

## Levels of Psychosocial Problems of Children Attending outpatient Clinics of the Paediatric Hospitals in the City of Baghdad

### مستويات المشاكل النفسية-الاجتماعية للأطفال المراجعين للعيادات الخارجية لمستشفيات الأطفال في مدينة بغداد

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#### الخلاصة

**هدف الدراسة:** تهدف الدراسة لمعرفة مستويات المشاكل النفسية والاجتماعية في عينة من الاطفال الذين يحضرون بصحبة احد الابوين الى العيادة الخارجية في مستشفيات الاطفال في مدينة بغداد.

**المنهجية:** دراسة وصفية أنجزت من 21 آب الى 10 تشرين الثاني 2013. عينة البحث كانت تصادفية غير الاحتمالية والتي تكونت من 138 طفل من الذين حضروا مع احد الابوين في إحدى العيادات الخارجية لمستشفيات الاطفال في مدينة بغداد. استخدم استبيان خاص وهو نسخة معدلة من (Paediatric Symptoms Checklist) ويتكون من جزئين: الأول يتضمن المعلومات الديموغرافية والتي تتضمن المعلومات الخاصة بالطفل مثل العمر والجنس والصف وعدد الاطفال في العائلة، والمعلومات الخاصة لكلا الوالدين كالعمر، التحصيل الدراسي والمهنة والثاني مقياس يتكون من 38 فقرة نظمت تحت خمسة تصانيف. أربعة اختيارات لكل فقرة، المجموع الكلي لنتائج المقياس يتراوح من صفر الى 114. تم تحليل البيانات النهائية لهذه الدراسة بواسطة تطبيق التحليل الوصفي مثل التكرارات والنسب المئوية والتوزيع والربيعات، والتحليل الإحصائي مثل مربع كاي Qui square. **النتائج:** 138 استبيان قد تم انجازها، 56.5% من العينة هم من الذكور، 29.7% من التلاميذ هم من الصف الخامس الابتدائي و 56.5% من العوائل تمتلك 4-6 طفل. نصف الآباء هم من أعمار عقد الأربعين بينما أكثر من نصف الأمهات هن من أعمار عقد الثلاثينات، 41.3% من الآباء حاصلين على الابتدائية بينما 54.3% من الأمهات حاصلات على الابتدائية، أما مستويات شدة المشاكل النفسية-الاجتماعية فقد بينت النتائج بأنها تراوحت من الخفيف (38.4%)، المتوسط (31.9%)، والشديد (29.7%). وجدت الدراسة أيضا بأن درجة شدة المشاكل النفسية-الاجتماعية التي يعاني منها الأطفال ذات ارتباط عالي مع أعمار الآباء والأمهات.

**الاستنتاج:** كشفت الدراسة الحالية بان أكثر من نصف العينة هم من الذكور، أيضاً وأن أكثر من نصف عوائل الاطفال هي عوائل تمتلك أربعة أطفال وأكثر، أقل من نصف الآباء وأكثر من نصف الأمهات من الحاصلين على شهادة الإبتدائية، ونصف الآباء من أعمار عقد الأربعينات وأكثر من نصف الإمهات هن من عقد الثلاثينات. أيضاً بينت الدراسة بان أكثر من نصف الاطفال يشكون من مستويات متوسطة وشديدة لمشاكل نفسية واجتماعية، وأخيراً بينت نتائج هذه الدراسة بان كلما تقدم اباء الاطفال اشكى هؤلاء الاطفال من شدة المشاكل النفسية والاجتماعية. **التوصيات:** توصي الدراسة بأن الصحة النفسية والاجتماعية يجب اعتبارها هدف وجزء من الخدمات المقدمة للأطفال، تقترح الدراسة بعمل برامج تثقيفية حول الصحة النفسية والاجتماعية في المستشفيات، والعيادات الخارجية والمنظمات غير الحكومية، وتوصي الدراسة بإجراء المزيد من البحوث ذات الأهتمام بالعوامل المؤثرة للصحة النفسية والاجتماعية للأطفال.

#### Abstract

**Objective:** The purpose of the study is to find out the levels of psychosocial problems in a sample of out-patient children attending the paediatric hospitals in Baghdad city at the time of this study.

**Methodology:** A descriptive study design was achieved from Aug. 21<sup>st</sup> through Nov. 10<sup>th</sup> 2013. A non-probability accidental sample of 138 children with age ranged from six to twelve year and more, who attended with their parent in one of the outpatient departments of paediatric hospitals in Baghdad city, participated in this study. A designed questionnaire was used for the study. This questionnaire is a modified version of Paediatric Symptoms Checklist (PSC) and it consists of two parts; a basic demographic characteristics which includes the information about the child: age, gender, class and number of children in the family; information about the parents such as age, level of education and occupation and secondly, a part forms the inventory. The inventory comprised of 38 items organised into five subcategories. Four choices were for each item. The total score of the inventory was ranged from zero to 114.

**Results:** One hundred and thirty eight questionnaires were completed. 56.5% of sample is male, 29.7% of the pupils are in fifth class, and 56.5% are of families having 4 to 6 child. Half of the fathers are of four decade old while more than half of the mothers are of three decade old; and 41.3% of parents and 54.3% of mothers have primary school. The severity of psychosocial problems of the participants ranged from mild (38.4%, n: 53); moderate (31.9%, n: 44); and severe (29.7%, n: 41). The study found that the higher severity of the child's psychosocial problems was significantly correlated with older age of their parents.

**Conclusions:** The present study revealed that more than half of children are male; and also more than half of the families have four children and more; less than half of fathers and more than half of mothers have primary school level of education; half of the fathers are from fourth decade and more than half of mothers are from third decade; the study indicated that more than half of children have level of psychosocial problems ranged between moderate to

severe. Finally, the results indicated that the older the parents are the severer levels of psychosocial problems have their children.

**Recommendation:** The study recommends that the psychosocial health should be considered as target and important aspect for such study as a part of child health service; suggest an educational program for the importance of psychosocial health, in hospitals, out-patients clinics, and non-governmental organizations in order to increase people's level of understanding regarding psychosocial health as well as preventing child's distress; and conduct further studies to provide critical information concerning factors that influence child's psychosocial health, with more concerns about other unstudied factors.

**Keywords:** psychosocial, children, out-patient, paediatric, Baghdad city.

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## INTRODUCTION

During routine check-up in primary care, it is important to have an idea regarding the psychosocial aspects among children attending the out-patient departments in paediatric hospitals. One way to recognize these problems is to use questionnaire which ought to be completed by parents.

Psychosocial problems, such as behavioural, emotional, and social difficulties, have been considered of a high prevalence among children (1,2,3).

Previous studies have indicated that 15% to 20% of children experienced psychosocial difficulties (4) and the majority of this Children with such psychosocial difficulties were treated by physicians at primary care centres. Physicians in these centres failed to identify these difficulties (5, 6, 7). It is well-reported that physicians could recognize just 17% of these children and leaving 83% of them with psychosocial difficulties undiagnosed (8). Untreated children with psychosocial problems were likely to have troubles in different aspects of their daily lives and daily activities and had severe continual problems (8).

It is argued that failing to identify psychosocial disorders in out-patient children is due to a number of different characteristics such as economic and cultural aspects(9). Many causes contributed to the failing in detection of the psychosocial problems which are most of paediatricians do not have sufficient training on psychosocial problems(5,6); have no enough time during office attendances to tackle mental health problems; their methods of referral to mental health are fairly inadequate; have no specific, validated screening methods to recognize children with the high need for treatment(9).

Many implications to progress the rate of recognition of children with psychosocial difficulties include the development of physicians' communication skills, encourage parents to reveal more psychosocial information to their child's physicians, and finally, written instruments for screening children with or at risk for psychosocial problems(11,12,13,14).

## OBJECTIVE

The purpose of the study is to find out the levels of psychosocial problems in a sample of out-patient children attending the paediatric hospitals in Baghdad city at the time of this study.

## METHODOLOGY

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A descriptive study was achieved from Aug. 21<sup>st</sup>2013 through Jan. 10<sup>th</sup> 2014. A non-probability accidental sample of 138 children with age ranged from six to twelve year, who attended with their parent in one of the outpatient departments of paediatric hospitals in Baghdad city, participated in this study. A designed questionnaire was used for the study. This questionnaire is a "Paediatric Psychosocial Symptoms Inventory (11)" (PEPSI) and it consists of two parts; a basic biographic characteristics and secondly, a part forms the inventory. The inventory comprised of 38 items organised into five subcategories. Three choices were for each item. The total score of the inventory was ranged from zero to 114.

The 38-item questionnaire was classified into 5 categories. They were scored from 0-3, with 0 indicating the absence of the symptom concerned, 1 indicating that the symptom rarely occurred, 2 indicating that the symptom occasionally occurred and 3 indicating frequent occurrence of the symptom. The total score of the inventory ranged from 0-114.

The categories included:

1. Items 5, 13, 20, 23, 27, 28, 35, and 38 represent the Mood symptoms (MS) with a score of 0-24;
2. Items 3, 4, 7, 8, 9, 10, 12, 24, and 32 represent the Behavioural symptoms (BS) with a score of 0-27;
3. Items 11, 19, 21, 22, 30, and 36 represent the Learning problems (LP) with a score of 0-18;
4. Items 6, 14, 17, 26, 29, 33, 34, and 37 represent the Somatic symptoms (SS) with a score of 0-24; and
5. Items 1, 2, 15, 16, 18, 25, and 31 represent the Personality characteristics (PC) with a score of 0-21

The questionnaire was completed by one of the researchers who interviewed randomly selected parents attending with their children, the out-patient department of paediatric hospital with various medical problems during the period of the study. The main target of the study was children from 6 to 12 years of age.

The statistical analysis was achieved by using the descriptive statistics (frequency and percentage) which was used to describe the demographic characteristics of the children participated; and to clarify the distribution of levels of the psychosocial problems to these characteristics. Chi<sup>2</sup> was used to determine the significant association between demographic characteristics and the severity of the problem; Pearson correlation was also used to find out the relationship within the variables.

## RESULTS:

The descriptive analysis consists of: a. the demographic characteristics of: the children (table 1); the fathers (table 2); the mothers (table 3); and the family (table 4), and levels of psychosocial problems.

**Table (1): Distribution of Demographical Characteristics of children with comparisons significance.**

			Children's characteristics				
	f	%	Gender	Year	f	%	Age
Boys	78	56.5%	C.S.	6-7	24	17.4%	C.S.
Girls	60	43.5%	P=0.148	8-9	33	23.9%	P=0.147
Total	138	100.0%	NS	10-11	40	29.0%	NS
			Class	≥ 12	41	29.7%	

Class	f	%	C.S.	Total	138	100%	Number of Kids
1 <sup>st</sup>	29	21.0%					
2 <sup>nd</sup>	15	10.9%		Number	f	%	C.S.
3 <sup>rd</sup>	10	7.2%	P=0.001 HS	≤ 3	46	33.3%	
4 <sup>th</sup>	23	16.7%		4-6	78	56.5%	P=0.001
5 <sup>th</sup>	41	29.7%		≥ 7	14	10.1%	HS
6 <sup>th</sup>	20	14.5%		Total	138	100.0%	
<b>Total</b>	<b>138</b>	<b>100.0%</b>					

C.S. based on Binomial & Chi-Square test; HS: Highly Sig. At P<0.01; NS: Non Sig. at P>0.05

Table (1) demonstrates that more than half of children is male (n= 78; 56.5%), less than third of them is of ≥ 12 years-old age (n= 41; 29.7%), followed by a smaller proportion who is in 10-11 years-old age (n=40; 29.0%), less than third of them is in the fifth class (n= 41;29.7%), more than half of children reported that the number of kids is (n= 78; 56.5%).

**Table (2): Distribution of Demographical Characteristics of Fathers with comparisons significance.**

Father's characteristics									
Age			Level of Education			Occupation			
years	f	%	Level	f	%		f	%	
20-29	5	3.6	Illiterate	5	3.6%	Self-employed	79	57.2	
30-39	56	40.6	Primary	57	41.3%	Employed	59	42.8	
40-49	69	50.0	Preparatory	53	38.4%	<b>Total</b>	<b>138</b>	<b>100.0%</b>	
≥ 50	8	5.8	Diploma +↑	23	16.7%				
<b>Total</b>	<b>138</b>	<b>100.0%</b>	<b>Total</b>	<b>138</b>	<b>100.0%</b>				
						C.S.			P=0.106
C.S.		P=0.001	C.S.		P=0.001				NS
		HS			HS				

C.S. based on Chi-Square test; HS: Highly Sig. At P<0.01; NS: Non Sig. at P>0.05

Table (2) shows that half of children's fathers is within 40-49 years-old age (n=69; 50.0%), followed by about two fifth who are within 30-39 years-old age (n=56; 40.6%), about two fifth of children's fathers are primary school graduate (n=57; 41.3%), more than half of children's fathers is self-employed (n=78; 56.5%).

**Table(3): Distribution of Demographical Characteristics variables of Mothers with comparisons significant**

Mother's Characteristics						
	Age		Level of Education		C.S.	
	f	%	f	%		C.S.
20-29	28	20.3		Illiterate	9	6.5
30-39	78	56.5	P=0.001	Primary	75	54.3
40-49	32	23.2	HS	Preparatory	43	31.2
<b>Total</b>	<b>138</b>	<b>100%</b>		Diploma +↑	11	8.0
				<b>Total</b>	<b>138</b>	<b>100%</b>
						P=0.001
						HS

C.S. based on Chi-Square test; HS: Highly Sig. At P<0.01

Table (3) shows that more than half of children's mothers is within 30-39 years-old age (n=69; 50.0%), more than half of children's mothers are primary school graduate (n=75; 54.3%).

**Table (4): Distribution of Demographical Characteristics of Family with comparisons significance.**

Family's characteristics								
Income			Residency			Having a Car		
Iraqi Dinar	f	%	Hose	f	%	Car	f	%
< Half Million	38	27.5	Own	70	50.7	Yes	43	31.2
Half -Million	83	60.1	Rent	59	42.8	No	95	68.8
> Million	17	12.3	Other	9	6.5	<b>Total</b>	<b>138</b>	<b>100.0%</b>
<b>Total</b>	<b>138</b>	<b>100.0%</b>	<b>Total</b>	<b>138</b>	<b>100.0%</b>	<b>C.S.</b>	<b>P=0.001HS</b>	
<b>C.S.</b>	<b>P=0.001HS</b>		<b>C.S.</b>	<b>P=0.001HS</b>				

C.S. based on Binomial & Chi-Square test; HS: Highly Sig. At P<0.01

Table (4) demonstrates that most of children's families have a monthly income of Half Million-Million Iraqi Dinar (n= 83; 60.1%), about half children's families live in their own houses (n=70; 50.7%), and lastly, the majority of families have no cars (n=95; 68.8%).

**Table (5): Distribution of Scaling Score of the studied sample of Psychosocial Problems with comparisons significance.**

Levels of psychological problems						
Levels	f	%	MS	SD	RS	C.S
Mild	53	38.4%	1.91	0.82	63.67	<b>P=0.428</b> <b>NS</b>
Moderate	44	31.9%				
Severe	41	29.7%				
<b>Total</b>	<b>138</b>	<b>100.0%</b>				

C.S. based on Binomial & Chi-Square test; HS: Highly Sig. At P<0.01

Table (5) reveals that the severity of psychosocial problems for less than two fifth of children is mild (n=53; 38.4%), and the severity of psychological problems is moderate for less than one third of children (n= 44; 31.9%).

**Table (6): Distribution in the levels of Psychosocial Problems according to Children's demographic characteristics with comparisons significance.**

		Levels of psychosocial Problems											C.S	
		Mild		Moderate		Severe		Total		Statistics				Ass.
		f	%	f	%	f	%	f	%	MS	SD	RS		
Age	Boys	32	23.1	26	18.8	20	14.6	78	56.5	1.8	0.81	61.5	F	<b>CC=0.102</b>
	Girls	21	15.3	18	13.1	21	15.1	60	43.5	2.0	0.84	66.7	F	<b>P=0.487</b>
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>138</b>	<b>100</b>	<b>1.9</b>	<b>0.78</b>	<b>63.9</b>	F	<b>NS</b>
Class	6-7	8	5.8	10	7.3	6	4.5	24	17.4	2.1	0.86	70.7	F	
	8-9	10	7.3	9	6.4	14	10.2	33	23.9	1.9	0.86	64.2	F	<b>CC=0.207</b>
	10-11	16	11.6	11	8.0	13	9.4	40	29.0	1.7	0.78	57.7	F	<b>P=0.403</b>
	≥ 12	19	13.8	14	10.2	8	5.7	41	29.7	1.9	0.82	63.2	F	<b>NS</b>
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>138</b>	<b>100</b>	<b>2.0</b>	<b>0.88</b>	<b>68.9</b>	F	
	1 <sup>st</sup>	11	8.0	10	7.3	8	5.8	29	21.1	2.4	0.70	80.0	F	
2 <sup>nd</sup>	5	3.6	4	2.9	6	4.5	15	10.9	1.9	0.81	62.3	F		
3 <sup>rd</sup>	1	0.7	4	2.9	5	3.6	10	7.3	1.8	0.87	60.2	F	<b>CC=0.246</b>	
4 <sup>th</sup>	9	6.4	8	5.8	6	4.5	23	16.7	1.9	0.75	61.7	F	<b>P=0.539</b>	
5 <sup>th</sup>	20	14.5	9	6.4	12	8.7	41	29.7	2.0	0.79	65.2	F	<b>NS</b>	
6 <sup>th</sup>	7	5.1	9	6.4	4	2.9	20	14.5	1.9	0.85	62.0	F		
<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>138</b>	<b>100</b>	<b>2.2</b>	<b>0.83</b>	<b>69.0</b>	F		

No. of Children	1-3	15	10.9	18	13.1	13	9.4	46	33.3	1.8	0.81	61.5	F	CC=0.144 P=0.570 NS
	4-6	35	25.4	21	15.3	23	16.7	78	56.5	2.0	0.84	66.7	F	
	≥7	4	2.9	5	3.6	5	3.6	14	10.2	1.9	0.78	63.9	F	
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>138</b>	<b>100</b>	<b>2.1</b>	<b>0.86</b>	<b>70.7</b>	<b>F</b>	

C.S. based on Chi-Square test and Contingency Coefficients; NS: Non Sig. at P>0.05

Table (6) describes that the severity of psychosocial problems is higher in females than in males (n=21; 35.0% vs. n= 20; 25.7) respectively; is higher in children in 8-9 years-old age (n=14; 42.4%), followed by children in 10-11 years-old age (n=13; 32.5%); is higher in children in 3<sup>rd</sup> class (n=6; 50.0%), followed by children in 2<sup>nd</sup> class (n=6; 40.0%); and finally, is higher in children's families that is consisted of 7 or more children (n=5; 35.7%), followed by families that is consisted of 4-6 children (n=23; 29.5%).

**Table (7): Distribution in the levels of Psychosocial Problems according to Fathers' demographic characteristics with comparisons significance.**

F.D.C	Levels	Levels of Psychosocial Problems						St			Ass.	C.S.
		Mild		Moderate		Severe		MS	SD	RS		
		No.	%	No.	%	No.	%					
Age	20-29	5	3.6	0	0.0	0	0.0	1.0	0.00	33.3	P	
	30-39	17	12.3	24	17.4	15	10.9	2.0	0.76	65.5	P	CC=0.336
	40-49	26	18.8	17	12.3	26	18.8	2.0	0.87	66.7	F	P=0.008
	≥ 50	5	3.6	3	2.2	0	0.0	1.4	0.52	45.8	P	HS
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>2.2</b>	<b>0.88</b>	<b>68.9</b>	F	
Educator	Illiterate	1	0.7	2	1.4	2	1.4	2.2	0.84	73.3	F	
	Primary	26	18.8	18	13.0	13	9.4	1.8	0.80	59.1	P	CC=0.180
	Preparatory	18	13.0	15	10.9	20	14.5	2.0	0.85	67.9	F	P=0.596
	Diploma +↑	8	5.8	9	6.5	6	4.3	1.9	0.79	63.8	P	NS
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>2.1</b>	<b>0.88</b>	<b>68.9</b>	F	
Occupatic	Self-employed	29	21.0	24	17.4	26	18.8	2.0	0.84	65.4	P	CC=0.081
	Employed	24	17.4	20	14.5	15	10.9	1.8	0.81	61.6	P	P=0.635
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>2.3</b>	<b>0.88</b>	<b>68.9</b>	F	NS

C.S. based on Chi-Square test and Contingency Coefficients; HS: Highly Sig. At P<0.01; NS: Non Sig. At P>0.05, P: Pass ; F: Failure

Table (7) shows that the severity of psychosocial problems is higher in children with fathers within age group 40-49 (n=26;18.8%); is higher in fathers with preparatory school (n=20;14.5%); is higher in fathers of self-employed group of occupation (n= 26; 18.8%).

**Table (8): Distribution in the levels of Psychosocial Problems according to Mothers' demographic characteristics with comparisons significance.**

M.D.C	Levels	Levels of Psychosocial Problems						St			Ass.	C.S.
		Mild		Moderate		Severe		MS	SD	RS		
		No.	%	No.	%	No.	%					
Age	20-29	13	9.4	11	8.0	4	2.9	1.7	0.72	56.0	P	CC=0.300



Education	30-39	22	15.9	24	17.4	32	23.2	2.1	0.83	70.9	F	<i>P=0.009</i> <i>HS</i>	
	40-49	18	13.0	9	6.5	5	3.6	1.6	0.76	53.1	P		
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>2.0</b>	<b>0.87</b>	<b>68.8</b>	<b>F</b>		
	Illiterate	1	0.7	5	3.6	3	2.2	2.2	0.67	74.1	F	<i>CC=0.209</i> <i>P=0.391</i> <i>NS</i>	
	Primary	28	20.3	23	16.7	24	17.4	1.9	0.84	64.9	P		
	Preparatory	18	13.0	12	8.7	13	9.4	1.9	0.85	62.8	P		
	Institute +↑	6	4.3	4	2.9	1	0.7	1.5	0.69	51.5	P		
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>1.9</b>	<b>0.86</b>	<b>68.7</b>	<b>F</b>		
	Occupat	Housewife	42	30.4	37	26.8	39	28.3	2.0	0.83	65.8	P	<i>CC=0.183</i> <i>P=0.090</i> <i>NS</i>
		Employed	11	8.0	7	5.1	2	1.4	1.6	0.69	51.7	P	
<b>Total</b>		<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>2.1</b>	<b>0.87</b>	<b>68.9</b>	<b>F</b>		

C.S. based on Chi-Square test and Contingency Coefficients; HS: Highly Sig. At P<0.01; NS: Non Sig. at P>0.05;

Table (8) reveals that the severity of psychosocial problems is higher in children with mothers within age group 30-39 (n=32; 23.2%); is higher in mothers with primary school (n=24; 17.4%); is higher in mothers of housewife group of occupation (n= 39; 28.3%).

**Table (9): Distribution in the levels of Psychosocial Problems according to Family demographic characteristics with comparisons significance.**

F.D.C	Levels	Levels of Psychosocial Problems										C.S.
		Mild		Moderate		Severe		S			Ass.	
		No	%	No	%	N	%	MS	SD	RS		
Income	< Half Million	14	10.1	14	10.1	10	7.2	1.9	0.80	63.2	P	<i>CC=0.225</i> <i>P=0.125</i> <i>NS</i>
	Half-Million	31	22.5	22	15.9	30	21.7	2.0	0.86	66.3	P	
	> Million	8	5.8	8	5.8	1	0.7	1.6	0.62	52.9	P	
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>1.9</b>	<b>0.86</b>	<b>68.5</b>	<b>F</b>	
Housing	Own	28	20.3	22	15.9	20	14.5	1.9	0.83	62.9	P	<i>CC=0.065</i> <i>P=0.964</i> <i>NS</i>
	Rent	21	15.2	19	13.8	19	13.8	2.0	0.83	65.5	P	
	Other	4	2.9	3	2.2	2	1.4	1.8	0.83	59.3	P	
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>2.1</b>	<b>0.87</b>	<b>68.6</b>	<b>F</b>	
Car	No	10	7.2	11	8.0	22	15.9	2.3	0.83	76.0	F	<i>CC=0.305</i> <i>P=0.001</i> <i>HS</i>
	Yes	43	31.2	33	23.9	19	13.8	1.7	0.77	58.2	P	
	<b>Total</b>	<b>53</b>	<b>38.4</b>	<b>44</b>	<b>31.9</b>	<b>41</b>	<b>29.7</b>	<b>2.2</b>	<b>0.89</b>	<b>68.7</b>	<b>F</b>	

C.S based on Chi-Square test and Contingency Coefficients; HS: Highly Sig. At P<0.01; NS: Non Sig. at P>0.05, P: Pass ; F: Failure

Table (9) shows that the severity of psychosocial problems is higher in children with family income of >Half-<1 million (n=30; 21.7%); is higher in family with own house (n=20; 14.5%); is higher in family has no car (n= 22; 15.9%).

**Table( 10): Association between study variables and the levels of psychological problems of the children**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1 Child's Age																
2 Class	.904**															
3 Number of kids	.512**	.517**														
4 Father's Age	.105	.023	.296**													
5 Father's Education	.353**	.373**	.146	.147												
6 Mother's Age	.094	.035	.123	.664**	-.066											
7 Mother's Education	.076	.104	-.113	.265**	.540**	.262**										
8 Family Income	.617**	.665**	.424**	.291**	.559**	.190	.414**									
9 Family Residency	-.283**	-.287**	-.347**	-.137	-.171	-.004	-.215	-.371**								
10 Having a Caregiver	-.182	-.214	-.303**	-.359**	-.232**	.053	-.184	-.295**	.382**							
11 Mood Symptoms	-.090	-.025	.080	-.005	-.016	.053	-.120	-.072	.090	.097						
12 Behaviour Symptoms	.056	.075	.065	-.020	.023	-.125	-.222**	.045	-.033	-.082	.241**					
13 Learning Problems	-.067	-.071	.072	.094	.071	.103	.055	-.022	.005	.072	.085	.004				
14 Somatic Symptoms	-.052	.027	.004	-.063	.072	-.098	-.057	.040	-.001	.015	.201	.298**	.138			
15 Personality Characteristics	-.086	-.078	-.042	.261**	.057	.085	-.090	.017	-.082	-.065	.186	.093	.145	.148		
16 Psychosocial Problems	-.066	.000	.067	.050	.065	-.035	-.182	.004	-.005	.003	.594**	.703**	.382**	.657**	.450**	

Table (10) describes that mother's level of education negatively correlates with child's behaviour ( $r = -0.222$ ;  $p < 0.05$ ), and child's mood positively correlates with his/her behaviour ( $r = 0.241$ ;  $p < 0.05$ ). Child's mood and behaviour positively correlate with his/her somatic ( $r = 0.201$ ;  $p < 0.01$ ) ( $r = 0.298$ ;  $p < 0.05$ ) respectively. Father's age and child's behaviour positively correlate with child's person ( $r = 0.261$ ;  $p < 0.05$ ) ( $r = 0.186$ ;  $p < 0.01$ ) respectively. Lastly, mother's level of education negatively correlates with child's severity of psychological problems ( $r = -0.182$ ;  $p < 0.01$ ). While, child's behaviour, learning, somatic, and person positively correlates with their severity of psychological problems ( $r = 0.594$ ;  $p < 0.05$ ), ( $r = 0.703$ ;  $p < 0.05$ ), ( $r = 0.382$ ;  $p < 0.05$ ), ( $r = 0.657$ ;  $p < 0.05$ ) respectively.

## DISCUSSION

These results are in agreement with that of Starfield and his colleagues<sup>(16)</sup>, on the other hand Micheal<sup>(17)</sup> indicated that correlates well with the childhood behaviour score. While epidemiologic studies indicate that up to half of paediatric and that (5.0% to 15.0%) of children have specific psychiatric disorders<sup>(18)</sup>.

It is important for paediatric health care providers to engage in routine and organized screening because of the dissimilar levels of sophistication of the parent population Kovacs<sup>(19)</sup>.

Furthermore Lakowski<sup>(20)</sup> indicated that practitioners may have a sense that a child has psychosocial problems but may not have an efficient means for identifying the problems in brief visits.

Therefore, evaluators in large mental health systems often must construct an overview an array of programs to aid in setting policy, even though they do not have first-hand experienced with the programs they described by Achenbach<sup>(21)</sup>.

Neuman<sup>(22)</sup> suggests that a program beginning with an overall statement of its goal can either select or adapt an existing global scale to measure client functioning and others described the evaluative process used to select a method for describing client functioning in child mental health services funded by the state of California.



These results are an evident for other study done by Walker<sup>(23)</sup> who concluded that their goal of their study is to develop a brief parent-completed screening questionnaire available in the waiting room, that will help busy physicians to identify school-aged children in need of psychosocial evaluation and they have concentrated their efforts on 6-12 year-old children, and that because they are less frequently than infants and toddlers and because many stresses and disorders become manifest during school age.

These findings in agreements with that of Lessing and Clark<sup>(24)</sup> who stated that the PSC correlates well with the best validated screening measure, and is reliable, and is an easily administered psychosocial screening instrument for children seen in paediatric settings and also added that the PSC agreed with longer CBCL in 89.0% of the cases in classifying children as well or at risk.

Humphreys and Ciminero<sup>(25)</sup> also demonstrated that among children referred for psychiatric or psychological evaluation, 87.0% scored in the at risk category on the PSC.

These findings in agreement with that of Jellinkand and his colleagues<sup>(26)</sup> who demonstrated that all of the parents of children in the target age range who entered the waiting rooms of three different outpatient paediatric practices were invited to participate in the screening study and parents were asked to complete both the PCS and the longer and well validated child behaviour checklist.

Also Landis<sup>(27)</sup> indicated that in a study sample that 77.0% of the parents listed occupations that were coded for socioeconomic class. Eighteen percent of them were from the upper SES groups (professional and minor professional), 44% from the middle (clerical, technical and managerial), and (labourers) SES groups.

While other study done by Jones<sup>(28)</sup> who determined that there were no significant differences with respect to sex of SES between children whose scores were above and below the cutting points on the PSC.

All of the parents of children in the target age range of outpatient paediatric practices were invited to participate in the screening study results. These findings in agreement with that of Goyette<sup>(29)</sup>, who reported two preliminary validation studies that indicate that 1-psc correlates well with the childhood behaviour checklist, and 2-most children referred for psychiatric evaluation score above the PSC cut-off score.

Also Connors<sup>(30)</sup> determined that PSC symptoms of the major diagnosis for children listed in the American Psychiatric Association. The clinical impressions of several paediatricians, psychologists, and child psychiatrists, and are view of items from other questionnaires reported to be the most useful in identifying children with emotional problems. Achenbach and his colleagues<sup>(31)</sup> determined that there are two subscales and children can be classified on the basis of their scores on either subscale, or combined subscale.

While child's behaviour, learning, somatic and person positively correlates with their severity of problems.

In a study done by Wimberger<sup>(32)</sup> who determined that CBCL cutting scores because it was believed that this subscale was most comparable in format to the PSC and had a satisfactory misclassification rate. Therefore, the points for the behaviour problems subscale (raw score 40 for 6 to-11-year old boys, 38 for 12-year-old boys, 41 for 6-to11-year-old girls, and 37 for 12-years-old girls).

## CONCLUSIONS

The present study revealed that more than half of children are male; and also more than half of the families have four children and more; less than half of fathers and more than half of mothers

have primary school level of education; half of the fathers are from fourth decade and more than half of mothers are from third decade; the study indicated that more than half of children have level of psychosocial problems ranged between moderate to severe. Finally, the results indicated that the older the parents are the severer levels of psychosocial problems have their children.

### RECOMMENDATIONS:

1. Psychosocial health should be considered as target and important aspect for such study as a part of child health services.
2. Suggesting an educational program for the importance of psychosocial health, in hospitals, out-patients clinics, and non-governmental organizations in order to increase people's level of understanding regarding psychosocial health as well as preventing child's distress.
3. Conducting further studies to provide critical information concerning factors that influence child's psychosocial health, with more concerns about other unstudied factors.

### REFERENCES:

1. Iseri, P., Ozten, E., Aker, A. Posttraumatic stress disorder and major depressive disorder is common in parents of children with epilepsy. *Epilepsy and Behavior*, 2006, 8, 250-255.
2. Katon, W., Lozano, P., Russo, J., McCauley, E., Richardson, L., & Bush, T. The prevalence of DSM-IV anxiety and depressive disorders in youth with asthma compared to controls. *Journal of Adolescent Health*, 2007, 41, 455-463.
3. Fozdar F, Torezani S. Discrimination and well-being: perceptions of refugees in Western Australia. *Int Migrat Rev*. 2008; 42: pp. 30 – 63
4. Hommel, K. A., Davis, C. M., & Baldassano, R. N. Medication adherence and quality of life in pediatric inflammatory bowel disease. *Journal of Pediatric Psychology*, 2008, 33(8), pp. 867-874.
5. Garg A, Butz A, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE Project. *Pediatrics*. 2007;120: pp. 547–558
6. Grosse S, Schechter M, Kulkarni R, Lloyd-Puryear M, Strickland B, Trevathan E. Models of comprehensive multidisciplinary care for individuals in the United States with genetic disorders. *Pediatrics*. 2009; 1 23: pp. 407– 412.
7. Frain, M. P., Bishop, M., Tschopp, M. K., Ferrin, M. J., & Frain, J. Adherence to medical regimens: Understanding the effects of cognitive appraisal, quality of life, and perceived family resiliency. *Rehabilitation Counselling Bulletin*, 2009, 52(4), 237-250.
8. George, A., Vickers, M. H., Wilkes, L., Barton, B. Chronic grief: Experiences of working parents of children with chronic illness. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 2006, 23(2), pp. 228-242.
9. Hayes, L. Problem behaviours in early primary school children: Australian normative data using the Strengths and Difficulties Questionnaire. *Australian and New Zealand Journal of Psychiatry*, 2007, 41, 231-238.
10. Ibrahim, H., Al-Ayed, & Al-Haider, F. A. Screening For Psychosocial Problems In Children Attending The Pediatric Clinic At King Khalid University Hospital, in Riyadh (Ksa); *J Family Community Med*; 2008, 15 (1): pp. 21-26
11. Centre for Community Child Health. A snapshot of early childhood development in Australia- Australian Early Development Index (AEDI) *National Report 2009*. Available at: [http://www.rch.org.au/aedi/studies/index.cfm?doc\\_id14792](http://www.rch.org.au/aedi/studies/index.cfm?doc_id14792). Accessed May 6, 2012.

12. Bayer J, Hiscock H, Scalzo K, et al. Systematic review of preventative interventions for children's mental health: what would work in Australian contexts? *Aust N Z J Psychiatry*. 2009; 43: pp. 695–710
13. Tatau Kahukura. Retrieved October 18, 2008, from [http:// www. moh.govt.nz](http://www.moh.govt.nz) Ministry of Health (2009). Disability Support Services Fact Sheet. Retrieved November 2, 2009, from <http://www.moh.govt.nz>
14. Ministry of Health. Frequently asked questions about the Strengths and Difficulties Questionnaire used in the B4 School Check. Retrieved September 8, 2009, from <http://www.moh.govt.nz>
15. Mitchell, M. C., Burns, N. R., & Dorstyn, D. S. Screening for depression and anxiety in spinal cord injury with the DASS-21. *Spinal Cord*, 2008, 48, pp. 547-551.
16. Heising, M., Elgen, I., Gillberg, C., Lie, S., & Lundervold, A. Chronic physical illness and mental health in children. Results from a large-scale population study. *Journal of Child Psychology and Psychiatry*, 2007, 48(8), pp. 785-792.
17. McCauley, E., Katon, W., & Russo, J. Impact of anxiety and depression on functional impairment in adolescents with asthma. *General Hospital Psychiatry*, 2007, 29, 214-222.
18. Maybery, D., Reupert, A., Goodyear, M., Ritchie, R. & Brann, P. Investigating the strengths and difficulties of children from families with a parental mental illness. *Australian e-Journal for the Advancement of Mental Health, Personality and Individual Differences*, 2009, 29, 799-810.
19. Flegler EW, Lieu TA, Wise PH, Muret-Wagstaff S. Families' health-related social problems and missed referral opportunities. *Pediatrics*. 2007; 119: e1332-e1341.
20. Brannan AM, Manteuffel B, Holden EW, Heflinger CA. Use of the Family Resource Scale in children's Mental Health: reliability and validity among economically diverse samples. *Adm Policy Ment Health*. 2006; 33: 182-197.
21. Shelton, K. H., & Harold, G. T. Inter-parental conflict, negative parenting, and children's adjustment: Bridging links between parents' depression and children's psychological distress. *Journal of Family Psychology*, 2008, 22(5), pp. 712-724.
22. Sills, M. R., Shetterly, S., Xu, S., Magid, D., & Kempe, A. Association between parental depression and children's health care use. *Pediatrics*, 2007, 119, 829-836.
23. Smylie, J., & Adomako, P. Indigenous children's health report: Health assessment in action. Retrieved October 23, 2009, from [http:// www.stmichaelshospital.com /pdf/crich/ ichr\\_report.pdf](http://www.stmichaelshospital.com/pdf/crich/ichr_report.pdf) Statistics New Zealand
24. Wagner, J. L., Smith, G., Ferguson, P., Horton, S., & Wilson, E. (2009). A hopelessness model of depressive symptoms in youth with epilepsy. *Journal of Pediatric Psychology*, 34(1), 89-96.
25. Centre for Community Child Health. A snapshot of early childhood development in Australia- Australian Early Development Index (AEDI) *National Report 2009*. Available at: [http://www.rch.org.au/aedi/studies/index.cfm?doc\\_id14792](http://www.rch.org.au/aedi/studies/index.cfm?doc_id14792). Accessed May 6, 2012.
26. Derauf C, LaGasse L, Smith L, et al. Infant temperament and high-risk environment relate to behavior problems and language in toddlers. *J Dev Behav Pediatr*. 2011;32:125–135
27. Bayer J, Hiscock H, Scalzo K, et al. Systematic review of preventative interventions for children's mental health: what would work in Australian contexts? *Aust N Z J Psychiatry* 2009; 43: pp. 695-710.
28. Shonkoff JP, Phillips DA, eds. From Neurons to Neighbourhoods: the Science of Early Childhood Development. Washington, DC: *National Academy Press*; 2000.

29. American Academy of Pediatrics. Periodic survey of fellows. Available at: <http://www.aap.org/en-us/professional-resources/Research/pediatrician-surveys/Pages/Periodic-Survey-List-of-Surveysand-Summary-of-Findings.aspx>. Accessed May 6, 2012.
30. Walker, L. S., Smith, C. A., Garber, J., & Claar, R. L. Appraisal and coping with daily stressors by pediatric patients with chronic abdominal pain. *Journal of Pediatric Psychology*, 2007, 32(2), pp. 206-216.
31. Achenbach, T.M., & Rescorla, L. A. Manual for the ASEBA School-Age Forms and Profiles. Burlington, VT: University of Vermont, *Research Centre for Children, Youth, and Families*. 2001, ISBN 0-938565-73-7
32. Warnick, E. M., Bracken, M. B., Kasl, S. Screening efficiency of the Child Behaviour Checklist and Strengths and Difficulties Questionnaire: A systematic review. *Child and Adolescent Mental Health*, 2008, 13(3), pp. 140-147.