DESCRIPTION OF EMOTION AND BEHAVIOR PROBLEMS AMONG URBAN CHILDREN AND ADOLESCENTS IN WEST JAKARTA

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ABSTRACT

Background: Emotional and behavioral problems (EBP) during childhood and adolescence are a common concern for parents and mental health stakeholders. Earlier studies have shown that child and adolescent EBP predict numerous problematic outcomes in adulthood that involve serious challenges across many important life domains including family functioning, mental health, education, and employment. The purpose of this study was to describe EBP among urban adolescents in West Jakarta.
Subjects and Method: A cross sectional study was conducted at several junior high schools in West Jakarta. A sample of 140 adolescents was selected for this study. The dependent variable was emotion and behavior problem (EBP). The data on EBP were collected by Strength and Difficulties Questionnaire (SDQ) and described accordingly.
Results: Ages of the sample ranged from 12 to 15 years. Girls shared 54%. As many as 30% of the sample had EBP, consisting of 40% behavior problem, 31% emotional problem, 15% hyperactivity, 8% peer relation problem, and 6% pro-social literacy problem.
Conclusion: As many as 30% urban adolescents have emotional and behavior problem of various types.

Keywords: children, adolescent, emotion, behavior problem.

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BACKGROUND

Indonesia in 2020 to 2030 is predicted to get a demographic bonus, namely the condition when the population of productive age is very large while the population of young people or children is getting smaller and old age is still not too large in proportion. The productive age group in 2020-2030 is those who are currently included in the youth population group (LDF FEB UI, 2017). Adolescence is a time when individuals develop from the first time they show secondary sexual signs until they reach sexual maturity, individuals experience psychological development and patterns of identification from childhood to adulthood, a transition from full socio-economic dependence to a relatively independent state (Gunardi et al., 2010).

According to Hurlock (1991) the term teenager is limited based on the chronological age, namely children who are in the age range of 12 to 18 years, who then Thornburg (1982) adds information on that saying that the age limit occurs because it is based on traditional constraints, while contemporary flow limits the age of adolescents between 11 up to 22 years. Likewise, the Mongks, Knoers and Haditono (2000) give their own limitations, namely the age of adol-

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escents in the age range of 12 to 21 years and also according to Hall (2008) who said that adolescents are in the age range of 12 to 25 years.

According to WHO, adolescents are residents in the age range of 10 to 19 years. According to Republic of Indonesia Minister of Health Regulation number 25 of 2014, adolescents are residents in the age range of 10-18 years. The many different definitions of adolescents indicate that there is no universal agreement regarding the limits of the teen age group. However, often adolescence is associated with the transition from children to adults. A period which is the preparation period towards adulthood in passing several important stages of development in life. In addition to physical and sexual maturity, adolescents also experience stages towards social and economic independence, building identity, acquisition of abilities for adult life and ability to negotiate (abstract reasoning) (WHO, 2015).

Mental health is a key factor for health development in adolescents. Teenagers with good mental health will be able to have the ability to interact socially in building good friendships with other people and their environment, success at school, ability to overcome personal problems, and have sincerity of ideals and goals in life. Research shows that adolescents who have good mental health tend to develop into a person who is full of confidence and has the potential to make a large contribution to the nation's development in a country (Patel et al., 2007).

The general prevalence of mental health problems in children and adolescents ranges from 10-20% (WHO, 2011) based on the characteristic of adolescents who have a great curiosity, love adventure and challenges and tend to dare to risk their actions without being preceded by careful consideration. If there is conflict and decision making is not right, then they will easily fall into risky behavior that is very likely to have short-term or long-term consequences in a variety of physical and psychosocial health problems. The behavior and risk characteristics of adolescents require the availability of qualified adolescent health services to be able to meet adolescent health needs, including services for reproductive health (Ministry of Health, 2017).

Adolescence experiences many changes in itself and usually often triggers conflicts between adolescents with themselves and conflicts with the surrounding environment. If these conflicts cannot be resolved properly, the development can bring negative impacts, especially the impact on the maturation of adolescent character and can cause mental emotional problems (Wiguna, 2009).

Mental emotional problems are a problem condition that shows one or more of the characteristics that can occur over a long period of time and have a negative impact on the child's performance in receiving education. Mental emotional problems can also be an indication of the individual's condition in experiencing an emotional change that if allowed to continue will be able to develop into a pathological state that can threaten people's mental health. Other terms mental

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emotional problems are psychological distress and emotional distress (Idaiani et al., 2009).

Mental emotional problems can be defined as a condition that indicates an individual experiences an emotional change that is inhibiting, obstructing, or making it difficult for someone in their efforts to adjust to the environment and experience (Idaiani, et al., 2009; Damayanti, 2011). Mental emotional and behavioral problems in adolescents are a serious problem because they have a major impact on their development, and cause health and reduce their productivity and quality of life. As an example, one and a half million children and adolescents in the United States are reported by their parents, who have persistent emotional, developmental and behavioral problems. Where there is a result of 41% of parents in the United States worried that their children experience learning difficulties and 36% worry about experiencing depression or anxiety disorders (Wiguna et al., 2010).

Behavioral problems are problems characterized by dissocial, aggressive or opposing behavioral patterns, which can recur and persist. This behavior in its extreme form will be a manifestation of a gross violation of the social norms found in children of that age, this violation can be permanent and will appear to be more severe than juvenile delinquency or adolescent rebellion in the usual manner. An assessment of the existence of behavioral problems needs to consider the level of development of the child.

Examples of behaviors that form the basis of the diagnosis include the following: excessive fights or harassment, cruelty to animals or humans, severe damage to other people's property, burning, stealing, repeated lying, skipping school and running away from home, temper tantrums. Each of these categories, if found, is enough to be a reason for the diagnosis of adolescents with behavioral problems. However, in the case of dissocial acts (actions that violate morals) a single one is not yet a strong reason to determine that the teenager has problems in his emotions and behavior. This diagnosis is not recommended unless dissocial behavior continues for six months or more (MOH, 1998).

Classification of groups of behavioral problems in PPDGJ III is divided into six, namely: (1) behavior problems that are limited to the family environment; (2) Behavior problems that are not grouped, which is characterized by the absence of effective cohesion with peer groups (an important difference with group behavior disorders); (3) Group behavior problems in which there is a strong bond of friendship with children his age which often consists of children who are also involved in criminal or dissocial acts; (4) The problem of resistance / rebellion, in this case is limited by the absence of more severe dissocial and aggressive actions such as those that violate the law or violate the human rights of others; (5) Other behavioral problems, and (6). Which behavioral problems Not Classified (MOH, 1998).

As an illustration, the prevalence of behavioral problems in adoles-

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cents in America has increased in the last few decades and more often appears in urban areas than in rural areas. In men under 18, there are around 6% to 16%, while in women there are 2% to 9% (American Psychiathric Association, 1994). Furthermore the study conducted by Kazdin (1998) added that the behavioral problems occurring were more prevalent in men than in women. Emotional and behavioral problems in children and adolescents in urban areas have a distinctiveness which is certainly not found in rural areas. Today's life is very closely related to environmental stress.

According to Fontana (Siegel, 2008) that environmental stress comes from different sources such as meeting residential buildings so that they have noisy neighbors, highways that often threaten security and comfort, and financial anxiety over the inability to pay for the needs that support the appearance of style living in the city like having cellphones, motorized vehicles, etc. There is a lot of evidence from several studies or studies about the relationship between urban ecology and the tendency to arise mental health disorders compared to rural areas. One of them is a research on "The Relationship between Urbanization and the Development of Psychological Disorders" is significant" (Sundquist, 2004).

With a strong study design, it shows that there is a relationship between the level of urbanization and the onset of the onset of psychosis (a symptom of psychiatric illness). It was explained that the increased risk in urban areas compared to rural areas was different in terms of social support, stressful life, and family obligations. Rurality (non-urban life) does not explain the large differences in the level of mental disorders while in urban areas there is a big difference. The situation of rural communities can be based on a more applicable socio-economic and cultural. Stable communities without rapid social change, with low divorce rates, moderate levels of alcohol consumption, low crime and adherence to traditional moral and religious values, encourage good mental health in children and adults.

In another study in the Mexican-American population, it was shown that the highest prevalence of mental disorders occurred in respondents living in large cities (35.7%) compared to those living in small cities (32.1%) and those living in rural areas (29,8 %). This shows the tendency of mental disorders is relatively more common in urban areas (William et al, 1998). A study of young adults in urbanized areas found that symptoms of general mental disorders were more prevalent in cities than in rural areas (Khartoum, Sudan). The risk factors are loneliness, expression of expulsion, isolation and lack of social support that occur when rural residents migrate from their families and siblings. There is evidence that social factors, especially life-threatening events, violence and lack of social support, play an important role in the etiology of common mental disorders. In fact, urban environment is one of many misfortunes, including poverty, violence and isolation (Leventhal, 2000).

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SUBJECTS AND METHOD

1. Study Design

This was a descriptive study conductrd at 5 junior high schools on March to May 2018.

2. Population and Sampling

A total 140 adolescents was selected by Multy Stage Cluster Sampling, with criteria aged 12 to 15 years, male and female, in the junior high school community in the West Jakarta.

3. Study Instruments

The instruments used in this study are the questionnaires of Strength and Difficulties Questionnaire (SDQ) which has been determined by the Indonesian Ministry of Health as an instrument for screening behavioral and emotional problems in children and adolescents in accordance with the Guidelines for Technical Guidelines for Health Screening and Periodic Examination in Educational Units Primary and secondary 2015. Questionnaires used in this study were SDQ in Children aged 11-18 years consisting of 25 questions.

The diagnosis of behavioral and emotional problems was based on the criteria agreed upon in the training module to diagnose behavioral and emotional problems issued by the Indonesian Ministry of Health.

Each SDQ subscale consists of five items. Each item was scored in a three-point criterion, namely: 0= incorrect, 1= somewhat correct, 2= true. Scoring from each subscale can be calculated by summing the scores of each relevant item in the subscale. The highest score of each subscale was 10 and the lowest score was 0.

SDQ has a sensitivity of 85% and specificity of 80%. Compared to other instruments in early detection of mental emotional problems in adolescents, SDQ was better at detecting problems of hyperactivity, intensity, and detecting problems of internalization and externalization.

4. Data Analysis

The data were analyzed descriptively.

Table 1. SDQ Score Interpretation

Self filling	Normal	Borderline	Abnormal
The total of difficulty score	0-15	16-19	20-40
Emotional symptom score	0-5	6	7-10
Behavior problem score	0-3	4	5-10
Hyperactivity score	0-5	6	7-10
Relationships with peers score	0-3	4-5	6-10
Prosocial behavior score	6-10	5	0-4

Source: Workshop CPD III, 2010

RESULTS

Score of emotional and behavioral problems in urban adolescents turned out to be more prevalent in young women at 54% while in young men 46%. The total score of subscale difficulty (emotional and behavioral problems) was 30%. Interpretation scores based on problem division are in the order behavioral problems by 40%, emotional symptoms by 31%, hyperactivity by 15%, problems with peer relationships at 8%, and problems in prosocial abilities by 6%.

DISCUSSION

In the study of adolescents who experience emotional and behavioral prob-

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lems, they are mostly young women that was equal to 54%. The results of this study show more female subjects who have behavioral problems than male subjects. This was in contrary to what Kazdin expressed in Conner and Lochman (2010) that behavior problems occur more in men than women.

According to Dahlan (2009) the results of research different from this theory are not contradictory. A researcher can use two types of interpretation methods in diagnostic research, namely clinical interpretation and statistical interpretation. The clinical interpretation can be in line with statistical interpretations, but it can also be out of line. Dahlan recommends clinical interpretation more than statistical interpretation. As far as the knowledge of the researcher, there was no other valid instrument in screening behavioral disorders in Indonesia, the SDQ clinically has good or satisfactory screening quality.

Early detection of mental emotional and behavioral problems in school-age children was very important to prevent more severe problems in later life. Schools and teachers as a secondary environment after the family was a party that has an important role in the development of mental health of children and adolescents.

Early detection of mental emotional problems and behavior of school-age adolescents can be done using the SDQ questionnaire that can be filled by parents, teachers or the children themselves. Even so, it still needs assistance from the BK teacher (Student Career Guidance) for all students selected as subjects or samples, and for students whose results have a borderline SDQ score so that they can be directly noticed and not develop into abnormal.

REFERENCE

Association AP (1994). Diagnostic and Statistical Manual of Mental Disorders. 4th Editio. Washington DC: American Psychiatric Association.

Bakare M, Ubochi V, Ebigbo P, Orovwigho A (2010). Problem and pro-social behavior among nigerian children with intellectual disability: the implication for developing policy for school based mental health programs. 36:37. Available from: Italian Journal of Pediatrics.

Damayanti M (2011). Masalah Mental Emosional pada Remaja : Deteksi dan Intervensi. Sari Pediatri, 13(1): 45–51.

Davies T, Craig TA (2009). Kesehatan Mental. Jakarta: EGC.

Depkes RI (1998). Pedoman Penggolongan dan Diagnosis Gangguan Jiwa di Indonesia (PPDGJ). Edisi III. Jakarta: Dirjen Pelayanan Medis Departemen Kesehatan RI.

Hall GS (2008). Adolescence: Its Psychology and Its Relations to Physiology, Anthropology, Sociology, Sex, Crime, and Religion 1931. Volume 1. Read Books: Harvard University.

Hurlock EB (1991). Psikologi Perkembangan Suatu Pendekatan Sepanjang Rentang Kehidupan (Terjemahan oleh Istiwidayanti dan Soedjarwo). Penerbit Erlangga.

IDAI (2010). Kuesioner kekuatan dan kesulitan, the strength and difficulties questionnaire (SDQ). Dalam: Workshop CPD III. Semarang.

Idaiani S, Suhardi, Kristanto AY

https://doi.org/10.26911/theicph.2019.03.31

(2009). Analisis Gejala Gangguan Mental emosional Penduduk Indonesia, Majalah Kedokteran Indonesia, 59(10): 473–479.
Kazdin AE (1998). Conduct disorder, in Morris, R. J. and Kratochwill, T. R. (eds) The practice of child therapy. 3rd Editio. Boston: Allyn and Bacon, pp. 199–230.
LDF FEB UI (2017) Prioritaskan Kesehatan Reproduksi Remaja Untuk Menikmati Bonus Demografi. Depok.
Mongks FJ, Knoers AMP, Haditono SR (2000). Psikologi Perkembangan: Pengantar dalam berbagai bagiannya. Yogyakarta: Gadjah Mada University Press.
Pusat Data dan Informasi Kementrian Kesehatan (2017) 'Infodatin Pusat Data dan Informasi Kementrian Kesehatan RI', Kementrian Kesehatan RI.
Thornburg DH (1982). Development in adolescence. Second Edi. California: Brook Cole Publishing Co.
WHO (2015). Adolescent Development: Topics at Glance, World Health Organization.
Wiguna T (2009). Masalah kesehatan mental remaja di era globalisasi. Jakarta: Departemen Ilmu Kesehatan Anak FKUI-RSCM.
Wiguna T, Manengkei PSK, Pamela C, Rheza AM, Hapsari WA (2010). Masalah Emosi dan Perilaku pada Anak dan Remaja di Poliklinik Jiwa Anak dan Remaja RSUPN dr. Ciptomangunkusumo (RSCM). Sari Pediatri, 12(4): 270–277.

https://doi.org/10.26911/theicph.2019.03.31