related studies (Harvey, 2000; Williford, Calkins and Keane, 2007; Yousefia, Far and Abdolahian,

2011). Interestingly, most of school-aged children with mental health problems in those studies were school-aged children with emotional symptoms and it was similar with current study. In this study, more than a half mothers were experiencing stress by having school-aged children with emotional problems (53.1%). This result is not surprising because the elements of emotional problems are not only emotional symptoms but also peer problem, and mother tends to have complaints about peer problem more than father.

Stephens (2009) described maternal parenting stress as "normal" situation for mothers, because they need to fulfill the traditional expectation of female gender to taking care their children and spend more time with them in the house than fathers. This study found that the majority mothers of school-aged children with mental health problems were unemployed, so they will spend lots of their times at home (68.2%). It means, they will focus more on raising children, cooking food and caring for household. When mothers perform their roles, they tend to be more overprotective than fathers and they will find any information about their children. The actions including what are their children doing, where their children are going, and with whom their children are spending the time. In order to have those information, mothers will ask anyone such as friends of children, parent of children's friends and teachers, to make sure that their children in the safe situation. Those conditions put mother to have more risk for parenting stress because they have to do everything by themselves.

Deater-Deckard, Chen and El Mallah (2013) mentioned that parenting stress in mothers occur when the demand of desired roles of mothers are not achieved and the resources are not enough available for them to become a successful mother. When they perceived that all of those roles are only their responsibilities, mothers will experiencing parenting stress. The more they feel that they cannot perform all of their "expected roles", the more they feel parenting stress, and the more they have poor relationship with their school-aged children with mental health problems.

. **Research hypothesis 8: There is a negative relationship between family income and mental health problem in school-aged children with mental health problems in Aceh province, Indonesia.**

The study revealed that there was no negative relationship between family income with mental health problems in school-aged children with mental health problems in Aceh province, Indonesia (r = .024, p > .05).

This finding did not support the hypothesis and the previous studies (Beiser et al., 2002; Davis et al., 2010). The study found that, mostly school-aged children with mental health problems derived from family with low family income (58.7%), and they tended to have more behavioral problems than emotional problems. One of the reasons to explain this result is the differences of criteria for low family income between this current study and previous studies. Some studies were using complex calculation based on per capita income of their countries, and it will be different among countries around the world.

In Indonesia, there are many considerations to put family with low income. One of the frequently used categories was developed by Badan Pusat Statistik (BPS) or statistic center agency of Indonesia. From 14 indicators, the researcher took one indicator (monthly family income less than Rp.600,000) to evaluate family income, because if the indicator is exist, the family is categorized as low family income (Bappenas, 2010). Another reason is, the questionnaire was fulfilled by mother, the bias in calculating family income might different from father's perspective, and some mothers assumed to guess their total income, especially for family with uncertain job and amount of salary.

Research hypothesis 9: There is a negative relationship between family environment-relationship dimension and mental health problem in school-aged children with mental health problems in Aceh province, Indonesia.

The study found that family environment - relationship dimension had a negative relationship on mental health problems in school-aged children with mental health problems in Aceh province, Indonesia at a low level (r = -.176, p < .05).

This study supported the hypothesis and previous studies (Nantacha Sanguenkulchai, 2013; Vatcharin Wuthironarith, 2013). O'Shea et al., (2001) mentioned that as a system, family plays important roles to achieve the appropriate

development of the children, and family functioning is the way to ensure the needs of children are fulfilled. In this point, successful children will determine by how family fulfill the children's needs for appropriate growth and development. The responsibility to perform those tasks is not only depending on father as a leader, but also mother and other family members in order to respond to family circumstances and rapid change of social situations. All of the family circumstances and social conditions that are already exist in family is called family environment (Zastrow and Kirst-Ashman, 2013).

This study focused on one of dimensions of family environment, which was relationship. The result of this study revealed that the majority of families of school-aged children with mental health problems were experiencing moderate level of family relationship (50.6%). Meanwhile, previous study found that, in families of parental depression, especially mother, and school-aged children with mental health problems, they showed low family relationship by having less family cohesion, less of expressiveness, and more family conflict (Van Loon et al, 2013). There are two potential reasons, why the level of family relationship was different between current study and previous study; *firstly*, the previous study recruited parents (father or mother) with depression in clinical setting, so they were already diagnosed with depression, meanwhile the current study only focus on mothers rated themselves by using BDI-II, and yet, they were not officially diagnosed with depression. *Secondly*, the previous study evaluated not only relationship dimension, but also its sub-dimensions such as cohesion, expressiveness, and conflict, and the current study only focused on relationship dimension. In the future, it will be better to investigate its sub-dimensions to capture better and detail comprehension about family relationship.

Limitation

The recruitment of participants is based on perception of teacher in the community setting (school environment) with small number of participants. Thus, selecting participants in the clinical setting with more variations is suggested in the further research, so the number of larger participants from both of community and clinical setting may increases the association among variables.

Implication for nursing practices

There are some implications based on the findings of the study, including:

1. The study revealed that school-aged children in Indonesia have a risk for mental health problems, so child psychiatric mental health nurses should give special attention to assist young school-aged children with mental health problems in the aspect of emotional symptoms and conduct problem.

2. Policy initiation about mental health problems in school setting should be promoted, in order to prevent and minimize the severity of mental health problems in school-aged children.

3. The nursing intervention for early detection by using standardized instrument should be conducted in elementary school and Pusat Kesehatan Masyarakat (Puskesmas) or Public Health Center in Indonesia, as initial assessment. Having detected by recommended instrument, psychiatric nurse should conduct school-based intervention focus on early intervention and prevention. In addition, mothers of children with mental health problems are also suggested to meet psychiatrist of psychologist, because they have higher risk for depression and by knowing their status, it may minimize the effect of depression on themselves and other family members.

4. Friendly curriculum should be discussed psychiatric nurse, principal and teacher in order to improve children academic competence and enhance their comprehension towards learned subjects. Psychiatric nurse should collaborate with teacher in order to increase academic competence of children by modifying teaching's approach and methods, and school environment (such as classroom and playground) in order to create convenient environment for children.

5. Nurses should aim to improve family relationship and reduce maternal parenting stress and maternal depression to minimize the risk and impact of mental health problems in both children and their families.

Recommendations for future research

Based on the research findings, the recommendations for future research are presented as below:

1. The replication of the study in Aceh province or other provinces in Indonesia with combination of school and clinical setting is needed, in order to give us another perspective of mental health phenomena in school-aged children. The replication study is needed to be expanded by adding some endogenous factors, i.e. interaction between peers, peer problems, such as abuse or bullying, interaction between parents and children, and interaction of children in the classroom.

2. A predictive study to investigate which factor from academic competence, maternal parenting stress, or family environment-relationship dimension, have more effect on mental health problems should be promoted. The major purpose is to set specific intervention based on specific variable which has more effect than any other variables.

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APPENDIX

Appendix A
Approval of thesis proposal

นิสิตผู้ทำวิจัยและอาจารย์ที่ปรึกษาวิทยานิพนธ์

รหัสนิสิต (ID)	5677233636
ชื่อ-นามสกุล	นายฟอซาน ซาปุตรา
(Name)	*Mr. Fauzan Saputra*
สาขาวิชา	พยาบาลศาสตร์ (การพยาบาลจิตเวชและสุขภาพจิต)
(Academic Program)	*Master of Nursing Science Program in Nursing Science (Psychiatric and Mental Health Nursing)*
ประธานกรรมการสอบ	ผู้ช่วยศาสตราจารย์ ดร. ประนอม รอดคำดี
(Chairperson)	*Asst. Prof. Dr. Branom Rodcumdee*
อาจารย์ที่ปรึกษาหลัก	รองศาสตราจารย์ ดร. จินตนา ยูนิพันธุ์
(Major-advisor)	*Assoc. Prof. Dr. Jintana Yunibhand*
อาจารย์ที่ปรึกษาร่วม	อาจารย์ ดร. สุนิศา สุขตระกูล
(Co-advisor)	*Dr. Sunisa Sukratul*
ผู้ทรงคุณวุฒิภายนอก	อาจารย์ ดร. ชูศักดิ์ ขัมภลิขิต
(External Examiner)	*Dr. Choosak Khampalikit*
ชื่อหัวข้อวิทยานิพนธ์	ปัจจัยคัดสรรที่สัมพันธ์กับปัญหาสุขภาพจิตของเด็กวัยเรียนที่มีปัญหาสุขภาพจิต ณ อาเจะห์ อินโดนีเซีย
(Title of Thesis)	*SELECTED FACTORS RELATED TO MENTAL HEALTH PROBLEMS IN SCHOOL-AGED CHILDREN WITH MENTAL HEALTH PROBLEMS IN ACEH PROVINCE, INDONESIA*
ครั้งที่อนุมัติ	19/2557
(Announcement No.)	
ระดับ	ปริญญาโท
(Level)	*Master degree*

จากมติคณะกรรมการบริหารคณะพยาบาลศาสตร์ ครั้งที่ 9/2558 วันที่ 29 มิถุนายน 2558

(Approval by Faculty Board No. 9/2015, June 29, 2015)

ประกาศ ณ วันที่ 13 กรกฎาคม พ.ศ. 2558

(Announce date July 13, 2015)

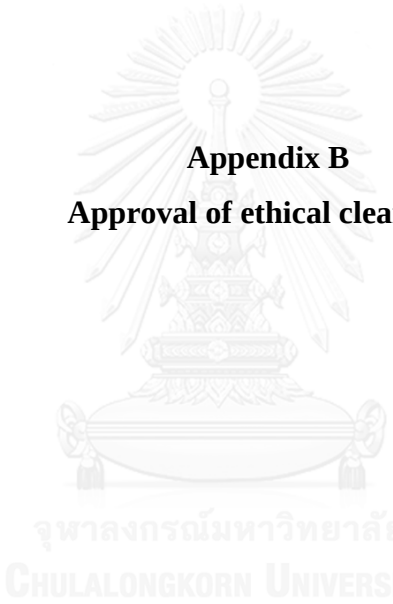
สุรีพร ธนศิลป์

(รองศาสตราจารย์ ดร. สุรีพร ธนศิลป์)

(Sureeporn Thanasilp, D.N.S.)

คณบดีคณะพยาบาลศาสตร์

Associate Professor and Dean, Faculty of Nursing



Appendix B

Approval of ethical clearance

MINISTRY OF EDUCATION
FACULTY OF NURSING UNIVERSITY OF NORTH SUMATRA
HEALTH RESEARCH ETHICS COMMISSION
Jl. Prof. Maas No.3 Campus USU Medan 20155INDONESIA. Tel: + 62-61-8213318
Fax: + 62-61-8213318, E-Mail: fkep_kepk@yahoo.co.id

Number : 551 / VII / SP / 2015
Re : Approval of Health Research Ethics Committee of the Faculty of Nursing University of Sumatera Utara

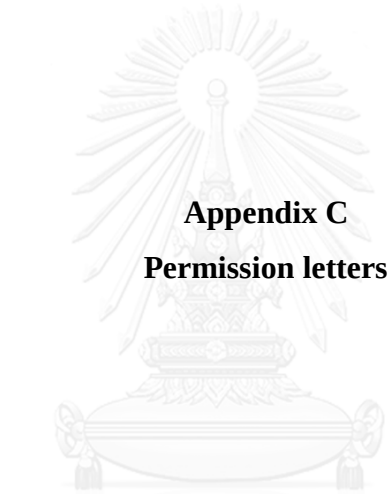
Health Research Ethics Committee of the Faculty of Nursing University of Sumatera Utara, hereby declare the research:

Name : Fauzan Saputra
Title : Selected Factors Related to Mental Health Problems in School-Aged Children With Mental Health Problems in Aceh Province Indonesia

has been assessed and it was decided that the research proposal is not contrary to the values and norms of humanity.

Medan July 9, 2015
HEC Nursing Faculty, USU
Chairman,

Sri Zahara Nasution, S.Kp, MNS
NIP. 197103052001122001



Appendix C

Permission letters

PEMERINTAH KABUPATEN ACEH UTARA
DINAS PENDIDIKAN, PEMUDA DAN OLAHRAGA
Jalan Mayjen Nyak Adam Kamil No. 7 Telp. (0645) 43423 – 40173 Fax. (0645) 45310
LHOKSEUMAWE 24313

IZIN PENELITIAN

Nomor : 800.2/650

1. Sehubungan dengan Surat Health Research Ethiscs Commission Faculty of Nursing University of North Sumatrera tanggal 9 Juli 2015.

2. Untuk maksud tersebut di atas Kepala Dinas Pendidikan, Pemuda dan Olahraga Kabupaten Aceh Utara dapat memberi Izin Penelitian kepada :

   Nama : **Fauzan Saputra**
   Tempat/Tgl. Lahir : Cunda. 07 Juli 1981
   Unit Kerja : Dinas Kesehatan Kota Lhokseumawe
   Pendidikan : Psychiatric Nursing, Faculty of Nursing Chulalongkorn University, Bangkok, Thailand

   Nama –nama Sekolah untuk melakukan Penelitian sebagai berikut :

No	NSPN	Nama Sekolah	Alamat
1	10105830	SDN 1 Syamtalira Bayu	Jl. Mesjid Mideun Syuhada, Keude Bayu
	10101096	SDN 5 Syamtalira Bayu	Jl. Medan-B. Aceh, Gp. Beunot
	60703259	MIN Punteut	Jl. Tugu Pahlawan, Gp. Beunot

   Dengan Judul : Selected Factors Related to mental Health Problems in School-aged Children With Mental Health Problems in Aceh Province, Indonesia

   Untuk maksud tersebut diatas, dipihak kami tidak menaruh keberatan untuk mengadakan penelitian di Lingkungan Dinas Pendidikan Pemuda dan Olahraga Kabupaten Aceh Utara, selama tidak bertentangan dengan peraturan dan perundang-undangan yang berlaku.

3. Demikian Surat Izin Penelitian ini kami keluarkan untuk dapat dipergunakan seperlunya .

Lhokseumawe, 23 Juli 2015
an. Kepala Dinas Pendidikan, Pemuda Dan Olahraga
Kabupaten Aceh Utara.
Sekretaris

SAIFULLAH. M.Pd
Pembina Tk.I
Nip. 19680217 199801 1 001

PEMERINTAH KABUPATEN BIREUEN
DINAS PENDIDIKAN DAN KEBUDAYAAN
Jln. Laksamana Malahayati No. 1 Bireuen Telp./ (0644) 21229 Fax (0644) 324210 Email; disdik_bireuen@gmail.com Kode Pos 24211
B I R E U E N

Nomor : 876 / / 2015
Lampiran : -
H a l : **Izin Mengadakan Penelitian**

Bireuen, 27 Juli 2015
Kepada Yth,
Sdr. Kepala
1. SDN 3 Percontohan Peusangan
2. SDN 5 Peusangan
3. SDN 28 Peusangan
di -
Tempat

Sehubungan dengan surat Faculty Of Nursing University Of North Sumatra Health Research Ethics Commission Nomor :551/VII/SP/.2015 Tanggal 09 Juli 2015 hal seperti tersebut pada pokok surat, kami mohon bantuan saudara untuk memberikan izin kepada :

N a m a : **FAUZAN SAPUTRA**
Tempat/Tanggal Lahi : Cunda 07 Juli 1981

Untuk mengadakan penelitian dan pengumpulan data / bahan di sekolah yang saudara pimpin untuk keperluan bahan penyusunan tesis dengan judul :

"SELECTED FACTORS RELATED TO MENTAL HEALTH PROBLEMS IN SCHOOL-AGED CHILDREN WITH MENTAL HEALTH PROBLEM IN ACEH PROVINCE, INDONESIA"

Demikian kami sampaikan untuk dimaklumi.

A.n. Kepala Dinas Pendidikan dan Kebudayaan
Kabid Pendidikan Dasar

PEMERINTAH KABUPATEN BIREUEN
DINAS PENDIDIKAN DAN KEBUDAYAAN
BIREUEN

ABDOLLAH, S.Pd
NIP. 19701213 199411 1 001

PEMERINTAH KOTA LHOKSEUMAWE
DINAS PENDIDIKAN PEMUDA DAN OLAHRAGA
دينس فنديدكن فمودا دان اولهرڬا
JL. Stadion Tunas Bangsa Telp.(0645) 45234-42335
Faxcimile (0645) 45234 LHOKSEUMAWE

Lhokseumawe, 24 Juli 2015

Nomor : 895.4/~~2773~~ /2015
Lampiran : -
Perihal : **Izin Mengadakan Penelitian**

Kepada Yth.
1. Kepala SDN 4 Muara Dua
2. Kepala SDN 5 Muara Dua
3. Kepala SDN 9 Muara Dua

di -
Tempat

Dengan Hormat,

Sehubungan dengan Surat Chairman Faculty Of Nursing University Of North Sumatera nomor : 551/VII/SP/2015, tanggal 9 Juli 2015 perihal sebagaimana tersebut pada pokok surat di atas, dengan ini kami memberikan izin kepada:

Nama	: **Fauzan Saputra**
Tempat/ Tanggala Lahir	: Cunda/ 7 Juli 1981
Unit Kerja	: Dinas Kesehatan Kota Lhokseumawe

Untuk mengadakan penelitian dengan judul **"SELECTED FACTORS RELATED TO MENTAL HEALTH PROBLEMS IN SCHOOL-AGED CHILDREN WITH MENTAL HEALTH PROBLEM IN ACEH PROVINCE, INDONESIA ".**

Selanjutnya kami mohon kepada saudara agar dapat memberikan bantuan informasi/data kepada yang bersangkutan sesuai dengan judul penelitian sebagaimana tersebut.

Demikian kami sampaikan atas bantuan dan kerjasama yang baik kami ucapkan terima kasih.

An.Kepala Dinas Pendidikan Pemuda dan Olahraga
Kota Lhokseumawe
Kabid Dikdas

Drs. Ibrahim A. Rahman, M.Pd
Nip.19661231 199801 1 006

Appendix D

List of the experts

No. 479 / 2015

Faculty of Nursing, Chulalongkorn University
Borommaratchachonnani Srisataphat
Building, Rama1 Road, Pathumwan,
Bangkok 10330, Thailand
Tel. (662)-218-1131 Fax. (662)-218-1130

August 16 , 2015

Faculty of Nursing, University of Indonesia
Prof. Dr. Bahder Djohan Road,
Kampus UI Depok, West Java, Indonesia

Dear Dean of Faculty of Nursing, University of Indonesia
(Dra. Junaiti Sahar, S.Kp, M.App. Sc., Ph.D.)

This is to inform you that Mr. Fauzan Saputra is our student in a Master of Nursing Science Program, Faculty of Nursing, Chulalongkorn University. He has been approved for conducting the thesis "SELECTED FACTORS RELATED TO MENTAL HEALTH PROBLEMS IN SCHOOL-AGED CHILDREN WITH MENTAL HEALTH PROBLEMS IN ACEH PROVINCE, INDONESIA" under supervision of Associate Professor Jintana Yunibhand, Ph.D., A.P.N. and Sunisa Suktrakul, Ph.D. Recognizing the expertise and experience of your Faculty staffs in mental health problems, it gives me a great pleasure to invite them to be the experts validating content of the instruments. This will be great contribution to the quality of the research. List of experts were as follows

1. Prof. Achir Yani S. Hamid, DNSc Professor in Psychiatric Nursing
2. Dr. Nani Nurhaeni, S.Kp., MN. Head of Pediatric nursing department
3. Dr. Mustikasari, S.Kp., MARS Faculty member of Psychiatric Nursing
4. Nur Agustini, S.Kp., MSi Faculty member of Pediatric Nursing
5. Yossie Susanti Eka Putri, S.Kp., MN Head of Psychiatric Nursing Department

Your kindly support is highly appreciated.

Sincerely,

Sunida Preechawong

(Sunida Preechawong, Ph.D.)
Assistant Professor and Deputy Dean

Appendix E

Participants information sheet

Participant Information Sheet

Title "Selected factors related to mental health problems in school-aged children with mental health problems in Aceh province, Indonesia"

Principle researcher's name: Fauzan Saputra

Position: Employee of Health office of Lhokseumawe district, Aceh Province, Indonesia.

Office address: Jl. Samudera, Lhokseumawe

Home address:Jln. Cut Nyak Dhien, No. 234, Panggoi Indah, Lhokseumawe, Aceh.

Telephone: 08123386940

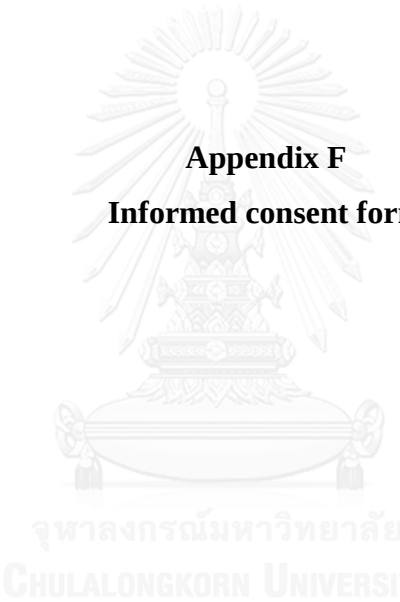
E-mail: saputrafauzan66@gmail.com

I am Fauzan Saputra, nursing student in master degree at Chulalongkorn University. I would like to ask your cooperation as a participant in my study.

1. The objectives of the study are:
   a. To study mental health problems in school-aged children in Aceh province, Indonesia.
   b. To study the relationship between age, gender, social competence, academic competence, maternal depression, maternal parenting behavior, maternal parenting stress, parental economic status, family environment-relationship dimension and mental health problems in school-aged children in Aceh province, Indonesia.
2. School-aged children with mental health problems is student ages 6-12 years old who has emotional or behavioral problems identified by guru BP or counseling teacher. The total number of participants needed is 154 and the desired participants are included counseling teachers, students with mental health problems, and their mothers.
3. The researcher will go to the elementary school, then introduce himself to guru BP and ask for their cooperation in answering the questionnaires during their free time. When the subjects agree to participate, the researcher will explain the purpose of the study and give the opportunity for the subjects to ask questions. The participant will receive the information from the researcher about the objectives of the study and the process of data

collection. Then, the researcher interviews the participants (counseling teachers). The total amount of time is about 20-60 minutes.

4. Having identified the group of school-aged children with mental health problems, they will be asked to fulfilled social competence questionnaire in 10-20 minutes, and every student will be provided with questionnaires and ask their mothers to fulfill and return them within 3 days.
5. The benefits of the project, the researcher wants to study mental health problems in school-aged children, because by knowing the factors, psychiatric nurses in Indonesia, especially in Aceh province will have a foundation to make a specific intervention related to identify factors to prevent and minimize the incidence and the impact of mental health problems in adults. This also may lead to special policy to concern about school-aged children with mental health problems.
6. There will be no harm for the teachers, students and their mothers in this study. Protection of individuals' right who volunteered as subjects by having each sign a consent form, which includes an explanation of the purpose of the research, assurance of confidentiality, informs about the questionnaire destruction when finishing the study as well as the option to withdraw from this study at any time with no consequence at all.
7. Information related directly to you will be kept confidential. The results of the study will be reported as total picture. Any indirect information which could be able to identify you will not appear in the report
8. Participants will receive souvenir from the researcher.
9. If the researcher does not perform upon the participants as indicated in the information, the participants can report to Komisi Etik Penelitian Kesehatan, Fakultas Keperawatan, Universitas Sumatera Utara, Jl. Prof. Maas No. 3 Kampus USU 20155, Medan, Indonesia, Phone +62618213318, email Fkep_kepk@yahoo.co.id.



Appendix F

Informed consent form

Informed Consent Form

Address……

Date…….

Code number of participant……

I who have signed here below agree to participate in this research project

Title "Selected factors related to mental health problems in school-aged children with mental health problems in Aceh province, Indonesia"

Principle researcher's name: Fauzan Saputra

Contact address: Jln. Cut Nyak Dhien, No. 234, Panggoi, Lhokseumawe, Aceh.

Telephone: 08123386940

I have (read or been informed) about the rationale and objectives of the project, what will be done upon me, risk/ham and benefit of this project. The researcher explains to me and I clearly understand with satisfaction.

I willingly agree to participate in this project and consent the researcher to respond to the questionnaires that the researcher interviews me for once is about 20-60 minutes. I have the right to withdraw from this research project at any time as I wish with no need to give any reason. This withdraw will not have any negative impact upon me by all means.

I have been guaranteed that the researcher will act upon me exactly the same as indicated in the information. Any of my personal information will be kept confidential. The results of the study will be reported as total picture. Any personal information which could be able to identify me will not appear in the report.

If I am not treated as indicated in the information sheet, I can report to Komisi Etik Penelitian Kesehatan, Fakultas Keperawatan, Universitas Sumatera Utara, Jl. Prof. Maas No. 3 Kampus USU 20155, Medan, Indonesia, Phone +62618213318, email Fkep_kepk@yahoo.co.id.

I also have received a copy of the information sheet and informed consent form.

Sign……	Sign……
(…….)	(…….)
Fauzan Saputra	Participant

Sign……..

(……)

Witness

Appendix G

Research instruments

Selected factors related to mental health problems in school-aged children with mental health problems in Aceh province, Indonesia

The purposes of this study are to study mental health problems of school-aged children in Aceh Indonesian and the relationship between age, gender, social competence, academic competence, maternal depression, maternal parenting behavior, maternal parenting stress, parental economic status and family environment-relationship dimension and mental health problem in school-aged children with mental health problems. In order to obtain objective information, please answer every question in the questionnaires, answering all of your information will be kept confidential and ensure we just use data for this study. Thank you.

Section 1 : Personal Information Sheet (Student).

Instruction : Please put a check symbol (√) in the available boxes based on your student situation.

1. Gender :

☐ Male ☐ Female

2. Age :

☐ 6-9 years ☐ 10-12 years

3. Cumulative grade point in last one year:

☐ 85-100 ☐ 75-84 ☐ 60-74

☐ 50-59 ☐ 0-49

Section 2: Strengths and Difficulties Questionnaire (SDQ)

Kuesioner Kekuatan dan Kesulitan Pada Anak

Untuk setiap pernyataan, beri tanda pada kotak Tidak Benar, Agak Benar atau Benar. Akan sangat membantu kami apabila andamau menjawab semua pernyataan sebaik mungkin meskipun anda tidak yakin benar. Berikan jawaban anda menurut perilakuanak itu selama enam bulan terakhir atau selama tahun ajaran ini.

Nama anak ..... Laki-laki/Perempuan

Tanggal lahir .....

	Tidak Benar	Agak Benar	Benar
Dapat memperdulikan perasaan orang lain	☐	☐	☐
Gelisah, terlalu aktif, tidak dapat diam untuk waktu lama	☐	☐	☐
Sering mengeluh sakit kepala, sakit perut atau sakit-sakit lainnya	☐	☐	☐
Kalau mempunyai mainan, kesenangan, atau pensil, anak bersedia berbagi dengananak-anak lain	☐	☐	☐
Sering sulit mengendalikan kemarahan	☐	☐	☐
Cenderung menyendiri, lebih suka bermain seorang diri	☐	☐	☐
Umumnya bertingkah laku baik, biasanya melakukan apa yang disuruh oleh orangdewasa	☐	☐	☐
Banyak kekhawatiran atau sering tampak khawatir	☐	☐	☐
Suka menolong jika seseorang terluka, kecewa atau merasa sakit	☐	☐	☐
Terus menerus bergerak dengan resah atau menggeliat-geliat	☐	☐	☐
Mempunyai satu atau lebih teman baik	☐	☐	☐
Sering berkelahi dengan anak-anak lain atau mengintimidasi mereka	☐	☐	☐
Sering merasa tidak bahagia, sedih atau menangis	☐	☐	☐
Pada umumnya disukai oleh anak-anak lain	☐	☐	☐
Mudah teralih perhatiannya, tidak dapat berkonsentrasi	☐	☐	☐
Gugup atau sulit berpisah dengan orang tua/pengasuhnya pada situasi baru, mudahkehilangan rasa percaya diri	☐	☐	☐
Bersikap baik terhadap anak-anak yang lebih muda	☐	☐	☐
Sering berbohong atau berbuat curang	☐	☐	☐
Diganggu, di permainkan, di intimidasi atau di ancam oleh anak-anak lain	☐	☐	☐
Sering menawarkan diri untuk membantu orang lain (orang tua, guru, anak-anak lain)	☐	☐	☐
Sebelum melakukan sesuatu ia berpikir dahulu tentang akibatnya	☐	☐	☐
Mencuri dari rumah, sekolah atau tempat lain	☐	☐	☐
Lebih mudah berteman dengan orang dewasa daripada dengan anak-anak lain	☐	☐	☐
Banyak yang ditakuti, mudah menjadi takut	☐	☐	☐
Memiliki perhatian yang baik terhadap apapun, mampu menyelesaikan tugas ataupekerjaan rumah sampai selesai	☐	☐	☐

Tanda tangan ..... Tanggal .....

Orangtua/Guru/Orang Lain (Jelaskan):

Terima kasih banyak atas bantuan anda

Section 3: Social Competence Questionnaire

Please put a check symbol (√) for the statements below that really like you:

Social Competence Questionnaire											
Name _____				Age	Birthday:	_____		_____	Boy ☐	Girl ☐	
						Month	Day		(check one)		
	Really True for me	**Sort of True for me**								**Sort of True for me**	**Really True for me**
Sample Sentence											
a.	☐	☐	Some kids would rather play outdoors in their spare time		**BUT**	Other kids would rather watch T.V.				☐	☐
1	☐	☐	Some kids find it hard to make friends		**BUT**	Other kids find it pretty easy to make friends				☐	☐
2	☐	☐	Some kids know how to make classmate like them		**BUT**	Other kids don't know how to make classmate like them				☐	☐
3	☐	☐	Some kids don't have the social skill to make friends		**BUT**	Other kids do have the social skill to make friends				☐	☐
4	☐	☐	Some kids understand how to get peers accept them		**BUT**	Other kids don't understand how to get peers accept them				☐	☐
5	☐	☐	Some kids wish they knew how to make more friends		**BUT**	Other kids how to make more friends as they want				☐	☐
6	☐	☐	Some kids know how to become popular		**BUT**	Other kids don't know how to become popular				☐	☐

The following section of 4-8 is proposed for mothers.

Section 4 : Personal Information Sheet (Mother)

Instruction : Please put check symbol in the available boxes based on your appropriate situation.

1. Age :

☐ 20-30 years ☐ 31-40 years ☐ > 40 years

2. Level of education :

☐ No Schooling ☐ Primary School ☐ Junior High School

☐ Senior High School ☐ Bachelor Degree ☐ Master Degree and above

3. Marital status :

☐ Married ☐ Widowed ☐ Divorced

4. Occupation :

☐ Housewife ☐ Government Employee ☐ Private Sector

5. Number of child(ren) :

☐ 1 ☐ 2 ☐ > 2

6. Family income/month :

☐ < Rp.600,000 Rp.600,000 – Rp.2,000,000 ☐ > Rp.2,000,000

Section 5 : Parent's Report (PR)

Instruction : Please put check symbol (√) for the statement that perfectly describe your parenting behavior toward your child, for this available options of answer:

0 = never 4= frequently

1= very rarely 5= very frequently

2= rarely 6= always

3= occasionally

No	Statements	0	1	2	3	4	5	6
1	I ask others what he does while he is away from me							
2	I avoid talking to him after he displeases me							
3	I make decision with him							
4	I see to it that he obeys what he is told							
5	I ignore misbehavior							
6	I forget rules that have been made							
7	I let him know all I have done for him when I want him to obey							
8	I check on what he is doing and who is he seeing all during the day							
9	I give him a lot of care and attention							
10	I avoid looking at him when I am disappointed in him							
11	I enjoy listening to him and doing things with him							
12	I am aware of his need for privacy							
13	I let him help me decide about things that affect him							
14	I set limits for activities to help him stay out of trouble							
15	I keep reminding him of past bad behavior							
16	I tell him that I worry about how he will turn out because of his bad behavior							
17	I withdraw from being with my child when he displeases me							
18	I let him dress as he wants							
19	I let myself be talked out of things							
20	I let him know that if he really cared he wouldn't do things to cause me worry							

Section 6 : Parental Stress Scale

Instruction : Please indicate your feeling and perception of being parent.

1 = Strongly disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly agree

No	Statements	1	2	3	4	5
1	I am happy in my role as a parent.					
2	There is little or nothing I wouldn't do for my child(ren) if it was necessary.					
3	Caring for my child(ren) sometimes takes more time and energy than I have to give.					
4	I sometimes worry whether I am doing enough for my child(ren).					
5	I feel close to my child(ren).					
6	I enjoy spending time with my child(ren).					
7	My child(ren) is an important source of affection for me.					
8	Having child(ren) gives me a more certain and optimistic view for the future.					
9	The major source of stress in my life is my child(ren).					
10	Having child(ren) leaves little time and flexibility in my life.					
11	Having child(ren) has been a financial burden.					
12	It is difficult to balance different responsibilities because of my child(ren).					
13	The behavior of my child(ren) is often embarrassing or stressful to me.					
14	If I had it to do over again, I might decide not to have child(ren).					
15	I feel overwhelmed by the responsibility of being a parent.					
16	Having child(ren) has meant having too few choices and too little control over my life.					
17	I am satisfied as a parent.					
18	I find my child(ren) enjoyable.					

Section 7 : Brief Family Relationship Scale
Instruction : Please put check symbol (√) in the statements below that appropriate to the relationship in your family.

No	Statements	Not at all	Somewhat	A lot
1	In our family, we really help and support each other			
2	In our family, we argue a lot.			
3	In our family, we spend a lot of time doing things together at home.			
4	In our family, we can talk openly in our home.			
5	In our family, we are really mad at each other a lot.			
6	In our family, we work hard at what we do in our home.			
7	In our family, there is a feeling of togetherness.			
8	In our family, we sometimes tell each other about our personal problems.			
9	In our family, we lose our tempers a lot.			
10	In our family, we often put down each other.			
11	My family members really support each other.			
12	My family members sometimes are violent.			
13	I am proud to be a part of our family.			
14	In our family, we really get along well with each other.			
15	In our family, we begin discussions easily.			
16	In our family, we raise our voice when we are mad.			

Section 8 : Beck Depression Index-II (BDI-II)

BDI – II

Nama :		Status Marital : (Menikah/Belum Menikah)*
Usia : thn	Agama :	Jenis Kelamin : (Laki-laki/Perempuan) *
Pekerjaan :		Pendidikan :

*Coret yang tidak perlu

Petunjuk : Kuesioner berikut ini terdiri dari 21 kelompok pernyataan. Mohon setiap kelompok pernyataan dibaca dengan cermat, setelah itu pilih satu dari pernyataan di dalam setiap kelompok yang paling menggambarkan perasaan anda selama 2 minggu terakhir, termasuk hari ini. Lingkarilah angka di samping pernyataan yang anda pilih. Apabila di dalam satu kelompok terdapat beberapa pernyataan yang terasa sama, lingkarilah angka yang paling tinggi dari kelompok pernyataan yang terasa sama tersebut. Pastikan bahwa anda tidak memilih lebih dari satu pernyataan di dalam setiap kelompok, termasuk pernyataan 16 (Perubahan pola tidur) dan pernyataan 18 (Perubahan selera makan).

1. Kesedihan 0. Saya tidak merasa sedih. 1. Saya sering kali merasa sedih. 2. Saya merasa sedih sepanjang waktu. 3. Saya merasa sangat tidak bahagia atau sedih sampai tidak tertahankan.	**3. Kegagalan masa lalu** 0. Saya tidak merasa gagal. 1. Saya telah gagal lebih dari yang seharusnya. 2. Saya melakukan banyak kegagalan di masa lalu. 3. Saya merasa gagal sama sekali (betul-betul gagal).
2. Pesimis 0. Saya tidak meragukan masa depan saya. 1. Saya merasa lebih meragukan masa depan saya dibanding biasanya. 2. Saya merasa segala sesuatu tidak berjalan dengan baik bagi saya. 3. Saya merasa masa depan saya tidak ada harapan dan akan semakin buruk.	**4. Kehilangan gairah** 0. Saya mendapatkan kesenangan dari hal-hal yang saya lakukan. 1. Saya tidak menikmati sesuatu seperti biasanya. 2. Saya hanya mendapatkan sangat sedikit kesenangan dari hal-hal yang biasanya bisa saya nikmati. 3. Saya tidak mendapatkan kesenangan sama sekali dari hal-hal yang biasanya bisa saya nikmati.

5. Perasaan bersalah 0. Saya sama sekali tidak merasa bersalah. 1. Saya merasa bersalah atas banyak hal yang telah atau seharusnya saya lakukan. 2. Saya sering merasa bersalah. 3. Saya merasa bersalah setiap saat.	**8. Mengkritik diri sendiri** 0. Saya tidak mengkritik atau menyalahkan diri sendiri lebih dari biasanya. 1. Saya mengkritik diri sendiri lebih dari biasanya. 2. Saya mengkritik diri sendiri atas semua kesalahan yang saya lakukan. 3. Saya menyalahkan diri sendiri untuk semua hal-hal buruk yang terjadi.
6. Perasaan dihukum 0. Saya tidak merasa bahwa saya sedang dihukum. 1. Saya merasa bahwa mungkin saya akan dihukum. 2. Saya yakin bahwa saya akan dihukum. 3. Saya merasa bahwa saya sedang dihukum.	**9. Pikiran-pikiran atau keinginan bunuh diri** 0. Saya tidak berpikir untuk bunuh diri. 1. Saya berpikir untuk bunuh diri, tetapi hal itu tidak akan saya lakukan. 2. Saya ingin bunuh diri. 3. Saya akan bunuh diri seandainya ada kesempatan.
7. Tidak menyukai diri sendiri 0. Saya tidak merasa kecewa pada diri sendiri. 1. Saya kehilangan kepercayaan pada diri sendiri. 2. Saya merasa kecewa pada diri sendiri. 3. Saya benci pada diri sendiri.	**10. Menangis** 0. Saya tidak menangis lagi seperti biasanya. 1. Saya lebih sering menangis dibanding biasanya. 2. Saya menangis bahkan untuk masalah masalah kecil. 3. Rasanya saya ingin sekali menangis tetapi tidak bisa.

11. Gelisah 0. Saya tidak lagi merasa gelisah atau tertekan dibandingkan biasanya. 1. Saya merasa lebih mudah gelisah atau tertekan dibanding biasanya. 2. Saya sangat tertekan dan gelisah sampai sulit untuk berdiam diri. 3. Saya sangat gelisah sehingga harus senantiasa bergerak atau melakukan sesuatu.	**14. Merasa tidak layak** 0. Saya merasa layak. 1. Saya merasa tidak layak dan tidak berguna dibandingkan biasanya. 2. Saya merasa lebih tidak layak dibanding orang lain. 3. Saya merasa sama sekali tidak layak.
12. Kehilangan minat 0. Saya tidak kehilangan minat untuk berelasi dengan orang lain atau melakukan aktivitas. 1. Saya kurang berminat untuk berelasi dengan orang lain atau terhadap sesuatu dibandingkan biasanya. 2. Saya kehilangan hampir seluruh minat saya untuk berelasi dengan orang lain atau terhadap sesuatu. 3. Saya tidak berminat akan apapun.	**15. Kehilangan tenaga (semangat)** 0. Saya memiliki tenaga (semangat) seperti biasanya. 1. Saya memiliki tenaga lebih sedikit dibanding yang seharusnya saya miliki. 2. Saya tidak memiliki tenaga yang cukup untuk berbuat banyak. 3. Saya tidak memiliki tenaga yang cukup untuk melakukan apapun.
13. Sulit mengambil keputusan 0. Saya dapat mengambil keputusan sebagaimana yang biasanya saya lakukan. 1. Saya agak sulit mengambil keputusan dibanding biasanya. 2. Saya lebih banyak mengalami kesulitan dalam mengambil keputusan dibanding biasanya. 3. Saya sangat mengalami kesulitan setiap kali mengambil keputusan.	**16. Perubahan pola tidur** 0. Saya tidak mengalami perubahan apapun dalam pola tidur saya. 1a. Saya tidur lebih dari biasanya. 1b. Saya tidur kurang dari biasanya. 2a. Saya tidur jauh lebih lama dari biasanya. 2b. Saya tidur sangat kurang dari biasanya. 3a. Saya tidur hampir sepanjang hari. 3b. Saya bangun 1-2 jam lebih awal dan tidak dapat tidur kembali.

17. Mudah marah

0. Saya tidak lebih mudah marah seperti biasanya.
1. Saya lebih mudah marah dibanding biasanya.
2. Saya jauh lebih mudah marah dibanding biasanya.
3. Saya mudah marah sepanjang waktu.

18. Perubahan selera makan

0. Selera makan saya tidak berubah (tidak lebih buruk) dari biasanya.

1a. Selera makan saya kurang dari biasanya.

1b. Selera makan saya lebih dari biasanya.

2a. Selera makan saya sangat kurang dibanding biasanya.

2b. Selera makan saya sangat lebih dibanding biasanya.

3a. Saya tidak punya selera makan sama sekali.

3b. Saya ingin makan setiap waktu.

19. Sulit berkonsentrasi

0. Saya mampu berkonsentrasi seperti biasanya.
1. Saya tidak mampu berkonsentrasi seperti biasanya.
2. Saya sangat sulit untuk tetap memusatkan pikiran terhadap sesuatu dalam jangka waktu yang panjang.
3. Saya merasa saya tidak mampu berkonsentrasi dalam semua hal.

20. Capek atau Kelelahan

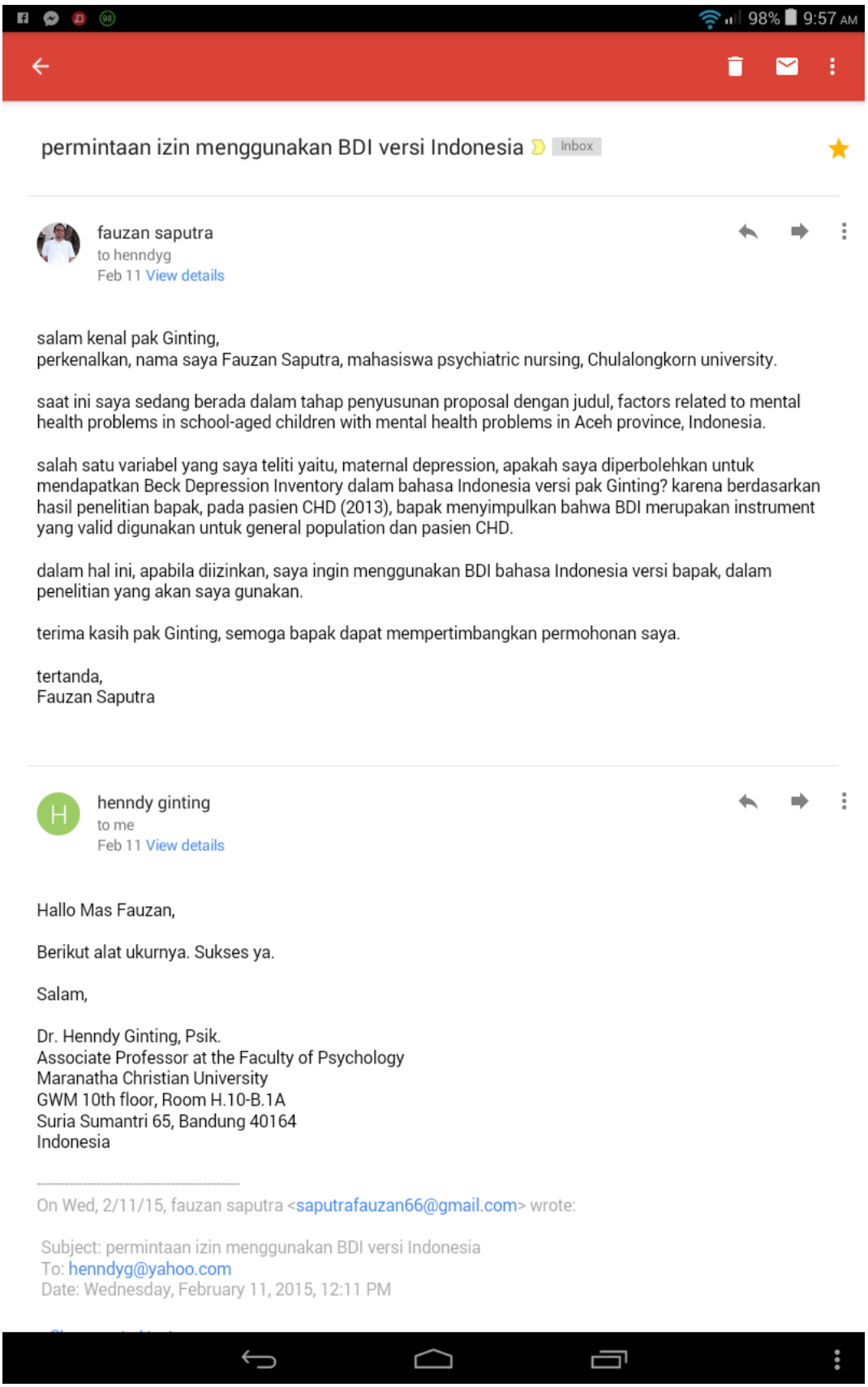
0. Saya tidak lebih capek atau lelah dibanding biasanya.
1. Saya lebih mudah capek atau lelah dari biasanya.
2. Saya merasa capek atau lelah untuk melakukan banyak hal yang biasanya saya lakukan.
3. Saya terlalu capek atau lelah untuk melakukan hampir semua hal yang biasanya saya lakukan.

21. Kehilangan gairah seksual

0. Saya tidak melihat adanya perubahan pada gairah seksual saya.
1. Gairah seksual saya berkurang, tidak seperti biasanya
2. Saya menjadi sangat kurang berminat pada aktivitas seksual saat ini.
3. Gairah seksual saya hilang sama sekali.

Appendix H

Permission letter to use Indonesian translation of BDI-II



permintaan izin menggunakan BDI versi Indonesia Inbox

fauzan saputra
to henndyg
Feb 11 View details

salam kenal pak Ginting,
perkenalkan, nama saya Fauzan Saputra, mahasiswa psychiatric nursing, Chulalongkorn university.

saat ini saya sedang berada dalam tahap penyusunan proposal dengan judul, factors related to mental health problems in school-aged children with mental health problems in Aceh province, Indonesia.

salah satu variabel yang saya teliti yaitu, maternal depression, apakah saya diperbolehkan untuk mendapatkan Beck Depression Inventory dalam bahasa Indonesia versi pak Ginting? karena berdasarkan hasil penelitian bapak, pada pasien CHD (2013), bapak menyimpulkan bahwa BDI merupakan instrument yang valid digunakan untuk general population dan pasien CHD.

dalam hal ini, apabila diizinkan, saya ingin menggunakan BDI bahasa Indonesia versi bapak, dalam penelitian yang akan saya gunakan.

terima kasih pak Ginting, semoga bapak dapat mempertimbangkan permohonan saya.

tertanda,
Fauzan Saputra

henndy ginting
to me
Feb 11 View details

Hallo Mas Fauzan,

Berikut alat ukurnya. Sukses ya.

Salam,

Dr. Henndy Ginting, Psik.
Associate Professor at the Faculty of Psychology
Maranatha Christian University
GWM 10th floor, Room H.10-B.1A
Suria Sumantri 65, Bandung 40164
Indonesia

On Wed, 2/11/15, fauzan saputra <saputrafauzan66@gmail.com> wrote:

Subject: permintaan izin menggunakan BDI versi Indonesia
To: henndyg@yahoo.com
Date: Wednesday, February 11, 2015, 12:11 PM

Appendix I
Data Analysis

Gender of Children * SDQMKat Crosstabulation

Count

		SDQMKat				
		emosional	conduct	Hyperactive	peer	Total
Gender of Children	Male	41	21	31	17	110
	Female	13	6	9	5	33
Total		54	27	40	22	143

Age of Children * SDQMKat Crosstabulation

Count

		SDQMKat				
		emosional	conduct	Hyperactive	peer	Total
Age of Children	6-9 yo	22	13	14	3	52
	10-12 yo	32	14	26	19	91
Total		54	27	40	22	143

Academic Competence of Children * SDQMKat Crosstabulation

Count

		SDQMKat				
		emosional	conduct	Hyperactive	peer	Total
Academic Competence of Children	High AC	17	11	11	12	51
	Moderate AC	36	15	26	10	87
	Low AC	1	1	3	0	5
Total		54	27	40	22	143

Family Income * SDQMKat Crosstabulation

Count

		SDQMKat				
		emotional	conduct	Hyperactive	peer	Total
Family income	<Rp.600,000	27	19	29	9	84
	Rp.600,000-Rp.2,000,000	24	6	9	9	48
	>Rp.2,000,000	3	2	2	4	11
Total		54	27	40	22	143

Social competence * SDQMKat Crosstabulation

Count

		SDQMKat				
		emosional	conduct	Hyperactive	peer	Total
Soccom_1	High SC	15	7	7	2	31
	Moderate SC	25	13	28	15	81
	Low SC	14	7	5	5	31
Total		54	27	40	22	143

Maternal parenting stress * SDQMKat Crosstabulation

Count

		SDQMKat				
		Emosional	conduct	Hyperactive	peer	Total
MStress_1	High	14	5	7	6	32
	Moderate	26	18	23	9	76
	Low	14	4	10	7	35
Total		54	27	40	22	143

Family relationship * SDQMKat Crosstabulation

Count

		SDQMKat				
		emosional	conduct	Hyperactive	peer	Total
BrieF_1	High	13	6	11	7	37
	Moderate	27	12	20	10	69
	Low	14	9	9	5	37
Total		54	27	40	22	143

Maternal parenting behavior * SDQMKat Crosstabulation

Count

		SDQMKat				
		Emosional	conduct	Hyperactive	peer	Total
MParent_1	High	2	5	8	4	19
	Moderate	40	19	27	16	102
	Low	12	3	5	2	22
Total		54	27	40	22	143

Maternal depression * SDQMKat Crosstabulation

Count

		SDQMKat				
		emosional	conduct	Hyperactive	peer	Total
MDepress_1	High	14	3	5	5	27
	Moderate	37	23	27	14	101
	Low	3	1	8	3	15
Total		54	27	40	22	143

Correlations

			Gender of Children	SDQ by Mother	Emotional	Conduct	Hyperactivity	Peer
Spearman's rho	Gender of Children	Correlation Coefficient	1.000	-.036	.020	.092	.028	-.067
		Sig. (2-tailed)	.	.671	.808	.275	.736	.430
		N	143	143	143	143	143	143
	SDQ by Mother	Correlation Coefficient	-.036	1.000	.056	.150	.051	.000
		Sig. (2-tailed)	.671	.	.503	.074	.546	.997
		N	143	143	143	143	143	143
	Emotional	Correlation Coefficient	.020	.056	1.000	-.329**	-.462**	-.137
		Sig. (2-tailed)	.808	.503	.	.000	.000	.104
		N	143	143	143	143	143	143
	Conduct	Correlation Coefficient	.092	.150	-.329**	1.000	-.029	-.265**
		Sig. (2-tailed)	.275	.074	.000	.	.730	.001
		N	143	143	143	143	143	143
	Hyperactivity	Correlation Coefficient	.028	.051	-.462**	-.029	1.000	-.282**
		Sig. (2-tailed)	.736	.546	.000	.730	.	.001
		N	143	143	143	143	143	143
	Peer	Correlation Coefficient	-.067	.000	-.137	-.265**	-.282**	1.000
		Sig. (2-tailed)	.430	.997	.104	.001	.001	.
		N	143	143	143	143	143	143

**. Correlation is significant at the 0.01 level (2-tailed).

Correlations

			Age of Children	Academic Competence of Children	Soccom_1	emo_1	cond_1	hyper_1	peer_1
Spearman's rho	Age of Children	Correlation Coefficient	1.000	-.199**	-.044	.094	.108	-.010	-.162*
		Sig. (1-tailed)	.	.009	.300	.133	.099	.453	.026
		N	143	143	143	143	143	143	143
	Academic Competence of Children	Correlation Coefficient	-.199**	1.000	.097	-.094	-.052	-.119	.101
		Sig. (1-tailed)	.009	.	.125	.133	.268	.078	.114
		N	143	143	143	143	143	143	143
	Soccom_1	Correlation Coefficient	-.044	.097	1.000	-.010	.017	.034	-.116
		Sig. (1-tailed)	.300	.125	.	.453	.421	.344	.083
		N	143	143	143	143	143	143	143
	emo_1	Correlation Coefficient	.094	-.094	-.010	1.000	-.272**	-.459**	-.137
		Sig. (1-tailed)	.133	.133	.453	.	.001	.000	.052
		N	143	143	143	143	143	143	143
	cond_1	Correlation Coefficient	.108	-.052	.017	-.272**	1.000	-.066	-.259**
		Sig. (1-tailed)	.099	.268	.421	.001	.	.217	.001
		N	143	143	143	143	143	143	143
	hyper_1	Correlation Coefficient	-.010	-.119	.034	-.459**	-.066	1.000	-.169*
		Sig. (1-tailed)	.453	.078	.344	.000	.217	.	.022
		N	143	143	143	143	143	143	143
	peer_1	Correlation Coefficient	-.162*	.101	-.116	-.137	-.259**	-.169*	1.000
		Sig. (1-tailed)	.026	.114	.083	.052	.001	.022	.
		N	143	143	143	143	143	143	143

**. Correlation is significant at the 0.01 level (1-tailed).

*. Correlation is significant at the 0.05 level (1-tailed).

Correlations

			Family Income	BrieF_1	SDQM_1	emo_1	cond_1	hyper_1	peer_1
Spearman's rho	Family income	Correlation Coefficient	1.000	.026	.024	-.097	.095	.103	-.005
		Sig. (1-tailed)	.	.380	.387	.124	.131	.111	.476
		N	143	143	143	143	143	143	143
	BrieF_1	Correlation Coefficient	.026	1.000	-.176*	-.013	-.122	.031	.018
		Sig. (1-tailed)	.380	.	.018	.438	.074	.356	.414
		N	143	143	143	143	143	143	143
	SDQM_1	Correlation Coefficient	.024	-.176*	1.000	.054	.169*	.198**	.080
		Sig. (1-tailed)	.387	.018	.	.262	.022	.009	.171
		N	143	143	143	143	143	143	143
	emo_1	Correlation Coefficient	-.097	-.013	.054	1.000	-.272**	-.459**	-.137
		Sig. (1-tailed)	.124	.438	.262	.	.001	.000	.052
		N	143	143	143	143	143	143	143
	cond_1	Correlation Coefficient	.095	-.122	.169*	-.272**	1.000	-.066	-.259**
		Sig. (1-tailed)	.131	.074	.022	.001	.	.217	.001
		N	143	143	143	143	143	143	143
	hyper_1	Correlation Coefficient	.103	.031	.198**	-.459**	-.066	1.000	-.169*
		Sig. (1-tailed)	.111	.356	.009	.000	.217	.	.022
		N	143	143	143	143	143	143	143
	peer_1	Correlation Coefficient	-.005	.018	.080	-.137	-.259**	-.169*	1.000
		Sig. (1-tailed)	.476	.414	.171	.052	.001	.022	.
		N	143	143	143	143	143	143	143

*. Correlation is significant at the 0.05 level (1-tailed).

**. Correlation is significant at the 0.01 level (1-tailed).

Correlations

			Soccom_1	MStress_1	BrieF_1	MParent_1	MDepress_1	SDQM_1
Spearman's rho	Soccom_1	Correlation Coefficient	1.000	.139*	.103	-.079	-.002	-.110
		Sig. (1-tailed)	.	.049	.110	.173	.491	.095
		N	143	143	143	143	143	143
	MStress_1	Correlation Coefficient	.139*	1.000	-.129	-.076	.289**	.173*
		Sig. (1-tailed)	.049	.	.062	.185	.000	.020
		N	143	143	143	143	143	143
	BrieF_1	Correlation Coefficient	.103	-.129	1.000	.036	-.234**	-.176*
		Sig. (1-tailed)	.110	.062	.	.333	.002	.018
		N	143	143	143	143	143	143
	MParent_1	Correlation Coefficient	-.079	-.076	.036	1.000	-.287**	.053
		Sig. (1-tailed)	.173	.185	.333	.	.000	.263
		N	143	143	143	143	143	143
	MDepress_1	Correlation Coefficient	-.002	.289**	-.234**	-.287**	1.000	.023
		Sig. (1-tailed)	.491	.000	.002	.000	.	.392
		N	143	143	143	143	143	143
	SDQM_1	Correlation Coefficient	-.110	.173*	-.176*	.053	.023	1.000
		Sig. (1-tailed)	.095	.020	.018	.263	.392	.
		N	143	143	143	143	143	143

*. Correlation is significant at the 0.05 level (1-tailed).

**. Correlation is significant at the 0.01 level (1-tailed).

Correlations

			emo_1	cond_1	hyper_1	peer_1	Soccom_1	MStress_1	BrieF_1	MParent_1	MDepress_1
Spearman's rho	emo_1	Correlation Coefficient	1.000	-.272**	-.459**	-.137	-.010	.052	-.013	-.287**	.236**
		Sig. (1-tailed)	.	.001	.000	.052	.453	.270	.438	.000	.002
		N	143	143	143	143	143	143	143	143	143
	cond_1	Correlation Coefficient	-.272**	1.000	-.066	-.259**	.017	.113	-.122	.162*	-.019
		Sig. (1-tailed)	.001	.	.217	.001	.421	.090	.074	.027	.410
		N	143	143	143	143	143	143	143	143	143
	hyper_1	Correlation Coefficient	-.459**	-.066	1.000	-.169*	.034	-.004	.031	.143*	-.158*
		Sig. (1-tailed)	.000	.217	.	.022	.344	.479	.356	.044	.030
		N	143	143	143	143	143	143	143	143	143
	peer_1	Correlation Coefficient	-.137	-.259**	-.169*	1.000	-.116	-.093	.018	.003	.020
		Sig. (1-tailed)	.052	.001	.022	.	.083	.135	.414	.488	.407
		N	143	143	143	143	143	143	143	143	143
	Soccom_1	Correlation Coefficient	-.010	.017	.034	-.116	1.000	.139*	.103	-.079	-.002
		Sig. (1-tailed)	.453	.421	.344	.083	.	.049	.110	.173	.491
		N	143	143	143	143	143	143	143	143	143
	MStress_1	Correlation Coefficient	.052	.113	-.004	-.093	.139*	1.000	-.129	-.076	.289**
		Sig. (1-tailed)	.270	.090	.479	.135	.049	.	.062	.185	.000
		N	143	143	143	143	143	143	143	143	143
	BrieF_1	Correlation Coefficient	-.013	-.122	.031	.018	.103	-.129	1.000	.036	-.234**
		Sig. (1-tailed)	.438	.074	.356	.414	.110	.062	.	.333	.002
		N	143	143	143	143	143	143	143	143	143
	MParent_1	Correlation Coefficient	-.287**	.162*	.143*	.003	-.079	-.076	.036	1.000	-.287**
		Sig. (1-tailed)	.000	.027	.044	.488	.173	.185	.333	.	.000
		N	143	143	143	143	143	143	143	143	143
	MDepress_1	Correlation Coefficient	.236**	-.019	-.158*	.020	-.002	.289**	-.234**	-.287**	1.000
		Sig. (1-tailed)	.002	.410	.030	.407	.491	.000	.002	.000	.
		N	143	143	143	143	143	143	143	143	143

**. Correlation is significant at the 0.01 level (1-tailed).

*. Correlation is significant at the 0.05 level (1-tailed).

VITA

My name is Fauzan Saputra, my nick name is Fauzan. I am studying master in Nursing Science Program with specialty in Psychiatric Nursing in Chulalongkorn University, Bangkok, Thailand. I was born at Cunda, Lhokseumawe city, Aceh province, Indonesia on July 7th, 1981. I am a muslim male with indonesian nationality, also a father for attractive young boy, Rayyan, and a husband for lovely wife, Poppy Melissa Ryan. Before I study in Faculty of Nursing, Chulalongkorn University, I was studied Bachelor of Nursing in University of Indonesia, Depok, Indonesia. When I was in bachelor degree, I had a research about "Motivation and Participation of People in Depok to fight Dengue Fever in Depok, West Java, Indonesia".

After I graduated from Bachelor of Nursing, I have many working experiences, such as I ever worked in community health center to take care patients with Tuberculosis and Leprae, and now I am working at Public Health Office in Lhokseumawe city as responsible person for HIV-AIDS program in my city.

Now I conduct a research to fulfill the requirement to get MNS in Faculty of Nursing, Chulalongkorn University, which is "selected factors related to mental health problems in school-aged children with mental health problems in Aceh province, Indonesia". my contact person are in email (saputrafauzan66@gmail.com), and phone (+66955269021).