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Exploring Perceived Family Distress and Negative Emotional States among Indonesian Adolescents

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Abstract---

Purpose: *Mental health problems related to negative emotional states are important factors in adolescents' development. Perceived family distress can be considered as one of the contributing factors. This study aims to describe the perceived family distress of Indonesian adolescents and its association with negative emotional states.*

Methodology: *A total of 909 Indonesian students from a public vocational high school were involved in this study (M_{Age}=15.93; SD_{Age}=.909; male=60.3%; female=39.7%). The Brief Family Distress Scale was used to measure perceived family distress, whereas negative emotional states was measured with the Depression Anxiety Stress Scale. Analysis was conducted with descriptive (by using crosstabs) and inferential statistics (both correlational and comparative).*

Results: *The results of categorization of perceived family distress (M=2.36; SD=1,695) showed that 83.1% were in the "no impairment", 9.2% in the "moderate impairment", and 7.8% in the "marked impairment". Sex, parents' marriage status, and live mate predicted perceived family distress. Perceived family distress was positively related to depression, anxiety, and stress. The increasing degree of perceived family distress was followed by the decrease in the percentage of subjects. But the majority of subjects at each level of family distress still had a normal negative emotional state.*

Applications/Originality/Value: *These results add to the description of perceived family distress among adolescents with collectivistic culture, especially from Indonesia. They can be considered by researchers in future studies focused on family distress and mental health, and practitioners in future interventions that help minimize the impact of perceived family distress to achieve optimal mental health.*

Keywords--- *Indonesian Adolescents, Distress and Negative, Exploring Perceived.*

I. INTRODUCTION

Mental health in adolescents and young adults is an important factor in individual development. Adolescents with healthy mental condition are physically healthier, more positive in social behaviors, and less risky behaviors (David, Park, & Mulye, 2010). Conversely, mental disorders in adolescents not properly addressed have severe influence on children's development, adolescents' disfunctioning, schoolwork, attendance, educational achievement, and potentials to be fulfilling and productive (WHO, 2018; WHO, 2019). Adolescent mental health problems may further extend to adulthood (Costello, Copeland, & Angold, 2011; Jones, 2013), disrupt transition to adulthood even

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if the problems do not persist into adulthood and even if the problems are subthreshold (Copeland, Wolke, Shanahan, & Costello, 2015). Half of all mental health cases in adult life start by the age of 14 and 75% by the age of 18 (Murphy & Fonagy, 2012). This number increases to three fourth by the age of 24 (Kessler et al., 2005).

Mental health issues constitute a major burden of disease for adolescents globally. Worldwide, it is estimated that 10–20% of adolescents experience mental health conditions, yet these remain underdiagnosed and undertreated (WHO, 2018). It is estimated that up to one in five adolescents will experience a mental disorder each year in which self-harm is the third leading cause of death for adolescents (UNICEF, 2019). In addition, both depression and anxiety become the ninth and eighth leading causes of illness and disability among all adolescents (WHO, 2018). The most common mental health problems found in adolescents are conduct disorders, depressions, anxiety disorders, and attention deficit/hyperactivity disorder, autism spectrum disorders, and substance use (David et al., 2010; Murphy & Fonagy, 2012). One in every five adolescents experiences significant symptoms of emotional distress (David et al., 2010). Among Indonesia adolescents, National Health Research reported that the prevalence of mental emotional disorders among adolescents of 15 years of age increased 3.8% from 6% in 2013 to 9,8% in 2018 (Balitbangkes, 2018). Previous research in Malang showed that 53.2% adolescents were at high-level of psychological distress (Widyasari & Yuniardi, 2019). In addition, 28.2% of 452 adolescent undergraduate students in Semarang suffered from depression from borderline to severe level (Kaloeti et al., 2018).

Many research has identified factors that strengthen resilience against problems among adolescents (David et al., 2010). Family cohesion is associated to higher levels of commitment, ruminative exploration, and exploration in depth. Specifically, affective bonding with the family can be a secure basis for adolescents to simultaneously explore their current identity commitment considered as a healthy stage of psychosocial development by Erikson (Prioste, Tavares, Silva, & Magalhães, 2019). Meanwhile, family crisis has been identified as one of the most important factors that influence the prevalence of mental disorder in children and young people in the form of problematic internalizing and externalizing behaviors (e.g. Greeson et al., 2011; Howell, 2011; Reiss, 2013) and more impairment due to mental and physical health problems in their adult years (e.g. Herrenkohl, Hong, Klika, Herrenkohl, & Russo, 2012; Sugaya et al., 2012).

Roberts (2000) defined crisis as an acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and distress and functional impairment emerged. Crisis in the family can include depression, marital discord, poor sibling adjustment, increasing parent stress (Weiss & Lunsky, 2011), complex trauma exposure from family in the form of physical abuse, sexual abuse, emotional abuse, neglect, domestic violence, intimate partner violence (Greeson et al., 2011; Tailor, Stewart-Tufescu, & Piotrowski, 2015), parents' marital status (divorce and remarriage) and relationship distress (Amato & Kane, 2011), family with member who needs palliative care (Hudson, 2013) or chronically-ill child (Gray, Graef, Schuman, Janicke, & Hommel, 2013). The 2004 B- CAMHS survey found that mental disorder were higher in young people with lone-parent (16%) compared with two-parent families (8%) (Green, McGinnity, Meltzer, Ford, & Goodman, 2005). Lone-parent, reconstituted families, no educational qualification parents, jobless parents, and hard pressed living area are some risk factors that can develop mental health problems in children and young people (Murphy & Fonagy, 2012).

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Similar results in previous studies were also found in Indonesia. A study conducted at Dr. Moewardi Hospital in diabetic patients concluded that high family support resulted in poor behavior of distress and conversely, low family support resulted in higher behavioral distress (Wardani& Pratiwi, 2017).Some research also identifiedthat there was a negative relationship betweenadolescent'sperception of family harmony with juvenile delinquency (Nawafilaty, 2016; Mulyasari, 2010). While other research found that there was a significant positive relationship between perception of parent's participation in parenting with maturity emotions in teens(Syarifah, Widodo, & Kristiana, 2012). A study conducted at 102 junior and senior high school students showed that their Perception on Interparental Conflict had adirect significant effect on anxiety as well as depression (Sholichah, 2018). Meanwhile, another study concluded that there was a positive and significant relationship between the harmony level of family and the adolescent's self-concept (Isminayah & Supandi, 2016). The above background confirms that family crisis is an important thing to be considered in terms of mental health problems. How Indonesian adolescents viewed their family crisis, referred to as perceived family distress in this study (Weiss & Lunsky, 2011), is important to be further examined. This study aims to describe the perceived family distress of Indonesian adolescents and its association with negative emotional states, i.e. depression, anxiety, and stress. This study is also intended to evaluate the construct validity of BFDS by studying its correlation with constructs related to mental health problems.

II. METHODS

This quantitative cross-sectional study involved Indonesian adolescents as participants. We present descriptive data on family crises assessments, which we refer to as perceived family distress, measured with The Brief Family Distress Scale (BFDS; Weiss & Lunsky, 2011). Tests on the correlations and differences in the level of perceived family distress according to some demographic characteristics as well as cross tabulations of the perceived distress category with other psychological variables were also carried out to get a description of the participants. The findings are based on participants' responses to questionnaires of demographic information and psychological scales of the constructs mentioned above. Concerning the correlation testing with psychological constructs, we hypothesized that perceived family distress would be positively correlated with negative emotional states (depression, anxiety, and stress).

Participants

The participants of this study were 909 students from a vocational high school in Semarang, Indonesia with the range of age between 14 and 18 years (M_{Age}=15.93; SD_{Age}=.909). Vocational high school was chosen because the decision of students to take vocational education is determined by family conditions such as economic conditions as well as the nature of parents' work and income (Maryati, 2009). By choosing vocational schools, parents expect to have greater opportunities for their children to find work in competitive life so that they can immediately reduce family's economic burden (Maryati, 2009). Previous research found that the family's socioeconomic position affects the life course development and interrelationships of family members (Conger, Conger, & Martin, 2010), appears to put stress on families in general, is associated with less satisfaction with several areas of family functioning, lower social support and quality of life than non-low-income families (Mansfield, Dealy, & Keitner, 2013). Although there are individual differences during childhood and adolescence, those conditions are then expected to help shape

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economic and educational achievements and also competence as a parent and romantic partner during adulthood (Conger et al., 2010). Participants were obtained using proportionate cluster random sampling representing students from grade X, XI, and XII. Only half of grade XII students were involved in this study because the other half were undergoing an internship for 1 semester. Participants consisted of 548 males (60.3%) and 361 females (39.7%). The majority of participants (n = 900) were Javanese (99.1%), while the rest were from other ethnic groups in Indonesia (n=9; 0.9%). Table 1 shows in more detail the characteristics of the participants.

Measures

Perceived Family Distress

Perceived family distress, which we have previously referred to family crisis assessments in this study, was measured with the Indonesian version of The Brief Family Distress Scale (BFDS; Weiss & Lunsky, 2011). BFDS is a single item scale that requires participants to rate where they and their families were in terms of crisis on a 10-point scale. Each point was grounded in the statement describing a point along the continuum from no stress to complete crisis. The response to this scale is divided into crisis groups, namely the 'no impairment' group or have a normal level of perceived family distress (responding 1 to 3), the 'moderate impairment' group or being in the category of non-referred level of distress (responding 4 to 5), and the 'marked impairment' groups are divided into the close to crisis group (responding 6 to 7) and the crisis group (responding 8 to 10).

Negative Emotional States

Negative emotional states in this study were measured with the Depression Anxiety Stress Scale (DASS) which was originally developed by Lovibond and Lovibond (1995). The short-form version of the DASS-21 has been tested in a large non-clinical sample (Henry & Crawford, 2005). The subscales of the DASS-21 may measure the three dimensions specified in the tripartite model (Brown, Chorpita, Korotitsch, & Barlow, 1997); low positive affectivity (DASS-Depression), physiological hyperarousal (DASS-Anxiety), and negative affectivity (DASS-Stress). This scale was then translated into Indonesian by Damanik (2011). Cronbach α examination results for DASS-21 was .871; while the Cronbach α for the depression, anxiety, and stress subscales were respectively .799, .662, and .726. Participants were asked to choose one of the responses within the range of 0 to 3 ('0' means 'the response does not suit me at all, or never' to '3' means 'very much matches me, or very often') on each item to describe their experiences during the past week. The total score was obtained from the sum of all responses, while the total score on each subscale was obtained by adding up all responses on that subscale. Participants were then grouped into five level categories, i.e. 'normal' (score $x<10$ for depression, score $x<8$ for anxiety, score $x<15$ for stress), 'mild' (score $10\leq x<14$ for depression, score $8\leq x<10$ for anxiety, score $15\leq x<19$ for stress), 'moderate' (score $14\leq x<21$ for depression, score $10\leq x<15$ for anxiety, score $19\leq x<26$ for stress), 'severe' (score $21\leq x<28$ for depression, score $15\leq x<20$ for anxiety, score $26\leq x<34$ for stress), and 'profound' (score $x\geq 28$ for depression, score $x\geq 20$ for anxiety , score $x\geq 34$ for stress).

Procedure

After conducting a literature study, researchers submitted a research permit letter to involve students in a vocational school. Participants were selected through proportionate cluster random sampling by taking into account

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the proportions of students in grade X, XI, and XII. Approval from the participants to engage in data collection activities voluntarily, as indicated by the signing of informed consent forms voluntarily, was conducted to meet ethical standards. The booklet was responded manually as soon as it was distributed and completed between 15 and 30 minutes.

III. RESULTS

Descriptive Statistics of Perceived Family Distress

Besides showing the number and percentage of participants based on several characteristics, Table 1 also shows descriptive statistics (mean and standard deviation) of perceived family distress. Characteristics are seen by considering several indicators, namely sex, school grade, age, tribe, birth order, total siblings, parents' marriage status, and live mate. The difference in the mean can be used as a reference level of perceived family distress on each characteristic if it is proven to be significantly different.

Table 1: Characteristics of research participants and descriptive statistics of perceived family distress.

Characteristics	**Total (%)**	**Descriptive Statistics of Perceived Family Distress**	
		Mean	**Std. Deviation**
Sex			
Male	548 (60.3)	2.24	1.665
Female	361 (39.7)	2.55	1.725
School Grade			
X	355 (39.1)	2.34	1.718
XI	358 (39.4)	2.31	1.656
XII	196 (21.6)	2.50	1.723
Age (years old)			
14	25 (2.8)	2.56	2.434
15	300 (33.0)	2.35	1.720
16	334 (36.7)	2.17	1.436
17	218 (24.0)	2.64	1.887
18	32 (3.5)	2.47	1.722
Tribe			
Javanese	900 (99.1)	2.36	1.693
Other Tribes	9 (0.9)	2.89	1.900
Birth Order			
Only Child	84 (9.2)	2.48	1.853
Oldest Child	335 (36.9)	2.49	1.847
Middle Child	159 (17.5)	2.56	1.597
Youngest Child	331 (36.4)	2.11	1.504
Total Siblings			
1	84 (9.2)	2.48	1.853
2	410 (45.1)	2.30	1.756
3	270 (29.7)	2.32	1.479
4	105 (11.6)	2.37	1.625
> 4	40 (4.4)	3.10	2.110
Parents' Marriage Status			
Married	775 (85.3)	2.27	1.610
Others (divorced, separated, or separated due to spouse's death)	134 (14.7)	2.93	2.040
Live Mate			
Both Parents	738 (81.2)	2.24	1.595
One of Parents	124 (13.6)	2.88	2.074
Others (other relatives, guardians, or live alone)	47 (5.2)	3.00	1.745

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Figure 1 portrays the histogram of perceived family distress data distribution based on participants' responses. Examination using One-Sample Kolmogorov-Smirnov Test showed test statistic =.322 (p=.000) which means that the data was not normally distributed. The response ranged from a mean of 2.38 (SD=1.695), with the majority of responses at the normal level of perceived family distress (no impairment), successively from the most, i.e. level 2 (367 people; 40.4%), level 1 (303 people; 33.3%), and level 3 (85 people; 9.4%).

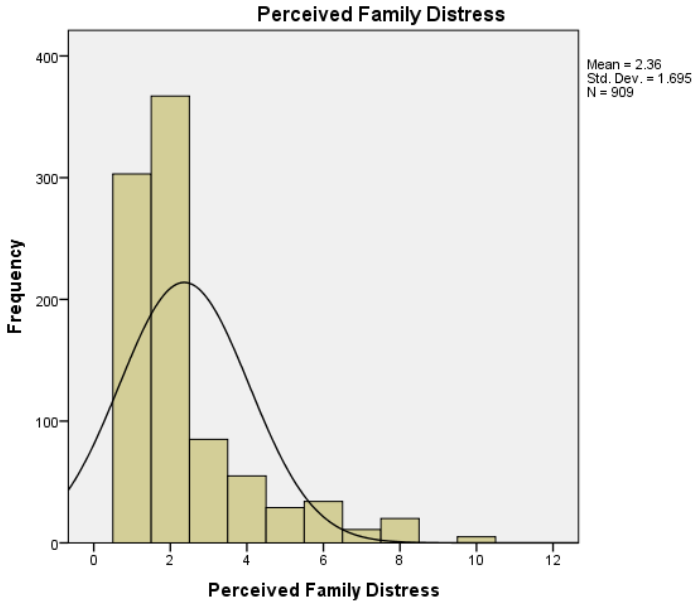

Figure 1: Histogram of perceived family distress data distribution based on participants' responses

Table 2 shows the grouping of participants into crisis groups, namely no impairment (83.1% at 'normal level' with a score of 1 to 3), moderate impairment (9.2% at 'non-referred level of distress' with a score of 4 to 5), and marked impairment (7.8%; i.e. 5.0% at 'close to crisis level' with a score of 6 to 7 and 2.8% at 'crisis level' with a score of 8 to 10).

Table 2: Data distribution of perceived family distress based on category.

Category	**Frequency**	**Percent**	**Valid Percent**	**Cumulative Percent**	**Note**
Normal	755	83.1	83.1	83.1	No Impairment
Non-Referred Level of Distress	84	9.2	9.2	92.3	Moderate Impairment
Close to Crisis	45	5.0	5.0	97.2	Marked Impairment
Crisis	25	2.8	2.8	100.0	
Total	909	100.0	100.0		

Cross tabulations were also performed to see the data distribution in each psychological construct at each level of perceived family distress (Table 3). The increasing degree of perceived family distress was followed by the decrease in the percentage of subjects. But the majority of subjects at each level of perceived family distress still had a normal level of negative emotional state (e.g. in a crisis situation, 76.0% of participants had normal levels of depression, 64.0% had normal levels of anxiety, 84.0% had normal levels of stress; e.g. in a close to crisis situation, 82.2% of

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participants had normal levels of depression, 62.2% had normal levels of anxiety, 93.3% had normal levels of stress).

Table 3: Results of crosstabs analysis of perceived family distress with other psychological variables.

Other Psychological Constructs		**Perceived Family Distress**				**Total (%)**
		Normal (%)	**Non-Referred Level of Distress (%)**	**Close to Crisis (%)**	**Crisis (%)**	
Depression	Normal	732 (97.0)	69 (82.1)	37 (82.2)	19 (76.0)	857 (94.3)
	Mild	18 (2.4)	12 (14.3)	5 (11.1)	5 (20.0)	40 (4.4)
	Moderate	5 (0.7)	3 (3.6)	2 (4.4)	1 (4.0)	11 (1.2)
	Severe	0 (0.0)	0 (0.0)	1 (2.2)	0 (0.0)	1 (0.1)
Anxiety	Normal	644 (85.3)	54 (64.3)	28 (62.2)	16 (64.0)	742 (81.6)
	Mild	75 (9.9)	14 (16.7)	8 (17.8)	2 (8.0)	99 (10.9)
	Moderate	34 (4.5)	12 (14.3)	7 (15.6)	7 (28.0)	60 (6.6)
	Severe	2 (0.3)	3 (3.6)	2 (4.4)	0 (0.0)	7 (0.8)
	Profound	0 (0.0)	1 (1.2)	0 (0.0)	0 (0.0)	1 (0.1)
Stress	Normal	751 (99.5)	76 (90.5)	42 (93.3)	21 (84.0)	890 (97.9)
	Mild	4 (0.5)	8 (9.5)	1 (2.2)	4 (16.0)	17 (1.9)
	Moderate	0 (0.0)	0 (0.0)	2 (4.4)	0 (0.0)	2 (0.2)

Examination of The Effect of Demographic Characteristics

The correlation between demographic characteristics and perceived family distress was examined with Spearman's rho. As shown in Table 4, significant correlations were found between sex, birth order, parents' marriage status, and live mate with perceived family distress, while school grade, age, tribe, and total sibling were not significantly correlated.

Table 4: Correlation between demographic characteristics of participants and perceived family distress.

		Perceived Family Distress	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1. Sex	r_{xy}	.121**							
	p	.000							
2. School Grade	r_{xy}	.045	.019						
	p	.174	.569						
3. Age	r_{xy}	.060	-.062	.790**					
	p	.070	.060	.000					
4. Tribe	r_{xy}	.041	.055	.095**	.107**				
	p	.221	.097	.004	.001				
5. Birth Order	r_{xy}	-.076*	-.022	.021	.089**	-.023			
	p	.021	.505	.534	.007	.483			
6. Total Siblings	r_{xy}	.063	-.023	.047	.097**	-.004	.365**		
	p	.056	.494	.159	.003	.896	.000		
7. Birth Order	r_{xy}	-.045	-.025	.015	.104**	-.002			
	p	.179	.443	.654	.002	.958			
8. Total Siblings	r_{xy}	.061	-.028	.049	.098**	-.003	.546**		
	p	.065	.400	.139	.003	.928	.000		
9. Parents Marriage Status	r_{xy}	.126**	-.020	-.018	.045	-.042	.036	-.038	
	p	.000	.539	.583	.172	.210	.283	.246	
10. Live Mate	r_{xy}	.158**	-.020	.008	.047	-.021	.045	.014	.810**
	p	.000	.551	.814	.153	.526	.180	.669	.000

**. Correlation is significant at the 0.01 level (2-tailed).

The Man-Whitney U Test and the Kruskal Wallis Test were conducted to see how differences in perceived family distress were assessed according to categorical characteristics (Table 5). The results were consistent with the correlation test above. Perceived family distress was not differed significantly by school grade and tribe

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(successively χ^2 =3.038, p=.219; χ^2 =-1,225, p=.220), on the contrary was differed significantly by sex, birth order, parents' marriage status, and live mate (respectively χ^2 =-3,643, p=.000; χ^2 =16,354, p=.001;χ^2 =-3.793, p=.000; χ^2 =23.751, p=.000). The mean of perceived family distress level in females (M=2.55; SD=1.725) was higher than males (M=2.24; SD=1.665). The mean of perceived family distress level in married parents (M=2.27; SD=1.610) was lower than others status - divorced, separated, or separated due to spouse's death (M=2.93; SD=2.040). While the mean of perceived family distress level from the lowest to the highest based on live mate, i.e. students living with both parents (M=2.24; SD=1.595), students living with one of the two parents (M=2.88; SD=2,074), and students living with other relatives, guardians, or live alone (M=3.00; SD=1,745).Differences according to birth order showed a distinctive pattern, from only child (M=2.48; SD=1.853) and oldest child (M=2.49; SD=1.847), increasing to the highest distress in middle child (M=2.56; SD=1.597), then decreasing to the lowest distress in youngest child (M=2.11; SD=1.504).

Table 4 also shows how negative emotional states were distinguished based on other categorized variables. The results vary, but sex differences across all variables showed consistently significant, where the mean of negative emotional states (both depression, anxiety, and stress) in women were higher (respectively M=3.91, SD=3.421; M=5.82, SD=3.049; and M=7.20, SD=3.342) than in men (respectively M=2.71, SD=3.090; M=4.42, SD=2.927; M=5.84, SD=3.413).

Table 5: Differences in perceived family distress, and negative emotional states according to categorical variables.

Grouping Variable	**Perceived Family Distress**		**Depression**		**Anxiety**		**Stress**	
	χ^2	**p**	χ^2	**p**	χ^2	**p**	χ^2	**p**
1. Sex	-3.643**	.000	37.674**	.000	51.469**	.000	39.510**	.000
2. School Grade	3.038	.219	9.011*	.011	6.116*	.047	15.262**	.000
3. Tribe	-1.225	.220	.371	.542	1.083	.298	1.212	.271
4. Birth Order	16.354**	.001	1.303	.728	.979	.806	3.732	.292
5. Parents Marriage Status	-3.793**	.000	8.119**	.004	5.532*	.019	3.815	.051
6. Live Mate	23.751**	.000	7.301*	.026	4.934	.085	4.618	.099
*. Difference is significant at the 0.05 level (2-tailed).								
**. Difference is significant at the 0.01 level (2-tailed).								

Examination of Bivariate Correlation among Psychological Variables

Finally, correlations, means, and standard deviations were computed for each scale and are listed in Table 6. The calculation of Spearman's rho showed that there was a positive and significant correlation between perceived family distress and negative emotional states, both depression, anxiety, and stress.

Table 6: Correlation of perceived family distress and negative emotional states.

		Perceived Family Distress	**1**	**1a**	**1b**	**1c**
1. Negative Emotional States	r_{xy}	.337**				
	p	.000				
a. Depression	r_{xy}	.306**	.821**			
	p	.000	.000			
b. Anxiety	r_{xy}	.262**	.844**	.609**		
	p	.000	.000	.000		
c. Stress	r_{xy}	.290**	.847**	.540**	.558**	
	p	.000	.000	.000	.000	
M		2.36	14.54	3.19	4.97	6.38
SD		1.695	8.367	3.276	3.053	3.449
**. Correlation is significant at the 0.01 level (2-tailed).						

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IV. DISCUSSION

The results of this study explained that the majority of participants were at the normal level of perceived family distress (83.1%). Only 9.2% and 7.8% experienced impairments at moderate and marked levels. Furthermore, the results of cross tabulations indicated that the majority of participants at each level of perceived family distress still have a normal level of negative emotional state (whether it was depression, anxiety, or stress), even when they were at a moderate and marked impairment level. These percentages indicate that non-normative life events, in this case family distress, will be experienced by a small proportion of the adolescent population; whereas conversely, the majority will experience a more normative or commonly experienced life (Papalia, Olds, & Feldman, 2009). Even without work responsibilities in adolescence or anticipating a very curtailed life span, hardship in several domains during childhood and adolescence (feeling unsafe in their schools or neighborhoods, witnessing or being victims of violence, having fewer economic resources in the household, and living in certain family structures) is associated with feeling relatively older (older subjective ages) and self-identifying as an adult in the late teens and twenties (Johnson & Mollborn, 2009). This might appear to contradict with common characteristics in adolescent experiences that are generally characterized by elevated stress, heightened risky behaviors, and increases in psychopathology. Reported by Silk et.al. (2009) and Tottenham, Hare, and Casey (2011) that adolescents experience greater fluctuations in daily emotional states, more extreme emotional experiences (both positive and negative), and stronger biases and faster reaction times toward emotional stimulation compared with children and adults.

We tried to explain these results in three ways, first, previous evidence of increased fluctuations in adolescents was observed as a result of comparison with other life periods (adolescents show a higher level than younger adolescents or childhood, and adulthood period) (Graber, 2013); while within the population itself, based on group norms, adolescents with negative emotional state experiences and non-normative life events remain in a smaller percentage (Balázs et.al., 2013). Second, collectivistic culture might also influence adolescent responses in the experience of family distress. Previous findingsshowed that adolescents who self-identified as collectivist were more likely to be achieved status and less likely to be diffused than either the individualistic or transitional groups (Lee, Beckert, & Goodrich, 2009). Lee et.al., (2009) also reported that collectivistic oriented youth had significantly higher scores in voicing opinions, self-assessing, and evaluative thinking. Furthermore, the achievement of identity would ultimately influence mental health, whereas identity distress was associated with psychopathological symptoms in adolescents (Wiley & Berman, 2013).

The last reason offered, was related to skeptical perspective on coping strategies in adolescents. Avoidant coping as in the case of conflict avoidance in relationships (Ubinger, Reliable, & Massura, 2013) or the extensive use of the internet in facing emotional or social difficulties (McNicol & Thorsteinsson, 2017) could not be ignored as having a role in overcoming problems by alleviating negative emotional states. It alleviated the problems temporarily because the nature of the coping strategy was not really overcoming the problem or the negative emotions more comprehensively and adaptively. Only then, this avoidant coping would lead to psychological symptoms in adolescents (Ubinger et.al., 2013), worse mental health outcomes and greater reports of physical health symptoms (Boals, vanDellen, & Banks, 2011). The third cause then implicates for the need of further research on adolescent

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coping today when they feel more family-related distress, especially among Indonesian adolescents, to certain coping adaptability in reducing negative emotional state.

The results of correlation and comparative testing in this study both sex, birth order, parents' marriage status, and live mate were related to perceived family distress. Men, the youngest child, adolescents with married parental status, and those who live with both parents, showed lower level of perceived family distress than women, the middle child, adolescents with other parents' marriage status (divorced, separated, or separated due to spouse's death), and those who live with a single parent, farther those who live with other than parents (other relatives, guardians, or live alone). Previous evidence explained that female adolescents consistently had greater vulnerability to experiencing symptomatology. Adolescent female groups were reported to have significantly higher level of emotional and behavioral problems, and experience greater peer chronic stress being the most likely to develop depression than men (Kaess et.al., 2011; Hankin et.al., 2015).Previous study that the birth order affected the psychological condition of young adults had been conducted (see Sudha & Anubhuti, 2014). The results of the study clearly confirmed that the oldest child had a higher distress level than the youngest child, and the youngest child had the lowest distress level. However, support that the middle child experiences the highest level of distress compared to the only child, the oldest child, and the youngest child still needs to be sought. The condition that the middle child is an 'abandoned' child may explain this. Furthermore, this study explained the influence of family situations such as parental relations and the presence of parents in playing a great role. Non-normative life events and distressing experiences in adolescence related to their family conditions also influence the development and functioning of adolescents in general, and the symptomatology development in particular (e.g. Reeb, Conger, & Wu, 2010; Rousseau et.al., 2014).Previous research in Indonesia agreed that family functioning was an important factor for support for self-improvement and the welfare of children and adolescents (Dewi & Soekandar, 2019; Ruswahyuningsih & Afiatin, 2015).

V. CONCLUSION

The increasing degree of perceived family distress was followed by the decrease in the percentage of subjects. But the majority of subjects at each level of perceived family distress still had a normal level of negative emotional state. Sex, parents' marriage status, and live mate predicted perceived family distress. There was a positive and significant correlation between perceived family distress and negative emotional states, both depression, anxiety, and stress. These results add to the description of perceived family distress among adolescents with collectivistic culture, especially from Indonesia. They can be considered by researchers in future studies focused on family distress and Mental health, specifically it can be directed by paying attention to cross-cultural studies and nowadays 'superficial' coping strategies in adolescents. Practitioners can also consider the results above in future interventions that help minimize the impact of perceived family distress to achieve optimal mental health.

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