Malaysian Youth Mental Health and Well-Being Survey

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Introduction and Literature Review

The rates of mental health problems amongst Malaysian teenagers have been noted to be quite high. At present the percentage of emotional problems is 49% and aggressiveness is 41%. These findings were highlighted by the Ministry of Health's Healthy Life-Style Campaign National Mental Health Survey in 2000.

Recently, the Ministry of Youth and Sports set up the National Institute for Youth Research (i.e., Institut Penyelidikan Belia Nasional). The aim of the Institute would involve advising the Minister of Youth and Sports about Youth policies. Data provides a rationale and basis for the implementation of National policies, and it is thus envisaged that having a large body of data which informs of the current trends of youth attitudes, life-styles and well-being would be a necessity.

Given the concerns with the rates of mental health problems amongst youth, this study was requested by the Minister of Youth and Sports to get a general overview, not just into the mental health status of Malaysian youth, but also into their lifestyles. This report begin with a literature review that examines some of the know findings about various aspects of youth lifestyle that are covered in the study. In addition to mental health, the review covers such topics as social support, substance abuse, sexual behaviours, pet ownership, bullying and family conflict. All these topics have been found to have some impact on youth mental health, and inform the reader about youth lifestyles. The report next provides some information on the methodological aspects of the study pertaining to subjects, sampling, measurement instruments and data collection procedures. The results are presented in the form of a series of tables that document the prevalence of various youth attitudes and behaviours. Finally, the report concludes with a summary of the major findings of this study, plus some suggestions for policy changes.

Mental Health

Measures of young people's mental health vary from study to study. Some researchers see mental health as encompassing a combination of outcomes such as the youth's self-concept, reading ability and life skills (Amato & Ochiltree, 1987). Other researchers have chosen academic indicators of performance such as reading, mathematical ability and behavioral problems (Cherlin et al., 1991; Svanum, Bringle & McLaughlin, 1982). Anxiety, depression and delinquency which are indicators of mental health problems have been used (Kalter, 1977, Pedro-Carrol, Cowen, Hightower & Guare, 1986). Finally,

others also consider anti-social behaviours such as sexual problems and drug involvement to be indicators of youth adjustment (Gibson, 1969).

There are also some researchers that offer a less symptomatic definition of mental health. Offer and Sabshin (1984) described four primary definitions of mental health. These include:

- mental health as the empirical profile of the statistically average adolescent or the majority of adolescents
- mental health as optimal functioning of the "ideal" adolescent
- mental health as the absence of clinically diagnosed disorders or symptoms
- mental health as a result of a changing system of time and culture.

"Positive" aspects of mental health or healthy personalities are those who "continue to grow, develop, and mature through life, accepting responsibilities, finding fulfillments, without paying too high a cost personally or socially, as they participate in maintaining the social order and carrying on our culture". (Frank, 1953). Jahoda (1955) notes that a mentally healthy person is one who perceives the world and himself correctly, independent of his personal needs. To ensure positive mental health, there are several basic features that have been identified:

- The person displays active adjustment, or attempts at mastery of his environ three basic features of mental health
- The person displays active adjustment, or attempts at mastery of his environment, in contrast to lack of adjustment or indiscriminate adjustment through passive acceptance of social conditions
- The person manifests unity of personality-the maintenance
- of a stable integration which remains intact in spite of the flexibility of behavior which derives from active adjustment

The overall rates of Mental Health problems in young people was found to be 17.7% in Australia (Zubrick et. el., 1995), 18.1% in Canada (Offord et al., 1987), 17.6% in New Zealand (Anderson, Williams, McGee & Silva, 1987),26% in The Netherlands (Verhulst, Berden & Sanders-Woudstra, 1985) and 17.9% in Puerto Rico (Bird et al., 1988). In Malaysia, the prevalence was found to be between 13.4% - 15.5%, of which the prevalence was 10.4% in urban areas and **11.1** % in rural areas (Toh et ai., 1997).

In Australian samples, by far the most prevalent disorders amongst young people are delinquency (9.5%) and thought problems (8.6%). Amongst U.S. children, the most commonly cited disorders are disruptive behaviour disorders, separation anxiety, overanxious disorder and depression (Velez, Johnson & Cohen, 1989). In New Zealand, Anderson, Williams, McGee and Silva (1987) reported that the most commonly diagnosed disorder was attention deficit disorder (6.7%), followed by oppositional disorder (5.7%).

Causes of Mental Health Problems

Many of the symptoms or serious difficulties that would signal mental illness in adulthood or childhood are understood to be a normal part of adolescence. Adolescents

may be expected to be extremely moody and depressed one day and excitedly "high" the next. Explosive conflict with family, friends, and authorities is thought of as commonplace. (Powers, Hauser and Kliner, 1989)

In order to understand the causes of mental health problems amongst youth, it is important to understand lifestyle. For this reason, the study also reviews various aspects of the young person's social experience. The rest of this review examines the various factors associated with mental health.

Bullying

Bullying is a common problem in all schools. Olweus (1994) describes four forms which are physical, verbal, social and psychological forms.

Physical bullying involves aggression such as hitting, tripping, punching, throwing objects, stealing and extortion. Usually, the bullies wait until the victim is vulnerable before launching their attack. This is usually something quite violent and the victim ends up with bruises and cuts.

Calling nasty names, swearing, belittling, threatening, ignoring and black mailing are forms of *verbal bullying.* Calling names usually includes statements that make fun of a person's physique or dress (i.e., "Four eyes", "Katek", etc.). Belittling may include statements such as "You are so poor, you cannot go buy a hand phone," and "You are so small, I could just squash you!" Where threatening the victim is concerned, the usual threats are about being beaten up if the victim does not comply.

Social bullying involves ignoring and ostracising. Bullies may encourage the other students in the class to ignore the victim, and not talk to him. They use rationales such as the victim being ugly, or not having a father. Generally, the reasons for ostracising the victim are usually petty and personal.

Finally, *psychological bullying* involves stalking, dirty looks, spreading rumours, and hiding and damaging the victim's possessions. Usually, bullies will take the victims belongings and hide it in some other person's desk. Others will deliberately step on the victim's school bag, break all their pencils and tear the pages of text books. Social and psychological bullying are sometimes also known as *relational bullying.*

There are various reports of the prevalence of bullying amongst students from other countries. In Australia, Zubrick et al. (1995), found that one in nine, or 14 percent of Australian school students had been victims of bullying. They noted that boys were bullied more often than girls, and that the bullying was most common amongst 10 to 14 year-olds. In addition, Woo and Loh (2004) carried out a study on 442 children aged 1012 years old to investigate the effects of bullying. The survey results indicated that 66.5% of children had been bullied at school. Of this number, 20.8% had been physically bullied, 54.1% had been verbally bullied and 35.1% had been subjected to relational types of bullying. Amongst adolescence the prevalence of antisocial behaviours such as

bullying or delinquency is much higher than in other developmental phases across the life span (Perren and Hornung, 2005).

There are many different negative effects of bullying on young people. Perren and Hornung (2005) studied 1107 adolescent (576 boys and 531 girls). School bullying and victimisation were assessed by five items each on bullying and on victimisation, and include physical, direct and indirect verbal, object-related and sexual forms. The result showed that bullied adolescents had lower peer acceptance than bullies and non-involved students.

A variety of factors have been found to be the cause of bullying. Negative family relationships were repeatedly identified as risk factors for antisocial behaviours as well as for victimisation. Perry, Hodges, and Egan (2001) reviewed various determinants of peer victimisation and found that insecure attachment or overprotective parenting styles can be risk factors for victimisation. Families of male victims seem to be overly close, whereas those from female victims seem to be emotionally abusive and unhealthy (Duncan, 2004). Bullying behaviour is also associated with parents' use of physical discipline and time spent without adult supervision (Espelage, Bosworth, & Simon, 2000), and with poor family functioning (Rigby, 1994). Families of bullies can be described by a lack of warmth, lack of closeness and are focused on power; similarly, families of bully-victims are often high in aggression and low in warmth (Duncan, 2004). Bullies, bully-victims, and victims report more negative family functioning than non-involved children (Stevens, De Bourdeaudhuij, & Van Oost, 2002), but bully-victims' parents may show particularly dysfunctional parenting (Bowers, Smith, & Binney, 1994; Smith & Myron Wilson, 1998). Low popularity and having no friends have been identified as risk factors for peer victimisation (Boulton, Trueman, Chau, Whitehand, & Amatya, 1999; Hodges, Malone, & Perry, 1997). Bullies tended to affiliate with other aggressive adolescents (Pellegrini, Bartini, & Brooks, 1999), and they could even be the leaders of their respective social clusters (Cairns, Cairns, Neckerman, & Gest, 1988).

Substance Abuse - Drinking and Smoking

Young people may be at risk for substance abuse. Amongst the various substances that they may be are tobacco, marijuana, alcohol and heroin.

Nor Afiah et al. (2006) conducted a cross-sectional study of 136 Form 6 students. The prevalence of smoking was 22.8% whereas the prevalence of alcohol intake was 47.8%. There were significant associations between smoking and males and smoking and alcohol intake

Malaysia is the tenth largest consumer of alcohol in the world (Assunta, 2006). Each year Malaysians spend over US$500million on alcohol. Whilst the per capita consumption is 7 litres, those who do drink alcohol consume heavily. Among the drinking population, the Malaysian Indians who make up about 8% of the population are by far the heaviest drinkers with an annual consumption of absolute alcohol exceeding 14 litres. Beer consumption in Malaysia at 11 litres per capita is comparable to that of European

countries known for their high consumption. The easy availability of alcoholic drinks in coffee shops, supermarkets, sundry shops and plantations together with aggressive advertising and promotions are driving Malaysians to drink. The average age for alcohol dependence is 22 years.

A cross sectional study was conducted by Rampal (2006) in Malaysia. All residents aged 18 years and above from selected households were included in this study. A standardized pre-tested structured questionnaire was used in this study. The study found that out of 17,246 respondents, the overall prevalence of ever and current smokers were 31.4% and 24.4% respectively. The prevalence for males was significantly higher (59.3% and 47.2% respectively) as compared to the females (4.7% and 2.6% respectively). Amongst the males respondents, the prevalence of current smokers was highest amongst the Malays (55.6%), followed by the Bumiputra Sarawak(50.9%), Bumiputra Sabah(50.2%), Chinese (34.2%) and Indians (33.4%). Amongst the females respondents the prevalence of current smokers was highest among the Bumiputra Sarawak (5.2%) followed by the Chinese (2.8%), Malay and Bumiputra Sabah (2.6%) and Indians (0.5%). There was a significant association between smoking and race and between current smoking status and education level. The study also showed that smoking was associated with race, age, sex, educational level and peer and family influence.

There are a variety of factors that may influence adolescent drinking behaviour. Several studies indicate that peers and parents exert an influential role in late adolescent drinking behavior. Woad, Read, Mitchell and Brand (2004) investigated 556 adolescents and found that peer influences (i.e., alcohol offers, social modeling, perceived norms), parental behaviors (i.e., nurturance, monitoring), and attitudes and values (i.e., disapproval for heavy drinking, permissiveness for drinking), and alcohol use and alcohol-related consequences. In a study of 1,012 adolescents from the Netherlands Van der V orst, Engels, Meeus, Dekovi6, and Vermulst, (2006) found that parental control in the form of monitoring was associated with lower alcohol use, especially among adolescent boys. In addition, Patock-Peckham and Morgan-Lopez (2006), found that traits such as impulsiveness or sensation seeking may serve to mediate or moderate other main effects on college drinking. High-sensation-seeking youth, for example, may find alcohol use more rewarding relative to other possible activities and related life goals.

When it comes to smoking, studies have found that the social environment also plays a role in encouraging behavior. Ewans et al. (2006) found associations between the immediate social environments, perceptions about social imagery, and adolescent tobacco use.

Research indicates that there are two broad perspectives as to why adolescents begin to smoke. The first perspective concerns the social environment that states suggests that smoking by family and friends may present the apparent advantages of smoking (U.S. Department of Health and Human Services, 1994) and support a positive image of smoking in the individual's mind (Gibbons & Gerrard, 1995). Research shows that having family and friends who are smokers increases the likelihood that an adolescent will smoke (Jackson, 1997; O'Loughlin, Renaud, Paradis, Meshefedjian, & Zhou, 1998). Most

Literature, however, suggests that friends or peers are a stronger influence than parents (Jackson, 1997; Pierce, Choi, Gilpin, Farkas, & Merritt, 1996). The second approach indicates that positive social images of smoking increase the likelihood of smoking behavior (Chassin, Presson, Sherman, Corty, & Olshavsky, 1981). The social image of smoking is usually one of coolness, popularity, and having more friends (Aloise-Young & Hennigan, 1996; Aloise-Young, Hennigan, & Graham, 1996). A positive social image of smoking increases the likelihood adolescents will at least experiment with smoking (Barton, Chassin, Presson, & Sherman, 1982; Burton, Sussman, Hansen, Johnson, & Flay, 1989). Normative influences, such as a favorable image of smokers, may also predict smoking in young men but not young women (Gibbons & Gerrard, 1995). Boys who try smoking also rate smokers as cooler and more glamorous than do girls who try smoking (Bowen, Dahl, Mann, & Peterson, 1991). Finally, there is some limited evidence that parents also exert a greater influence over boys than girls (Males, 1995).

Marital conflict

Numerous studies have found that inter-parental conflict affects young people's adjustment. Researchers have chosen to measure inter-parental conflict in various ways. Fincham and Osbourne (1993) propose that conflict should be characterised and measured along four dimensions: frequency, intensity, duration and diversity. Some researchers rely on reports of various forms of hostility such as quarrels, sarcasm and physical abuse (Porter & O'Leary, 1980). Rands, Levinger, and Mellinger (1981) defined three major styles of conflict resolution: attacking, avoiding, and compromising or discussing. An "attacking" resolution style involves being verbally abusive, angry, and sarcastic; an "avoiding" style involves withdrawing after arguments, avoiding talking, and becoming cool and distant. Adopting a "discussing" style involves trying to understand a partner's feelings, as well as using reasoning tactics to smooth things over and work out a compromise. In other cases, children have been asked to rate the frequency of their observations of their parent's conflict (Kurdek & Sinclair, 1988).

Inter-parental conflict creates a tense and stressful family environment. Silburn et al. (1996) show that when there is discord, parents avoid discussing fears and concerns, do not talk to each other about sadness, have problems making decisions, find planning family activities difficult due to misunderstandings and are unable to confide in each other. High-discord families are also less likely to do things together for enjoyment, show signs of care for one another, and are more likely to quarrel. When compared with families who were functioning well, more parents in families with high discord reported that they were not too happy with their lives. Parents in discordant as compared with non-discordant families were 12 times more likely to report their marital relationship to be fair or poor. Grych and Fincham (1990) noted that children are likely to experience adjustment problems if they are exposed to frequent parental conflict that is aggressive, poorly resolved, and for which children blame themselves and feel personally threatened. On the other hand, if children are exposed to occasional, well-resolved, and nonchildfocused conflict between parents, they are less likely to experience adjustment difficulties. The type of conflict also matters. Camara and Resnick (1989) found that verbal attacks and avoidance tactics used by the mother and father to resolve conflict, as

Well as physically violent behavior from the father, were associated with poorer adjustment. On the other hand, parents who used negotiation and compromise to resolve disagreements were more likely to have children who displayed greater social competence in interactions with their peers. Dadds, Atkinson, Turner, Blums and Lendich (1999) studied 10-14 year old school students. The results showed that interparental conflict severity, parental conflict-resolution styles, and child appraisals can all make specific contributions to the prediction of specific child-adjustment problems, and that relationships between the above variables show consistent intergenerational gender patterns. In the long run, parents' marital discord appears to be negatively related to offspring's marital harmony and positively related to offspring's marital discord (Amato & Booth, 2001).

Social support

Social support is defined two ways. Firstly information which affords the perception of being cared for, esteemed and valued by members of one's social network (Dubow, Tisak, Causey, Hryshko, & Reid, 1991 ; Dubow & Ullman, 1989), and secondly as the availability of people on whom we can rely, and who let us know that we are cared for and valued (Sarason, Levine, Basham, & Sarason, 1983). Major sources of support for the adolescents come from the family, peers, and teachers.

Social support affects the adolescents' mental health. Students who have high family support have higher scholastic self-esteem (Dubow & Ullman, 1989). Peer support become increasingly important through adolescence (Furman & Buhrmester, 1992). Both parent and peer support remains necessary because both correlate with self-worth (East & Rook, 1992). Increasingly through adolescence, peers provide support for the daily life of the adolescent (friendships, dating, clothing, hairstyles, leisure activities and so forth), whereas parents continue to be the major source of support for issues of long-term life style choice such as personal values and career considerations (Jurkovic & Ulrici, 1985 ; O'Brien, 1990).

Pet Ownership

Pets are an important part of many people's lives. They provide companionship and entertainment for their owners. In Malaysia, many people own pets. To some, the pets perform security functions, whereas to others they are a form of companionship. Many studies suggest that having a pet may help alleviate mental health problems. Serpell (1990) noted that pet owners, when compared with non-pet owners, had less minor health problems and higher self esteem. In the study, the reduction in minor health problems also resulted in an increase in healthy behaviours such as physical exercises (i.e., regularly walking the pet). Thus, it would appear that the pet also improved the owner's ability to carry out tasks, thus increasing overall general self-efficacy. Many pet owners also appear to experience lower levels of anxiety as a result of the ownership of their pets. Dog owners reported experiencing a reduction in their fear of being the victim of crime (Serpell, 1990). In addition, they also report to have a slight increase in self-esteem. Whilst these studies have been conducted on foreign pet owners, we wonder if the same results are also observable amongst Malaysian pet owners. In addition, no specific studies have examined the impact on the owner's self-efficacy.

Pets appear to have a positive impact on their owners for a number of reasons. Some are a source of love, affection and companionship (Cusack, 1988). They also provide social benefits to their

owners. Other pets promote social relationship between people whether they are in an institutional setting or simply strangers on the street. The pet acts as an icebreaker, thus facilitating social relationship between people (Cusack, 1988). Finally some studies suggest that pets assist in promoting positive family interactions. Allen (1998) noted that couples with pets report greater closeness and satisfaction in marriage as compared to non-pet owners.

Obesity

One in every five adult Malaysians is either overweight or obese. Around 7.9 per cent of the nation's obese adult population is women and 4.7 per cent are men. According to the World Health Organization, some 79 per cent of the deaths due to such diseases currently occurred in the developing countries and, these countries would see over 100 per cent rise in coronary deaths during 1990-2020. Apart from hereditary factors and endocrinal disorders, the chief culprit of obesity is a combination of unhealthy eating habits and a sedentary lifestyle. Statistics show that every year globally, around two million deaths are attributed to physical inactivity. Most people indulge in static mental exercise such as surfing the internet, watching the television and reading - in Malaysia's case, even the latter is not pursued and hence, the unflattering impression of a nation of corpulent and mentally-lazy slobs. The fast-food revolution and the carbohydrate-laden two-minute noodles as convenient substitutes for wholesome food also contribute to weight gain.

Asia lags behind the U.S. and Europe in its obesity statistics, but Thailand, Malaysia, Japan and the Philippines have all reported troubling increases in recent years. The U.S. continues to lead the way, with as many as 37% of its children and adolescents carrying around too much fat. But other countries are rapidly catching up. According to statistics presented recently at the European Congress on Obesity in Helsinki, Finland, more than 20% of European youngsters between the ages of 5 and 17 are either overweight or obese. Children in North Africa and the Middle East aren't far behind. Across Asia too, childhood obesity is on the rise, and the trend has been documented even in urbanized areas of sub-Saharan Africa.

Obesity is an escalating global health problem. According to statistics cited by the International Food Information Council, the percentage of overweight children in several countries is as follows: 16.1% in Singapore (school children), 14.3% in Thailand, and 7.8% in Malaysia. The National Health and Nutrition Survey III, on the other hand, illustrated that 27% of children under the age of 12 are obese, reflecting a significant increase in obesity over a twenty-year period. Scientific studies reveal that 60% of the children ages 5 to 10 years are overweight and have early biochemical or clinical signs or symptoms of cardiovascular risk factors. In addition, 25% of these children have two or more risk factors. Obesity in the early years can cause psychological, physiological and social problems. As obesity increases and fitness decreases, children are developing chronic diseases at earlier ages. Overweight and obese children tend to grow quicker and are sometimes mistaken for older children. They are more likely to be discriminated against and to develop negative attitudes about being overweight. Even though poor diet and physical inactivity are the primary reasons for obesity, others reasons such as friends and peer pressure groups, sedentary activities, emotional problems, slower rate of metabolism, heredity, environmental factors, and hormone imbalance can also cause obesity.

Sexual Behaviours

Most of the studies on sexual behaviours appear to have been carried out in the United Kingdom and the United States of America. In 1938 to 1950, approximately 7% of Causasian North American females had intercourse by age 16 (Kinsey et ai., 1948). By 1971, one third of never-married girls 16 years of age had had intercourse, with the figure rising to 44% by 1982 (Hofferth & Hayes, 1987; Zelnik & Kantner, 1980). Large increases occurred between 1971 and 1979, after which time the percentage of sexually active girls remained stable or perhaps even declined. Negro girls had significantly higher rates of intercourse than Caucasian girls at all time points, although the difference had dropped to only 13% by 1982. Historically, boys were much more likely to make their sexual debut as teenagers than girls. Estimates of selected samples from the 1940s to 1960s are that one-third to two thirds of male teenagers were sexually active (Hofferth & Hayes, 1987). Cumulative percentages using the National Longitudinal Survey of Youth by age of initiation, sex, and race in 1983 tell the story (Hofferth & Hayes, 1987). Sixty percent of Caucasian male teens had intercourse by age 18, and 60% of Caucasian girls just a year later, by age 19. Greater gender disparities are evident for Negro teenagers: 60% of Negro male teens had intercourse by age 16, and 60% of Negro girls two years later, by age 18.Racial differences for boys are greatest at early adolescence. Indeed, in 1983, 42% of Negro boys had had intercourse by age 15 or earlier; in some male subgroups, pre-pubertal initiation is common. It is not uncommon for a teen to have first intercourse at age 14 or 15 and then not to have sexual relations again for a year or two.

Teens who rate perceived communication with their parents as poor are more likely to initiate sex early; they also are likely to begin smoking and drinking early *(lessor & lessor,* 1977). are often uncomfortable discussing sexual topics associated with reproduction with their post pubertal children, as are their children (the exception being mothers and daughters about menarche; (Brooks-Gunn & Ruble, 1982). Teenagers who are not doing well in school and have lower educational aspirations are more likely to have sex during adolescence than those faring better in school (Hofferth & Hayes, 1987).

A variety of perspectives on youth behaviours have been covered in this research review. In general, it would appear that there are many familial and social factors that affect youth mental health and well-being. Given this, it is important that studies are regularly carried out that seek to monitor the ever changing pattern of the youth's social experiences. Given this, the Malaysian Youth Life-Styles and Well-Being survey encompasses the following areas:

- Mental Well-Being
- Physical Well-Being
- Social Function
- Social Habits
- Family Behaviours
- Career Progression and Education
- Community and National Attitudes