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Mental Health and Quality of Life Among Spanish-born and Immigrant Children in Years 2006 and 2012

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ABSTRACT

Background: One of every five children and adolescents in the European Union suffers from behavioural, and emotional disturbances.
Objectives: To compare factors associated with the quality of life and mental health of immigrant and Spanish children aged 4–14 years both during the years 2006 and 2012 and to evaluate changes over this time period.
Design and Methods: An epidemiologic age and sex matched case-control study (1:2) was conducted. The study group were 677 immigrant children and 1354 matched Spanish children (controls). This study was conducted using data obtained from the Spanish National Health Surveys done in 2006 and 2012. We used the Strengths and Difficulties Questionnaire to obtain the score for variables derived from mental health and the Kidscreen-10 questionnaire to score the Health-Related Quality of Life.
Results: Spanish girls scored higher in conduct problems (2.04 ± 0.1) and better in problems with peers (1.21 ± 0.08) regarding immigrant girls (1.82 ± 0.12–1.92 ± 0.13 respectively). Concerning total scores, immigrant children obtained significantly lower scores in quality of life (81.29 ± 0.76) and in problems with peers (2.04 ± 0.09) than their matched Spanish children (84.4 ± 0.45 and 1.26 ± 0.06) in 2006. Immigrant children had lower total scores in prosocial behaviour (8.62 ± 0.11) compared to the matched Spanish children (8.92 ± 0.06) in 2012. The total average scores of immigrant children in terms of quality of life, emotional symptoms, behavioural problems, hyperactivity and problems with peers were significantly better in 2012 (86.58; 1.84; 1.46; 3.77 and 1.48 respectively) than in 2006 (81.29; 2.15; 1.90; 4.58 and2.04).
Conclusions: Immigrant children had a poorer quality of life and mental health than matched Spanish children in 2006.

Introduction

The challenges faced by immigrants when leaving their country include changes in environment and integration at the institutional, cultural and socio-economic levels (Fox, Burns, Popovich, & Ilg, 2001). The most common problems are: family separation, poverty, low educational level, poor working conditions, discrimination and lack of social integration (Hernández-Plaza, Pozo, & Alonso-Morillejo, 2004). These problems are positively associated with risk factors for common mental disorders (depressive, behavioural, and self-esteem disorders) (Del Amo et al., 2011). Hernández Quevedo and Jiménez Rubio (2010) and Breslau et al. (2011) show that immigrants have higher rates of common mental disorders such as depression and anxiety than the native population. Also, previous studies (Belhadj Kouider, Koglin, & Petermann, 2015; Hilario, Oliffe, Wong, Browne, & Johnson, 2015; Stevens et al., 2015) reported that immigrant adolescents showed more emotional and behavioural problems than native adolescents.

Adolescence is considered a period of development wherein individuals build their own identity. For adolescents, social pressures can be intensified by the demands of the developmental phase as well as by cultural adaptation, giving rise to conflicting changes in the individual's social identity. Besides, immigrant adolescents have to confront adaptation to school peer groups and a new social and cultural environment (Motti-Stefanidi et al., 2008). All these factors have an impact on their identity (Belhadj Kouider et al., 2015).

Between 1998 and 2014, the number of foreigners registered as residents in Spain increased more than seven times, from 637.058 to 5.023.487 (Instituto Nacional de Estadística, INE, 2014). In January

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2014, the Spanish foreign population accounted for 11% of the population registered in the census, and of this, children accounted for 14.5% (Instituto Nacional de Estadística, INE, 2014). In the last two decades, the immigrant population increased considerably in Spain, but after the beginning of the economic crisis in 2008, this trend first suffered a slowdown, then stabilization and it has recently experienced a slight decline (Vázquez, Vargas, & Aller, 2014).

The presence of risk situations in the life of immigrant children and youth (low level of economic resources, parental conflicts, lack of peer support) can lead to risk behaviours that lead to health problems (Belhadj Kouider et al., 2015; Hilario et al., 2015). Moreover, previous studies (Beiser, Goodwill, Albanese, McShane, & Nowakowski, 2014; Belhadj Kouider et al., 2015; Sun, Chen, & Chan, 2016) reported that immigrant children present significantly greater mental health problems and lower well-being. Also, immigrant children are more likely to be exposed to physical and mental risks due to limited usage of health services (Sun et al., 2016), high acculturation stress, low English language competence, discrepancies in children's and parent's cultural orientation (Belhadj Kouider et al., 2015), levels of parent's depression and somatization, and resettlement stress (Beiser et al., 2014). Exposure to adverse situations at an early age is a risk factor for mental disorders (World Health Organization, 2013) and these symptoms usually remain stable until adulthood (Ortuño-Sierra, Fonseca-Pedrero, Paíno, & Aritio-Solana, 2014).

Several studies (Gaspar et al., 2009; Ravens-Sieberer et al., 2007) show how quality of life is related to health, individual aspects (self-esteem, emotions) and social aspects (family relations, school, peers). Mental health problems can affect the social and emotional development of young people and their ability to manage emotions, behaviours and interactions with others (Bot, de Leeuw den Bouter, & Adriaanse, 2011). Similarly, mental illness affects not only the individual, but also family, friends and society, producing social costs associated with health care (Rajmil et al., 2010). In that way, previous studies (Pantzer et al., 2006; Salinero-Fort, Jiménez-García, de Burgos-Lunar, Chico-Moraleja, & Gómez-Campelo, 2015) reported that health-related quality of life (HRQoL) was higher in native adolescents than immigrants. Also, previous studies (Pantzer et al., 2006) observed that quality of life was higher in groups of higher socio-economic level, with significant differences between the highest and lowest levels. Moreover, the socio-economic status was shown to be significantly associated with mental health (Wille, Bettge, & Ravens-Sieberer, 2008).

One of every five (20%) children and adolescents in the European Union suffers from behavioural or developmental problems, emotional disturbances and 12% have clinically diagnosed mental disorders as reported in 2009 (Braddick, Carral, Jenkins, & Jané-Llopis, 2009). In Spain, 2.2% of children have some type of behavioural disorder and 1% mental health problems (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2014). The WHO Atlas on Child and Adolescent Mental Health Resources (Belfer, 2008) documented the failure of the countries in the provision of the appropriate policy, training and services for child and adolescents mental health. In addition, there are gender differences (Derluyn, Broekaert, & Schuyten, 2008; Lemos, Nunes, & Nunes, 2013; Stevens et al., 2015). Immigrant girls present with more depression problems, while immigrant boys present with more behavioural problems (Derluyn et al., 2008).

In Spain, Font-Ribera et al. (2014) describe how, in Spanish adolescents and children, there are major differences between immigrants and natives in determinants of health such as obesity, physical activity, and mental problems. What is more, Stevens et al. (2015) compared the emotional state and behaviour in adolescents internationally (An Internationally Comparative Study of Immigration and Adolescent Emotional and Behavioural Problems: Effects of Generation and Gender), showing data from Denmark, Germany, Greece, Iceland, Ireland, Italy, the Netherlands, Spain, the United States, and Wales (n = 53.218). In Spain, they studied children whose countries of origin were Ecuador, Morocco and Colombia, and showed how immigrant children and adolescents presented with higher levels of bullying, lower life satisfaction and more psychosomatic symptoms than native adolescents.

In Spain, there are previous studies (Gotsens et al., 2015; Salinero-Fort et al., 2015; Sevillano, Basabe, Bobowik, & Aierdi, 2014) which show a higher prevalence of mental health problems and difficulties in the access to health services in the adult immigrant population, as compared to the native population. But there are no population studies in Spain which compare the HRQoL and the mental state among immigrant and native children and adolescents. Authors such as Font-Ribera et al. (2014) in their study of related inequalities in child and adolescent health in Spain and reported that there is a lack of studies of child and adolescent health, especially in children under the age of 13.

The objectives of this study were: a) to describe and assess the status of mental health and HRQoL of children aged 4 to 14 b) to compare the HRQoL and mental health of immigrant to Spanish children during the years 2006 to 2012; c) to identify factors associated with having a poorer HRQoL and mental health, and d) to observe changes in the HRQoL and mental health in the child immigrant population in 2006 compared to that in 2012.

Methods

We conducted an epidemiologic matched case-control study (1:2) using individualized data obtained from the Spanish National Health Surveys (SNHS) done from 2006 to 2012, conducted by the Spanish Ministry of Health and the National Statistics Institute (INE).

Data Source

The SNHS were carried out on a representative sample of the non-institutionalized population of Spain. The multistage cluster sampling method is used. Within each household a child aged 0–15 years and an adult aged 16 years or more were randomly selected in the SNHS 2006, and a child aged 0–14 years and an adult aged 15 or more in the SNHS 2012 were chosen to complete the questionnaire. The minor interview was completed by the parent or guardian. More details on the methodology can be found on the Web Site of the Instituto Nacional de Estadística (INE) (2006, 2011). The sample size was composed of 9122 children (2006) and 5495 children (2012). For the current study we have only analyzed children aged 4 to 14 (N = 2031).

The subjects were classified as immigrants (cases) if they chose the "foreigner" option as an answer to the question "What is the nationality of …?" We found a total of 677 immigrant children (415 in the SNHS 2006 and 262 in the SNHS 2012). Those subjects who answered "Spanish" to this question were used to create the control group. Two controls were randomly selected for each case, matched by age, gender, province and town size with a total of 1354 (830 in the SNHS 2006 and 524 in the SNHS 2012).

Study Variables

They have been created from several questions included in the questionnaires, and identical in both surveys. The main variables in this study were mental health and the quality of life (continuous dependent variables). For variables derived from mental health, we used the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001; Marzocchi et al., 2004), which consists of 25 questions divided into 5 scales (emotional symptoms, conduct problems, hyperactivity, peer relationship problems and prosocial behaviour) of 5 items each. For each scale, score ranges between 0 and 10, from lower (better) to higher (worse) for all scales except prosocial behaviour that would be the reverse.

The HRQoL variable was obtained by means of the Kidscreen-10 (Ravens Sieberer et al., 2010), applicable to children aged 8–14 years, which consists of 10 questions, each with 5 response options, with