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Family Functioning and Health-related Quality of Life among Adolescents of Low Socio-Economic Status

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Abstract. Lower level of health-related quality of life has the potential to be experienced by adolescents with low socioeconomic status. This condition can hamper the productivity of adolescents who will enter their productive age. For this reason, it is important to strive the enhancement of health-related quality of life among adolescents with low socioeconomic status, especially by involving the family as adolescents' microsystem. This research is important as an effort to collect empirical information that can be used in improving the health related quality of life in adolescents with low socio-economic status. We hypothesized that a functional family can help adolescents with low socioeconomic status achieve a better health-related quality of life. The purpose of this study was to determine whether the dimensions of family functioning simultaneously have significant contribution in the health-related quality of life among adolescents from low socioeconomic status background. One hundred and nine adolescents with low socioeconomic status who live in East Kalimantan province were involved as participants in this study. Convenience sampling technique was used to select participants. Self Report Family Inventory Version II (Beavers and Hampson) was used to measure dimensions of family functioning variable. KIDSCREEN 27 (Ravens-Sieberer) was used to measure health-related quality of life variable. The data in this study were analyzed by multiple regression test. The research findings showed that simultaneously dimensions of family functioning has positive and significant contribution to health-related quality of life as perceived by participants ($F=8,320$; $sig\ p=0.000$), with total contribution 28.8%. This shows that family strength-based approach should be added in developing intervention to enhance health-related quality of life in adolescents with low socioeconomic status.

Keywords: adolescence; family functioning; health related quality of life; low social economic status.

INTRODUCTION

It is recorded 241,000 people with low socioeconomic status in East Kalimantan according to data from the Statistics Indonesia of East Kalimantan Province (2021). Despite the percentage increase in poverty being relatively low, this situation entails a significant impact on the population, especially teenagers experiencing a storm and stress periods (Jahja, in Saputro, 2017). Adolescents from low socioeconomic status families are prone to experiencing poor quality of life. For instance, adolescents become more susceptible to physical disorders such as respiratory disorders, fever, and

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flu (Astri, 2014; Suharto, 2016). From the psychological aspect, adolescents of low socioeconomic status are vulnerable to emotional disorders, personality disorders, stress, and depression (Brebahama et al., 2018; Noviwati & Narendri, 2017; Sumara et al., 2017). From the social perspective, adolescents with low socioeconomic status appear to develop unhealthy social relationships such as having relationships associated with violence and committing juvenile delinquency (Tjandarningsih, in Astri, 2014; Sumara et al., 2017). Furthermore, the current situation of financial barriers leads adolescents with low socioeconomic status to have limited access to quality education and are exposed to discrimination in the education setting (Krisnayanti et al., 2018); Astri, 2014). As aforementioned, adolescents with low socioeconomic status are vulnerable to experiencing obstacles in various aspects of life, including physical, psychological, social relations, and education. This indicates that adolescents with low socioeconomic status face low health-related quality of life or health-related quality of life.

Health-related quality of life is a multidimensional concept that incorporates individual perceptions of physical, and psychological well-being, social relationships, and family functioning or relationships with parents (Ravens-Sieberer et al., 2014). According to Raven-Sieberer et al. (2014), health-related quality of life among adolescents covers several aspects, namely physical health, psychological health, relationships with parents and independence, social support and peer groups, and the school environment. Various studies have examined the factors that correlate with health-related quality of life, namely self-compassion, parent educational status, parental wealth, resilience, the role of gratitude, social support, demographic variables such as gender and age, psychosocial factors among others status economics, parenting, and life experiences (Adine et al., 2018; Hasibuan et al., 2018; Krisnayanti et al., 2018; Molla et al., 2021; Novita & Novitasari, 2017; von Rueden et al., 2006). These studies correlate more personal factors with health-related quality of life. Little did have studied how family dynamics may affect health-related quality of life. Meanwhile, it is essential to observe the influence of the family on adolescent development since the family is the microsystem or the closest environment to the individual. Meanwhile, the microsystem is dominant in individual development (Bronfenbrenner, in Gamayanti, 2014).

Several research results show that the dynamics that occur in the family can affect the quality of life in association with health in psychological and social dimensions. To illustrate, the quality of relationships between families affects the level or sense of loneliness experienced by adolescents (Hidayati, 2018). Additionally, the absence of parents in the lives of adolescents can lead to insecurity, difficulty in socializing, and the risk of suffering from psychosis (Yandri & Juliawati, 2018). Subsequently, extreme family conflict and lack of communication between family members can result in juvenile delinquency (Sumara et al., 2017). The quality of family relationships and poor communication, as well as the existence of conflicts such as in the mentioned cases, indicates that the family does not carry out its functions optimally (Sumara et al., 2017). Thus, one of the family circumstances that modify the achievement of optimal health-related quality of life among adolescents with low income is family functioning.

Family functioning is to see the extent to which a family is able to carry out the tasks needed to nurture, organize, and manage the family (R. Beavers & Hampson, 2000). There are five dimensions of family functioning described by Beavers & Hampson (2000) namely, the health/competence dimension, the cohesiveness dimension, the conflict dimension, the leadership dimension, and the emotional expression dimension. The dimension of health/competence is an atmosphere of happiness within the family, a sense of optimism, problem-solving skill, negotiation skill, love of family, parental coalition strength, autonomy and individuality, and a sense of responsibility (R. Beavers & Hampson, 2000). The cohesion dimension is the connectedness

between family, togetherness, and the prevalence to enjoy time together (R. Beavers & Hampson, 2000). The conflict dimension is openness to problem-solving; being open in contention, debate, and willingness to negotiate and accept responsibility in the event of problems (R. Beavers & Hampson, 2000). The leadership dimension is the strength and consistency of adult leadership patterns in the family (commonly parents), the guidance from adults, and the extent to which monitoring is performed (R. Beavers & Hampson, 2000). The emotional expression dimension is the expression of positive emotions such as warmth and care between family members (R. Beavers & Hampson, 2000)

A healthy functioning family can facilitate adolescents to achieve a health-related quality of life – both in terms of physical, psychological, relationship with parents, and school environment (Ravens-Sieberer et al., 2014). Referring to the health/competence dimension, a family functioning can be responsible for supporting its members (R. Beavers & Hampson, 2000), such as acting as the provider of first-hand care when ill, and providing food sources for each family member. Such family capacity can promote the attainment of health-related quality of life in terms of physical health. In line with this, Safriani (2010) reveals that a well-functioning family will have a positive influence on an individual's physical health.

Then, in the regard to the conflict dimension, functioning families develop an open attitude toward each other in dealing with problems (R. Beavers & Hampson, 2000). If family members display openness to a problem, this will hone good problem-solving skills (Tavitian et al., 1987). Following good problem-solving skills, adolescents can adapt to the pressures they encounter (Abdollahi et al., 2018). Therefore, the health-related quality of life in the psychological aspect will be achieved.

In addition, referring to the leadership dimension, functioning families have reliable leaders and there is positive communication within the family (R. Beavers & Hampson, 2000). The theory about the characteristics of parenting initiated by Baumrind (Asiyah, 2013) suggests that the presence of family leaders who will direct and enforce rules complemented by warmth and positive communication are characteristics of parenting that implements democracy. Such an atmosphere in the family assists adolescents achieves a health-related quality of life, particularly in relationships with the parent.

Furthermore, referring to the cohesion dimension, functioning families can develop connectedness, togetherness, and positive affective responses between family members with equitable intensity (Beavers & Hampson, 2000; Gunawan & Setianingrum, 2018). Moreover, noting the dimensions of emotional expression, a functioning family develops positive, warm, and caring emotional expressions (R. Beavers & Hampson, 2000). Considering that the family has an important role in the emotional development of a child (Retnowati et al., 2003), a positive emotional atmosphere in the family may help adolescents achieve a health-related quality of life, mainly in the psychological health aspect. Additionally, a cohesive family can initiate an efficient and mutually supportive family environment, which will serve adolescents to achieve good academic performance and learning satisfaction (Herawaty & Wulan, 2013). Shortly, the cohesion dimension in the functioning family is significant in the school environment to promote health-related quality of life.

In Indonesia, the majority of research on health-related quality of life mostly relates to personal variables and has not examined the family aspect (Adine et al., 2018; Hasibuan et al., 2018; Krisnayanti et al., 2018; Palu & Nurdin, 2014; Tsani & Listiyandini, 2018; Wijayanti et al., 2020; Yudha, 2014). Meanwhile, the family is a microsystem that is a significant role in individual development (Bronfenbrenner, in Gamayanti, 2014), whereas the dynamics that occur

in the family will eventually influence the individuals in it, including adolescents. In Indonesia, those who are teenagers in general still live with their parents so they are more likely to be exposed to the dynamics in their families. This study aimed to analyze the role of the family functioning dimensions simultaneously on the health-related quality of life among adolescents coming from low socioeconomic status. The hypothesis proposed by the researcher is that the dimensions of family functioning simultaneously play a role in health-related quality of life in adolescents with low socioeconomic status – the direction of the relationship is the higher the family functioning, the higher the health-related quality of life will be, otherwise, the lower the family functioning, the lower the health-related quality of life will be.

METHOD

This study proposes a hypothesis simultaneously that there is a role for family functioning dimensions on health-related quality of life among adolescents with low socioeconomic status under the prejudice that the higher the family functioning, the higher the health-related quality of life, as well as the lower the family functioning, the lower the health-related quality of life. To validate these hypotheses, this study applied a quantitative approach with a non-experimental design.

This study involved adolescents from low socioeconomic status residing in East Kalimantan as participants. Of the 109 participants in this study, the majority were female (51%), were in the late development of adolescence stage, comprising 17-20 years (53%), had married parents (74%), did not have a chronic disease (92%), and did not involve in harmful habits such as smoking, drinking alcohol, rarely exercising/lack of physical activity, risky sexual relationships (92%). The criteria for low socioeconomic status refer to the Statistics Indonesia of East Kalimantan Province in 2020 that one of the criteria for residents with low socioeconomic status is a household with an income of below IDR 2.3 million per month. Research participants were selected through convenience sampling. The collection was carried out in April - May 2020 through direct interaction (face to face), where the researcher visited every participant who matched the predetermined characteristics. Participants were required to fill out the questionnaire provided and during the data collection process, the researcher followed the health protocol; washing hands before and after data collection, maintaining distance, wearing masks, and only visiting the environment or green zone areas that have been announced by the East Kalimantan government.

Self Report Family Inventory Version II (SRFI II) from Beavers and Hompson (2000) was used to measure family functioning variables in this study. SRFI II is an instrument in the form of a self-report questionnaire. The SRFI II statement consists of 36 items, with a rating range of five Likert scales. There are six dimensions in SRFI II, including the Health/competence dimension (e.g., "We all have say in family plan"), conflict dimension (e.g., "Adults in the family compete and fight with each other"), cohesion dimension (e.g., "Our happiest times are at home"), leadership dimension (e.g., "There is confusion in our family because there is no leader"), and emotional expression dimension (e.g., "Family members pay attention to each other's feeling"). The higher the score obtained on a dimension, the lower the perceived family functioning of the individual in that dimension will be; conversely, the lower the score obtained on a dimension, the higher the perceived family functioning of the individual in that dimension. To be able to be applied in the Indonesian setting, SRFI II has gone through a process of back translations, expert judgment by two lecturers of Family Psychology, and readability test on five teenagers, a reliability test, and an item analysis. In the expert judgment process, experts provide input to simplify the translated sentences on several items without reducing the real meaning to make items easier for participants

to understand. Cronbach's alpha reliability coefficient for each dimension of SRFI II was .859 for the health/competence dimension, .814 for the conflict dimension, and .698 for the emotional expression dimension. The reliability coefficient of Cronbach's alpha for the cohesion dimension was .266 and the leadership dimension was .541. Given the reliability coefficient of the cohesion dimension was low, the researcher did not include it in the hypothesis test. Meanwhile, item analysis using item rest correlation showed that the majority of SRFI II items had a coefficient > 0.20 . This value implies that the items in SRFI II are reliable (Crocker & Algina, in Azwar, 2016). As for items 13, 18, and 36, the item rests correlation coefficient was < 0.20 . Therefore, the reliability coefficients of the dimensions that overshadowed these items are classified as good and fairly good, thus the researcher maintained these items.

KIDSCREEN 27 developed by Ravens-Sieberer was utilized to measure health-related quality of life variables in this study. KIDSCREEN 27 is an instrument in the form of a self-report questionnaire. The KIDSCREEN 27 statement contains 27 items, with a rating range of five Likert scales and all items are deemed favorable. There are five dimensions in KIDSCREEN 27, namely the physical well-being dimension (e.g., "Have you felt fit and well?"), psychological well-being dimension (e.g., "Have you been in a good mood?"), relationship with parents and independence dimensions (e.g., "Have you been able to talk to your parent(s) when you wanted to?"), social and peer support dimension (e.g., "Have you and your friends helped each other?"), and school environment dimension (e.g., "Have you been happy at school?"). According to The Kidscreen Group Europe (2006) the KIDSCREEN-27 score can be perceived as a unidimensional research instrument. Briefly, the higher the total score obtained, the higher the health-related quality of life perceived by the participants will be. Conversely, the lower the total score obtained, the lower the health-related quality of life perceived by the participants will be. The researcher used the Indonesian version of KIDSCREEN-27 which has been applied in the research of sRahmawati et al. (2019). In this case, the reliability coefficient of Cronbach's alpha obtained was $> .70$. Cronbach's alpha reliability coefficient for KIDSCREEN 27 was .87. Meanwhile, item analysis using item rest correlation showed that the majority of KIDSCREEN 27 items had a coefficient > 0.20 . This value denotes that the items in KIDSCREEN 27 are reliable (Crocker & Algina, in Azwar, 2016). As for item numbers 1, 10, and 11, it attained an item rest correlation coefficient of < 0.20 . Given the reliability coefficients of the dimensions that embraced these items are deemed as good, the researcher maintained these items.

A multiple regression test was used to analyze the main data of the study. Previously, the researcher conducted an assumption test including a normality test, a Pearson correlation test, a linearity test, and a multicollinearity test. Subsequently, a t-test was also completed to examine the difference in scores of health-related quality of life variables in terms of demographic data, especially gender.

RESULTS AND DISCUSSION

Descriptive Statistical Overview Score Dimensions of Family Functioning and Health-related Quality of Life

The results of descriptive statistical analysis showed that the mean score of the health/competence dimension in SRFI II was $M=37.53$ ($SD=10.583$), the conflict dimension score was $M=21.48$ ($SD=6.999$), the emotional expression dimension score was $M=10.39$ ($SD = 3.435$), and the leadership dimension score was $M = 4.66$ ($SD = 2.029$). Meanwhile, the mean score of KIDSCREEN 27 was $M=93.46$ ($SD=11.827$).

Assumption Test

Normality test

The results of the normality test using the Kolmogorov Smirnov which was carried out on the unstandardized residual score between each functioning family dimension (SRFI II) and the total health-related quality of life score (KIDSCREEN 27) showed that the data were normally distributed with a p-value > .05 (table 1).

Table 1.

Normality test of scores on the dimensions of family functioning and health-related quality of life

Dimension	Health/Competency and Health	Conflict and Health	Leadership and Health	Emotion Expression and Health
Kolmogorov-Smirnov	0.046	0.053	0.051	0.046
Asymp. Sig (2-tailed)	0.200*	0.200*	0.200*	0.200*

Linearity Test

The results of the linearity test between the scores for each family functioning dimension and the total health-related quality of life score showed that the data were linear with a significance value of deviation from linearity > 0.05 (table 2).

Table 2.

Linearity test of the scores on the dimensions of family functioning and health-related quality of life

Linearity	F	Sig
Health/Competency and Health-related Quality of Life Dimensions	0.968	0.528
Conflict and Health-related Quality of Life Dimensions	0.904	0.593
Leadership and Health-related Quality of Life Dimensions	0.988	0.450
Emotion Expression and Health-related Quality of Life Dimensions	0.708	0.762

Multicollinearity Test

To detect the presence or absence of multicollinearity symptoms, tolerance and Variance Inflation Factor (VIF) methods were used. There was no multicollinearity in the research data since the tolerance value was > 0.10 and the VIF value was < 10.00.

Table 3.

Multicollinearity test results

Variable	Collinearity Statistics	
	Tolerance	VIF
Health/ Competency	0.119	8.377
Conflict	0.405	2.467
Leadership	0.417	2.401
Emotion Expression	0.339	2.948

Correlation Test

The results of the Pearson Product Moment correlation test showed that there was a significant negative correlation between the scores of the dimensions of family functioning and the health-related quality of life scores among the participants of this study, with a significance

value of $p < .05$ (table 4), which was signed with a negative correlation direction. According to Beavers & Hampson (2000), high SRFI II scores specify low family functioning; on the other hand, low scores indicate high family functioning. Concurrently, according to The KIDSCREEN Group Europe (2006), a lower KIDSCREEN 27 score indicates a lower health-related quality of life in individuals and vice versa. Therefore, a negative correlation direction indicates the lower family functioning in each dimension of SRFI II, as a result, the lower the health-related quality of life among participants.

Table 4.
 Correlation test results

Variable	Pearson Correlation	Sig. (2-tailed)
Health/ Competency	-0.522**	0.000
Conflict	-0.410**	0.000
Leadership	-0.370**	0.000
Emotion Expression	-0.466**	0.000

T-Test

Based on the results of the independent t-test, it was found that there were differences in health-related quality of life scores between male and female participants ($F = 1.420$; sig $p = .000$).

Hypothesis testing

Multiple regression analysis showed that there was a significant effect of the dimensions of family functioning on health-related quality of life simultaneously ($F = 8.320$; sig $p = 0.000$), with a total contribution of 28.8%. Meanwhile, when viewed partially or on the respective dimension (individually or independently) according to a significant t value, there was no significant effect of each dimension of family functioning on the health-related quality of life among participants involved. The complete hypothesis test results are presented in Table 5.

Table 5.
 Multiple regression test results

	R	R ²	F	Sig	B	t	Sig
Simultaneously	0.536	0.288	8.320	0.000			
Constant					118.196	27.053	0.000
Health/ Competency					-0.315	-1.171	0.244
Conflict					-0.195	-0.885	0.378
Leadership					0.391	0.520	0.604
Emotion Expression					-0.588	-1.195	0.235

The findings of this study imply that there was a significant simultaneous influence of the dimensions of family functioning on the health-related quality of life among adolescents with low socioeconomic status sampled in this research ($F = 8.320$; sig $p = 0.000$), with a total contribution of 28.8%. This finding corroborates the bioecological theory proposed by Bronfenbrenner (in Gamayanti, 2014) that individual development is influenced by the microsystem or the immediate environment, in this case, the family.

This finding enforces the results of former studies that family functioning contributed to

health-related quality of life. It is evidenced by the results of Herzer et al. (2011) who discovered that adolescents with inflammatory bowel infections had a significantly lower health-related quality of life when family communication was inefficient, which is an indicator of dysfunctional families (R. Beavers & Hampson, 2000). Furthermore, other research findings exhibit that adolescents whose families are dysfunctional appear to have difficulty managing emotions, which in turn may hinder the quality of life in the psychological well-being (Butler, 2015). The results of other studies also disclosed that families who could carry out their functions well allowed parents to develop closeness easier with their teenagers (Li, L., Bai et al., 2018), which could facilitate adolescents achieving health-related quality of life in the relationship with parents (R. Beavers & Hampson, 2000).

The findings of this study show that the dimensions of family functioning simultaneously contributed to the health-related quality of life by 28.8%. Simply, there were 71.2% of other factors that could explain health-related quality of life. These various factors may differ in form, such as self-compassion, resilience, and gratitude (Adine et al., 2018; Hasibuan et al., 2018; Krisnayanti et al., 2018; Nurtsani & Listiyandini, 2018; Wijayanti et al., 2020).

Regardless of the dimensions of family functioning simultaneously playing a pivotal role in health-related quality of life, this is not the case partially. This denotes that to be able to contribute to the health-related quality of life of the participants, the family must possess characteristics that are seen as a unity: healthy/competent relationships, the ability to manage conflict, the presence of a reliable leader, cohesion, and empathic, warm emotional expression. When a family holds all of these characteristics, it becomes a well-functioning family (Beaver & Hampson, 2003). It can also be understood that to be able to contribute to adolescent development, the characteristics of this family cannot stand alone but interact together as a unit.

The results of the Pearson correlation test showed that the relationship between leadership dimensions in family functioning and health-related quality of life resulted in the lowest correlation strength ($R = -.370$; $p = .000$) compared to other dimensions. Family functioning in the leadership dimension is characterized by the assignment of chores in the home, such as a mother cooking for the family, older children taking care of the younger children, and a father going to (W. R. Beavers & Hampson, 2003). However, this may not be experienced optimally by the families of the participants in this study. Poverty makes the assignment of roles in the family obscure. For instance, the mother takes care not only of the house but also helps the father earn a living, or the children cook and find livelihood as well. On the one hand, this implies that the assignment of roles in the family is not rigid and there is flexibility, therefore it can promote cooperation between family members. However, on the other side, when the mother and children also play the role of breadwinners, they have the same portion as the father in making decisions in the family. Under such conditions, it may be challenging in one family to identify a dominant leader who can direct all family members, final decision-makers, or the main accountable person because all family members feel they have the same apportion. Without a leader, it may trigger chaos in the dynamics of family life.

The findings of this study also found that there were differences in health-related quality of life scores in male and female participants. This is following the findings of Gaspar et al. (2009) that there were differences in health-related quality of life scores in adolescent males and females. The findings of this study also expressed that female adolescents had a higher health-related quality of life scores than boys. This is similar to the findings of Sunarti et al. (2018) that adolescent girls could solve life's problems better than boys. Good problem-solving skills can improve the quality of life (Meyers et al., 2011).

This research expands the understanding of the importance of involving family variables or other microsystems around the individual in assessing health-related quality of life. Previous studies on health-related quality of life focus more on exploring personal factors that are assumed to correlate or contribute to it, such as self-compassion, resilience, the role of gratitude, and so on (Adine et al., 2018; Hasibuan et al., 2018; Krisnayanti et al., 2018; Palu & Nurdin, 2014; Nursani & Listiyandini, 2018; Wijayanti et al., 2020; Yudha, 2014).

This research has some limitations. The criteria for low socioeconomic status in this study refer to those specified by Statistics Indonesia of East Kalimantan, namely household income of less than IDR 2.3 million per month. To ensure that the participants met these criteria, the researcher asked the (prospective) participants about the income of their families in one month. Related to this, there is a potential for participants' inaccuracy in providing reliable answers regarding the income of their parents or family. The criteria for low socioeconomic status should be determined based on more objective data, such as data from the village office or sub-district office where the participants reside. Another limitation is that the sample in this study is not representative in terms of the youth population from low socioeconomic classes in East Kalimantan or Indonesia in general because the number of samples used in the study only covered 0.047% of the total low-income population in East Kalimantan when conducting this research (Statistics Indonesia of East Kalimantan Province, 2021). Therefore, there should be prudence in generalizing the findings of this study in a wider context.

CONCLUSION

The results of this study suggest that there was a simultaneously significant role of the dimensions of family functioning on health-related quality of life. These findings indicate that a functional family can facilitate adolescents with low socioeconomic status to achieve a good health-related quality of life. The development of interventions to improve the health-related quality of life in adolescents with low socioeconomic status can involve the family, among others, by providing education to families regarding optimizing family functioning and increasing the portion of the family's role in the planning and implementation of health-related quality of life interventions. Relevant parties (such as family supervision institutions, government agencies that focus on the welfare of citizens, mental health services, and communities of family welfare) can help low socioeconomic families to be empowered and able to provide for the needs of members, own reliable leaders, have openness, warmth, and caring between family members, which are characteristics of a family functioning.

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