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Improving adolescent mental health through spiritual coping using MCHC application

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ABSTRACT

Background: Family is one of the factors that influence adolescent mental health. Adolescents often have problems with closeness to parents, communication, openness, and support, and those with poor mental health can be at risk for self-harm. One of the coping methods that can be used to increase the interaction between parents and adolescents is spiritual coping.
Purpose: This study aimed to determine differences in the level of mother-adolescent interaction and its effect on adolescent mental health after the application of spiritual coping interventions.
Methods: A quantitative study using a pretest-posttest quasi-experimental design with a control group was conducted among 52 public health volunteers and their adolescent children. This study described data of two groups before and after spiritual coping interventions through the Mother and Child Heart Connection (MCHC) Caring System. The Parent-Child Interaction Questionnaire-Revised (PACHIQ-R) and Mental Health Inventory (MHI) questionnaires were used for data collection.
Results: The results of the independent t-test showed a sig. value of 0.036 ($p>0.05$), indicating a significant difference in the level of interaction and mental health between the intervention group and the control group before and after the intervention.
Conclusion: The application of spiritual coping interventions through the MCHC application positively affected the interaction between mothers and adolescent children. Spiritual coping increased the acceptance and awareness of mothers that could improve their interaction and mental health condition of adolescents.

Keywords: Spiritual coping, mother-adolescent interaction, adolescent mental health

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INTRODUCTION

Adolescence is a crucial period of physical, intellectual, and psychological development of any individuals (Meisyalla, 2022). Changes in adolescence are associated with high risks of mental disorders (Lee et al., 2021). Mental disorders can bring detrimental consequences to health and limit adolescents' opportunities to have a good life in adulthood (WHO, 2021).

The World Health Organization (WHO) reported that one in seven children aged 10-19 years old experience a mental disorder, accounting for 13% of the global disease burden in this age group (WHO, 2021). According to the result of the basic health research, especially related to the prevalence of mental disorders among adolescents in Indonesia, it is reported that 6% of adolescents aged 15 and more experience emotional disorders, and 6.2% of adolescents aged 15-24 experience depression (Kemenkes RI, 2019). Suciodologists noted that 4.2% of students in Indonesia had thought of committing suicide, especially adolescents with severe depression (Meisyalla, 2022).

Mental disorders in adolescents can be affected by both internal and external factors from the individuals. The more risk factors the individuals face, the greater the potential impact on their mental health would be (Mustamu, Hasim, & Khasanah, 2020). These factors include pressure, bullying, and economic and family problems (Rachmawati, 2020).

The family is one of the essential and influential factors in adolescent development. It is because the family is the smallest social unit close to adolescents. Adolescents often have problems with closeness to parents, communication, openness, and support (Fernando & Elfida, 2018). A study shows that family harmony is significantly related to adolescent stress levels (Windarwati et al., 2020).

Family bonding can shape adolescent behaviors that guide their social relationships (Yekta et al., 2015). The family can also be a support system for adolescent problems through communication and interaction by mothers. Mothers are considered to have higher opportunities to build a more intense closeness than fathers; it is because mothers are part of the family and are responsible for maintaining the harmony of interpersonal relationships (Fernando & Elfida, 2018).

One of the strategies to deal with family problems is coping mechanisms. Coping is a factor that determines an individual's ability to make adjustments to stressful life events (Purnama, 2017). Each individual has a coping mechanism for dealing with every problem in life; however, the spiritual aspect of an individual's coping is rarely considered. Spirituality contributes to individual health and well-being, including greater tolerance for emotional demands and physical illness (Harrad, Cosentino, Keasley, & Sulla, 2019).

Spiritual coping is a process of adaptation and acceptance through positive thinking, acting, and hoping for spiritual power that involves God in solving problems (Purnama, 2017). This coping strategy can be applied through practice and belief, for example, praying, remembering God, and believing in power beyond the family's ability. Such practices can provide direction about the wisdom of the problem, increase the ability to solve problems, and accept whatever happens (Widayati, Rohmin, & Purwandari, 2018). Accordingly, this study aimed to determine the effect of spiritual coping on the interaction between mothers and adolescents so that adolescent mental health could be improved.

RESEARCH METHOD

Research design

This quantitative study employed a pre-posttest quasi-experimental design with a control group to see the effect of the intervention on the research subjects. Data collection was performed online while the intervention was conducted offline. The respondents in the intervention group were given a spiritual coping intervention through the MCHC (Mother Child Heart Connection) Caring System application. This spiritual intervention consisted of nine stages, including intention, reflection, repentance, sincerity, prayer, body scan, detoxification, relaxation, and surrender.

Research setting and time

The study was conducted in Rowosari Public Health Center (PHC) by a community mental health unit that had been established by the PHC. Data collection was carried out twice on August 10, 2022, for pre-intervention data and the intervention implementation, and on August 1, 2022, for post-intervention data collection.

Population

The population in this study were health volunteer mothers and their adolescent children aged 10-18 years old in Meteseh Village, Semarang City.

Sampling

A non-probability sampling technique with purposive sampling was used. The respondents were recruited based on the criteria that followed the research objectives. The inclusion criteria were volunteer mothers with adolescent children aged 10-18, had a smartphone with a good internet connection, and were willing to be respondents. In contrast, the

exclusion criteria were mothers who were not willing and unable to follow the series of the research processes until the end. The samples in this study were 52 health volunteer mothers and 52 adolescent children aged 10-18 years old.

Instruments

This study utilized two instruments for data collection, namely the Parent-Child Interaction Questionnaire-Revised (PACHIQ-R) and Mental Health Inventory (MHI). The PACHIQ-R is a tool used to measure the level of interaction between mothers and adolescents. It contains 25 favorable and unfavorable statements with 5 Likert scales: never (0), almost never (1), sometimes (2), almost always (3), and always (4) for favorable statements, and vice versa for unfavorable statements. This instrument was tested for validity with a score of 0.755, indicating that the tool is valid. The MHI was used to measure adolescent mental health levels. It consists of 15 favorable and unfavorable statements with 5 Likert scales: always (5), often (4), sometimes (3), rarely (2), and never (1) for favorable statements, and vice versa for unfavorable statements. This instrument was tested for validity with a score ranging from 0.208 to 0.758.

RESULTS AND DISCUSSION

PACHIQ-R

This study was conducted on 52 health volunteer mothers and their adolescent children aged 10-18. The result of the analysis of respondents' responses to the PACHIQ-R are shown in Table 1

Table 1. Characteristics of the respondents (n=52)

Variable	Group		*p*
	Intervention N (%)	Control N (%)	
Age (year)			
Mean ± SD (Min-Max)	43.6 ± 6.7 (30-54)	46.4 ± 6.2 (37-62)	0.352[a]
Number of children			
1 (one)	12 (42.9)	6 (25.0)	
2 (two)	11 (39.3)	12 (50.0)	0.276[b]
3 (three)	5 (17.9)	4 (16.7)	
4 (four)	0 (0)	2 (8.3)	
Occupation			
Housewife	24 (85.7)	22 (91.7)	
Private employee	2 (7.1)	1 (4.2)	0.772[b]
Self-employed	1 (3.6)	1 (4.2)	
Labor	1 (3.6)	0 (0)	

[a]: *Levene test,* [b]: *Pearson chi-square test*

Table 1 shows that in the intervention group, the mean age was 43.6, with an age range of 30 to 54. The majority of respondents were housewives, as many as 24 respondents (85.7%), and had one child, as many as 12 (42.9%). In the control group, the mean age was 46.4, with an age range of 37 to 62. Most respondents were housewives, as many as 22 (91.7%) and had two children, as many as 12 (50.0%).

Table 2. Distribution of respondents based on PACHIQ-R Scores before and after the intervention in the intervention group and control group (n=52)

Variabel	Intervention (n=28)		Control (n=24)		*p*
	n	(%)	n	(%)	
Pretest					
Above mean score	14	50.0	11	45.8	0.788[b]
Below mean score	14	50.0	13	54.2	
Total	28	100.0	24	100.0	
Posttest					
Above mean score	24	85.7	14	58.3	0.033[b]
Below mean score	4	14.3	10	41.7	
Total	28	100.0	24	100.0	

[b]: P*earson chi-square test*

Table 2 shows that before the intervention, 14 (50%) respondents in the intervention group scored the PACHIQ-R above the mean, and the other 14 (50%) scored below the mean. After the intervention, changes in the PACHIQ-R scores were found, in which 24 (85.7%) respondents scored above the mean and 4 (14.3%) scored below the mean.

In the control group, before the intervention, 13 (54.2%) respondents scored the PACHIQ-R below the mean, and 11 (45.8%) scored above the mean. Changes in the PACHIQ-R scores after the intervention were indicated, in which 14 (58.3%) respondents scored above the mean and 10 (41.7%) respondents scored below the mean.

Table 3. Differences in PACHIQ-R Scores before and after the intervention in the intervention group and the control group (n=52)

	Mean Difference	*Pretest*		*Posttest*		*p*
		Mean±SD	Min-Max	Mean±SD	Min-Max	
Intervention	8.5	86.0±8.3	64-100	94.5±7.7	78-105	0.001[b]
Control	2.0	86.4±7.6	72-100	88.3±6.6	69-98	0.361[b]

[b]: *Paired t-test*

Table 3 shows the results of the paired t-test, indicating a difference in the PACHIQ-R scores before and after the intervention in the intervention group (p=0.001, p<0.05). In contrast, no difference in PACHQ scores before and after the intervention was found in the control group (p=0.361, p>0.05).

Table 4. The effect of the intervention on PACHQ scores between the intervention group and the control group (n=52)

	Intervention		Control		*p*
	Mean ± SD	Min-Max	Mean ± SD	Min-Max	
Before	86.0 ± 8.3	64-100	86.4 ± 7.6	72-100	0.853[c]
After	94.5 ± 7.7	78-105	88.3 ± 6.6	69-98	0.003[c]
Delta	8.5 ± 11.5	-22-32	2.0 ± 10.3	-23-16	0.036[c]

[c]: *Independent t-test*

Table 4 shows a significant difference in the PACHIQ-R scores before and after the intervention between the intervention group and control group (p=0.853, p>0.05 and p=0.003, p<0.05). There was a significant difference in the PACHIQ-R delta score between the intervention and control groups (p=0.036 <0.05). Therefore, it could be concluded that the intervention provided an effect on increasing PACHIQ-R scores.

MHI

The MHI questionnaire was administered to 52 adolescents aged 10 to 18. The result of the MHI questionnaire is presented in Table 5.

Table 5. Characteristics of the respondents (n=52)

Variables	**Intervention (n=28)**		**Control (n=24)**		***p***
	n	**%**	**n**	**%**	
Age (years)					0.387[a]
Mean ± SD (min-max)	15.7 ± 2.5 (12-18)		15.8 ± 2.4 (11-18)		
Education					
Elementary	11	39.3	8	33.3	0.163[b]
Secondary	10	35.7	14	58.3	
Higher education	7	25.0	2	8.3	
Inconvenient experience					
Personal problem	9	32.1	7	29.2	0.481[b]
Relationship with parents	6	21.4	3	12.5	
Relationship with siblings	1	3.6	2	8.3	
Relationship with friends	2	7.1	0	0	
Never	10	35.7	12	50.0	

[a]: *Levene test,* [b]*: Pearson chi-square test*

Table 5 shows that the mean age of respondents in the intervention group was 15.7, with an age range of 12 to 18 years old.

Table 6. Distribution of respondents based on MHI scores before and after the intervention in the intervention group and control group (n=52)

Variable	Intervention (n=28)		Control (n=24)		*P*
	n	(%)	n	(%)	
Pretest					
Psychological Well-being	16	57.1	16	66.7	0.573[b]
Psychological Distress	12	42.9	8	33.3	
Total	28	100.0	24	100.0	
Posttest					
Psychological Well-being	18	64.3	17	70.8	0.042[b]
Psychological Distress	10	35.7	7	29.2	
Total	28	100.0	24	100.0	

[b]: *Pearson chi-square test*

Table 7. Differences in PACHQ scores before and after the intervention in the intervention group and control group (n=52)

	Pretest		*Posttest*		*p*
	Mean±SD	Min-Max	Mean±SD	Min-Max	
Intervention	60.3±10.6	37-74	62.8±7.9	48-74	0.000[c]
Control	55.7±10.9	30-70	56.0±10.5	31-70	0.083[c]

[c]: *Wilcoxon test*

Tables 6 and 7 show the increase in adolescents' psychological well-being in the intervention group, from 57.1% to 64.3%, before and after the intervention. Differences in MHI scores were also found in the intervention group before and after the intervention. However, no difference in MHI scores was found in the control group.

Table 8. The effect of intervention on MHI scores between the intervention group and control group (n=52)

	Intervention Group		Control Group		*p*
	Mean Rank	Sum of ranks	Mean Rank	Sum of ranks	
Before	29.91	837.50	22.52	540.50	0.079[d]
After	31.64	886.00	20.50	492.00	0.008[d]
Delta	33.04	925.00	18.88	453.00	0.001[d]

[d]: *Mann-Whitney test*

Table 9. PACHIQ-R and MHI correlation test results (n=52)

Variable		PACHIQ-R	MHI
PACHQ	r	1	0.591
	sig		0.000[e]
MHI	r	0.591	1
	sig	0.000	

[e]*: Pearson correlation*

Tables 8 and 9 show a significant difference in the MHI scores after the intervention between the two groups (p=0.008 <0.05). In addition, a relationship between the level of mother-adolescent interaction (PACHIQ-R) and adolescent mental health (MHI) was found. Therefore, it could be concluded that there was an effect of the intervention on improving adolescent mental health.

DISCUSSION

This study was conducted on 52 mothers with adolescent children aged 10 to 18 years old. The results showed a significant difference in the quality of interaction between mothers and their adolescent children in the intervention group before and after the intervention. This study's results align with several previous studies that showed the positive impacts of spiritual coping on the quality of interactions between individuals, especially within the family.

A previous study was conducted on 1,580 mothers who had children with hearing loss to examine the relationship between mother-child interaction, spiritual well-being, and behavior disorders in children. The results showed a significant relationship between the mother's spiritual well-being and children' behavior disorders with p<0.01

(Mohammad et al., 2021). This study reported the important role of the mother's spiritual well-being in influencing the behavior disorders of children. Spiritual coping strategies play a role as a source of emotional support. With spiritual coping, individuals become dependent on the belief in the relationship with God in dealing with negative feelings. This belief leads to the individual's confidence in the great power of God, who has control over all things. Spiritual coping also provides emotional support and explanation that leads to optimism about events that occur in life. Positive judgments that are developed will help individuals to control anxiety and feelings of hopelessness. Therefore, it can be concluded that a good spiritual coping strategy can produce spiritual well-being for mothers (Onyishi et al., 2022) (Mohammad et al., 2021).

Strong belief and religion can increase mothers' ability to find solutions cognitively, emotionally, and physiologically to overcome various kinds of problems and stress they experience. It is because mothers will pay more attention to the God's existence and seek His help to overcome conflicts and suffering. Thus, mothers will be able to overcome difficulties more calmly. Spiritual well-being improves self-regulation ability in mothers and contribute to accepting responsibility in a conflict, adapting to the environment, and communicating more effectively. Mothers with good spiritual well-being can achieve better psychological well-being and pay full attention to the interactions, thoughts, and feelings of themselves and their family members. Mothers will also have the ability to accept feelings more appropriately, which can lead to less conflict and disagreement with each other. In this way, mothers will have better mental health, including decreased depression, anxiety, and psychological stress. This condition will significantly facilitate mothers to have a more intimate relationship and reduce conflict with their teenage children (Mohammad et al., 2021) (Gok et al., 2017) (Onyishi et al., 2022).

Fitri and Nashori 2021 also studied the contribution of Islamic spiritual coping to mothers' stress while accompanying their children to learn from home. This study, which was conducted on 319 maternal respondents, showed that Islamic spiritual coping contributed negatively to the parenting stress of mothers with a p-value of 0.003. This result shows that good Islamic spiritual coping skills can reduce the parenting stress of mothers in assisting their children in learning from home during the pandemic (Fitri & Nashori, 2021).

Coping is a response that aims to reduce the physical, emotional, and psychological burden associated with stressful life events and unpleasant things in everyday life. In coping, a combination of cognitive processes, behavior, and emotions is constantly changing to manage all kinds of demands (internal and external) that are considered burdensome or put excessive pressure on oneself (Purnama, 2017). Meanwhile, religiosity is one of the factors that can predict and prevent problems occurring in parenting styles to children and other family members. Religiosity is also one of the factors that can predict family resilience and significantly reduce parenting stress (Purnama, 2017) (Fitri & Nashori, 2021) (Widayati, Rohmin, & Purwandari, 2018).

In this study, spiritual coping was carried out through an application called MCHC (Mother Child Health Connection Caring System). MCHC contains nine stages of spiritual coping: intention, reflection, repentance, sincerity, prayer, body scan, detoxification, relaxation, and surrender. This spiritual coping practice is taught in the step of a moment of awareness (mindful) in generating intentions and impulses to try to cleanse the soul of unpleasant emotions. A mindful person will be able to accept things with full awareness and try to improve the ability to solve various problems due to the belief in help from God (Dwidiyanti & Munif, 2022).

Adolescence is one of the most stressful periods in human life. The challenges of development and transformation from childhood to adulthood often become an obstacle for adolescents in adjusting to their new cognitive capacities and behavioral, physical, and emotional changes. In addition, adolescence is marked by the increasing need for autonomy and individualization from parents. Various changes and problems during this period have made adolescents vulnerable to mental disorders such as depression (Armitage, Parkinson, Halligan, & Reynolds, 2020).

In adolescence period, parents are the key to helping adolescents to overcome the difficulties they are experiencing. Also, parents need to negotiate and balance the needs between adolescents and parents for their respective autonomy and authority. The changes often result in a shift of characteristics and frequency of conflicts that become more frequent during interactions between mothers and their children. As a result, the relationship between mothers and adolescents finds more conflict than in the previous age period. Thus, it is no wonder that many parents describe adolescence as the most challenging and often anxiety-provoking period for their children. (Petro, 2017) (Martiani, Lestari, & Hertinjung, 2021) (Ravindran et al., 2019).

The relationship between adolescents and mothers is one of the determining factors in the success of adolescents in dealing with various changes, as well as minimizing the risk of adolescent mental disorders, which can later impact the next stage of development. Good interaction between mothers and adolescents can increase the ability of adolescents to obtain meaning from religious and spiritual behaviors. This becomes important in the adolescent period since it is associated with significant changes in the decision-making process about religion, the meaning of life, and building a coherent philosophy of life to contribute to development in later age periods (Krok, 2015). A study conducted by Karimi et al. on the relationship between mother-child interaction and the mental health of adolescent girls showed that the quality of interaction between mothers and adolescents has a positive influence on adolescent mental health ($p=0.16$, $p<0.001$) (Karimi et al., 2019).

Mothers become one of the determinants of the mental health condition of adolescents. Spiritual coping for mothers with teenage children focuses on how mothers can deal peacefully with all conditions and changes in their children. The use of spiritual coping and religious behavior in the family is closely related to better welfare, social skills, and behavioral

problems in children (Petro et al., 2017). Parents, especially mothers, are the first people to be a means for children to learn to socialize. A study shows that the religiosity of children tends to be the same as the level of religiosity of their parents (Fernando & Elfida, 2018) (Karimi et al., 2019).

Religion as a source of protection can assist adolescents in dealing with stress and pressure from problems occurring during puberty and, therefore, improve their mental health. Furthermore, the relationship between mother and children is closely related to the individual's physical, psychological, social, and spiritual well-being (Roh, 2016). Therefore, the quality of interactions between adolescents and mothers that occurs due to increased mothers' spiritual well-being will significantly help improve the mental health of adolescent children (Karimi et al., 2019).

CONCLUSION

This study showed a significant difference in the quality of interaction before and after the intervention in the intervention group. The spiritual coping strategy provided in this study could improve mothers' spiritual well-being, affecting the quality of the interaction between mothers and their adolescent children. Spiritual well-being in mothers creates an intimate relationship between mothers and adolescents and minimizes conflicts between them. Quality interactions with mothers will foster adolescents' confidence and strength to appreciate and instill religious values they receive from their mothers. This will also affect adolescents' mental health conditions and minimize the incidence of depression or other adolescent mental disorders.

Limitations of the Study

Some respondents could not access the application used in this study, so the researchers had to prepare other intervention media in the form of video, thus extending the time of data collection. It is, therefore, necessary to review the respondents' accessibility to the intervention media before its administration.

Recommendations

Mothers have a significant role in assisting adolescents in carrying out developmental tasks according to their age. Mothers also play a role in helping adolescents solve various problems they have. Therefore, the quality of interaction between mothers and adolescents needs to be considered and ensured that they are good so that adolescents can manage their problems. Spiritual coping strategies can be given to mothers to improve their spiritual well-being. Research that provides spiritual coping interventions can be carried out further to create a better quality of interaction between mothers and adolescents to minimize the incidence of mental illness in adolescents.

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ETHICAL CLEARANCE

All procedures implemented in this study involved mothers and adolescents in Meteseh Village, Tembalang District, Semarang City, Central Java Province, Indonesia. All procedures in this study were in accordance with the ethical standards of the institutional/national research committees. This study was also conducted with the permission of the Health Research Ethics Committee of the Faculty of Medicine, Diponegoro University.

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