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Caretaker mental health and family environment factors are associated with adolescent psychiatric problems in a Vietnamese sample

Kelcey Jane Stratton [a,b,c,*], Alexis Christine Edwards [b], Cassie Overstreet [b,c], Lisa Richardson [d], Trinh Luong Tran [e], Lam Tu Trung [f], Nguyen Thanh Tam [g], Tran Tuan [h], La Thi Buoi [h], Tran Thu Ha [h], Tran Duc Thach [h], Ananda Beth Amstadter [b]

[a] Hunter Holmes McGuire VA Medical Center, 1201 Broad Rock Boulevard (116-B), Richmond, VA 23249, USA
[b] Virginia Institute for Psychiatric and Behavioral Genetics, Virginia Commonwealth University, 800 East Leigh Street, Biotech 1, Suite 101, Richmond, VA 23219, USA
[c] Virginia Commonwealth University, Department of Psychology, 806 West Franklin Street, Richmond, VA 23284, USA
[d] Murdoch University, School of Psychology, Perth, Australia
[e] Health Department of Da Nang City, Da Nang City, Vietnam
[f] Da Nang Mental Health Hospital, Da Nang City, Vietnam
[g] Vietnam Veterans of America Foundation, Hanoi, Vietnam
[h] Research and Training Center for Community Development, Hanoi, Vietnam

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ABSTRACT

Little is known about risk factors for adolescent mental health in Vietnam. The present study investigated the relationship between caretaker mental health and adolescent mental health in a cross-sectional Vietnamese sample. Primary caretakers completed measures of their own mental distress and general health status using the Self-Reporting Questionnaire-20 (SRQ-20) as well as reports of adolescent mental health using the parent version of the Strengths and Difficulties Questionnaire (SDQ). Multivariate regression models were used to examine the relationships between the caretaker and adolescent health variables. The demographic factors of age, sex, ethnicity, religious affiliation, and household wealth status demonstrated significant relationships with SDQ subscale scores. Caretaker mental health was positively associated with adolescent mental health, and this association remained significant even after accounting for other relevant demographic variables and caretaker general health status. Understanding correlates of adolescent mental health difficulties may help identify youth and families at risk for developing psychiatric problems and inform mental health interventions in Vietnam.
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1. Introduction

Psychiatric disorders in children and adolescents produce significant social and economic consequences for the individual, their immediate families, and the global community (Demyttenaere et al., 2004; Kessler et al., 2007). Although children and adolescents account for an estimated 20% of mental health cases globally, obtaining prevalence rates in low-income countries has proven difficult due to lack of services available and insufficient data gathering systems (World Health Organization, 2005). Recognizing this gap, increased effort has been placed on examining the impact of child and adolescent mental health issues and identifying potential risk factors associated with the development and maintenance of psychiatric disorders in youth.

Existing literature on youth in low-income countries has suggested a number of factors that may be related to mental health risk. Similar to high-income countries, low socioeconomic level, limited access to education, poor physical health, traumatic childhood experiences, and family disruption have been identified frequently as putative risk factors for youth mental health disorders in low-income countries (Fuhr and De Silva, 2008; Patel et al., 2008; Graham and Jordan, 2011). Sex has also been shown to have important implications for mental health; cross-cultural study of internalizing and externalizing symptoms among youth suggests that boys tend to have more externalizing problems but lower internalizing symptoms than girls (Crijnen et al., 1997), a finding that is largely consistent with Western samples (e.g., Angold and Rutter, 1992; Lewinsohn et al., 1993).

Despite the identification of risk factors implicated in mental health problems that are shared by high- and low-income youth

* Corresponding author at: Hunter Holmes McGuire VA Medical Center, 1201 Broad Rock Boulevard (116-B), Richmond, VA 23249, USA.
Tel.: +1 804 675 5000x2432; fax: +1 804 675 6853.
E-mail address: Kelcey.Stratton@va.gov (K.J. Stratton).

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samples, youth mental health in low-income countries may be uniquely influenced by other important factors. Demographic variables such as ethnicity, family wealth status, and religious affiliation have not been well studied among youth in low-income countries; there is some evidence that these factors may have significant effects on the family environment and, in turn, youth mental health. In contrast to findings from the United States, in which minority ethnicity and lower household wealth status have been found to confer risk for youth mental illness (e.g., Garrison et al., 1989; Schraedley et al., 1999; Wight et al., 2005), previous work in Vietnam did not find any interaction between family wealth status and child physical and mental health status (Fuhr and De Silva, 2008). This finding suggests that further work is needed to clarify the relationship between these factors in other cultures and contexts. With regard to religious affiliation, most studies of religion and mental health in developing nations have focused on adult samples, and suggest that religious beliefs may reduce risk of mental illness (Sipsma et al., 2013), likely through increasing positive coping and social support (Steglitz et al., 2012). However, very little attention has been given to this topic among youth. One study of mental health among urban-dwelling Brazilian adolescents suggested that having a greater commitment to religious practices was associated with fewer psychiatric symptoms (Cucchiaro and Dalgalarrondo, 2007). By comparison, findings among Western minority ethnicity and low-income adolescent samples are mixed, with some studies supporting religion as a protective factor against adolescent substance abuse (Kulis et al., 2012), and others finding no relationship between religious involvement and substance use (Parsai et al., 2010). Religion and socioeconomic status are particularly interesting targets for future work on youth mental health because these factors may indicate the influence of more general familial factors, since religion and wealth status represent broader aspects of the environment in which children are raised.

Within the extant literature, it is unclear the degree to which various familial and environmental factors impact youth psychiatric problems in low-income countries. Much of the work conducted in this area has focused on family disruption, including studies of authoritarian parenting style and parental violence (Evans et al., 2005; Goodman et al., 2007), or familial separation (Graham and Jordan, 2011), and less is known regarding the possible impact of the parents' general mental health status on their children's psychiatric outcomes. Parental history of mental illness has been linked with increased risk of psychiatric disorders in their children (Dean et al., 2010). Although this relationship is present in both high- and low-income areas (Kessler et al., 2010), hardships and stress associated with economic difficulties and other environmental factors may compound psychiatric symptoms experienced in low-income countries. The unique obstacles and barriers associated with gaining access to mental health care in low-income countries, such as lack of education and/or outreach, differences in stigma across cultures, and limited numbers of specialized mental health providers, may contribute to increased rates of mental illness (Belfer, 2008). Low- and lower-middle income countries often have significant gaps in mental health diagnosis reporting, fewer mental health workers, and a lower median percentage of health expenditures dedicated to mental health. Further, many of these countries lack community mental health care, and most mental health treatments, including psychotropic medications and psychosocial interventions, are widely unavailable in primary care clinics (Nguyen et al., 2005; Saraceno et al., 2007; Niemi et al., 2010).

Research on parent–child mental health in low-income nations has suggested an intergenerational effect for psychiatric difficulties, although this association may be mediated, in part, by additional environmental factors. For example, Reed et al.'s (2011) review of data on forcibly displaced children and adolescents in low- and middle-income countries revealed a relationship between parental mental and physical health and the future psychiatric symptoms in their offspring. Specifically, the study noted a contribution of several factors including poverty, malnutrition, loss of social support, and family violence as stressors conferring risk for psychopathology in children (Reed et al., 2011). In another study conducted in Afghanistan, a school-based survey addressing caretaker–child associations demonstrated a stronger likelihood of ratings of child mental health problems from multiple informants as parental psychiatric symptoms increased (Panter-Brick et al., 2009). Additionally, investigation of child mental health in the context of parental migration identified that caretaker mental health status was a consistently important predictor of emotional and conduct disorders among children in four Southeast Asian countries, which included Indonesia, the Philippines, Thailand, and Vietnam (Graham and Jordan, 2011). While these studies support the relationship between youth psychiatric problems and highly stressful life experiences, including displacement, violence, and living in a combat zone, the findings also highlight the impact of caretaker health and household dynamics on youth mental health. More work is needed to better understand the association between parent and child mental health in low-income countries and within specific cultural contexts, and to examine how this association may relate with other identified risk factors.

Cross-cultural research on the parent–child mental health relationship is particularly limited with regard to Southeast Asian samples. The World Health Organization (WHO) has begun to collect data on youth mental health in countries such as Thailand, Sri Lanka, and India, but a lack of information on child and adolescent mental health persists in Vietnam (World Health Organization, 2005). A few studies have begun to fill this gap; for example, previous work with the present sample used the 25-item Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) to determine prevalence estimates of mental health problems in Vietnamese adolescents, and identified a probable "caseness" of 9.1% (Amstadter et al., 2011). In this sample, "caseness" of probable mental health problems was defined by the SDQ cut-off score of 14, which included scores in the borderline range (scores of 14–16) and abnormal range (scores of 17–40) on the total difficulties score. Other reports on youth and caretaker health identified much higher rates of child psychiatric problems in Vietnam, and found that an estimated 20% of the sample had SDQ scores in the abnormal range, and an additional 18% of the sample scored in the borderline range (Tuan et al., 2003; Fuhr and De Silva, 2008). Further, 20% of caretakers reported depression symptoms, suggesting the potential for parent mental health to have a significant impact on the overall family environment (Tuan et al., 2003). Graham and Jordan (2011) employed an alternate SDQ scoring model in their sample of Southeast Asian children, and used only the SDQ subscale scores of "emotional symptoms" and "conduct problems" as predictors for cases of mental disorders. In their Vietnamese sample of children under the age of 12, the prevalence of abnormal scores, defined as scores >4 for emotional symptoms and >3 for conduct problems, yielded rates of 24% and 9%, respectively. While the rate of SDQ caseness in the present sample is low in comparison to other studies of youth mental health in Vietnam, it is consistent with work conducted by Steel et al. (2009) in adult samples in Vietnam, which estimated mental distress rates of 2–9%. Mental health symptom reporting in youth and adult samples may vary as the result of many contextual factors, and exploration of these factors represents a target of the current study.

Given the high psychiatric prevalence estimates and the paucity of research in this area, there is a need to better understand