http://www.dx.doi.org/10.14718/ACP.2019.22.1.5

Problemas emocionais e comportamentais nas crianças: associação entre funcionamento familiar, coparentalidade e relação conjugal

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How to quote this article: De Souza, J. & Crepaldi, M.A. (2019). Emotional and Behavioral Problems of Children: Association between Family Functioning, Coparenting and Marital Relationship. *Acta Colombiana de Psicología,* 22(1), 95-106. doi: http://www.dx.doi.org/10.14718/ACP.2019.22.1.5

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Recibido, enero 3/2018; Concepto de evaluación, abril 20/2018; Aceptado, mayo 16/2018

Resumo

Este estudo teve como objetivo descrever o funcionamento familiar, a relação conjugal e a coparentalidade em famílias, além de identificar as associações entre essas variáveis com problemas emocionais e comportamentais em crianças de 5 a 11 anos. No total, foram entrevistadas 50 mães cujos filhos seguiam tratamento psicológico nos Serviços de Saúde Pública. Os instrumentos utilizados foram FACES IV, a Entrevista de Identificação Familiar, o SDQ, a Escala de Relação Coparental, o Inventário de Percepção Parental (PPI) e a Escala Floreal. Os resultados indicam que o funcionamento familiar emaranhado se encontra correlacionado com sintomas de hiperatividade e com problemas de relacionamento e de conduta na criança; enquanto uma boa relação mãe-filho correlaciona negativamente com sintomas de hiperatividade e dificuldades emocionais; as práticas educativas negativas correlacionam positivamente com problemas de comportamento, emocionais e sintomas de hiperatividade. Finalmente, o funcionamento familiar emaranhado teve maior repercussão nos sintomas de problemas de conduta e de relacionamento com pares. Os resultados sugerem que diferentes tipos de problemas emocionais e comportamentais da criança são influenciados e influenciam diferentemente a dinâmica familiar, e que o funcionamento da família está associado com a saúde mental da criança.
Palavras-chave: funcionamento familiar, coparentalidade, infância, saúde mental, psicologia da família.

Problemas emocionales y comportamentales en los niños: asociación entre el funcionamiento familiar, la coparentalidad y la relación conyugal

Resumen

El presente estudio tuvo como objetivo describir el funcionamiento familiar, la relación conyugal y la coparentalidad en familias, además de identificar las asociaciones entre estas variables con problemas emocionales y comportamentales en niños de 5 a 11 años. En total, se entrevistó a 50 madres cuyos hijos seguían tratamiento psicológico en los Servicios de Salud Pública. Los instrumentos utilizados fueron el FACES IV, la Entrevista de Identificación Familiar, el SDQ, la Escala de Relación Coparental, el Inventario de Percepción Parental (PPI) y la Escala Floreal. Los resultados señalan que el funcionamiento familiar enmarañado se encuentra correlacionado con síntomas de hiperactividad y con problemas relacionales y conductuales en el niño; mientras que una buena relación madre-hijo correlaciona negativamente con síntomas de hiperactividad y dificultades emocionales; y las prácticas educativas negativas correlacionan positivamente con problemas de comportamiento, síntomas de hiperactividad, y problemas emocionales y de conducta. Finalmente, el funcionamiento familiar enmarañado tuvo mayor repercusión en los síntomas de problemas de conducta y de relación con pares. Los resultados sugieren que diferentes tipos de problemas emocionales y comportamentales del niño son influenciados e influencian diferentemente la dinámica familiar, y que el funcionamiento de la familia está asociado con la salud mental del niño.
Palabras clave: funcionamiento familiar, coparentalidad, infancia, salud mental, psicología de la familia.

Emotional and Behavioral Problems of Children: Association between Family Functioning, Coparenting and Marital Relationship

Abstract

This study aimed to describe family functioning, marital relationship and coparenting in families, and identify the associations of these variables with the emotional and behavioral problems of children aged 5 to 11 years. 50 mothers whose children received psychological treatment in Public Health Services were interviewed. The instruments used were: FACES IV, Family Identification Interview, SDQ, Co-parenting Relationship Scale, Parent Perception Inventory (PPI) and Floreal Scale. Results showed that enmeshed family functioning was correlated with hyperactivity symptoms, relationship problems, and conduct problems of the child. Good mother-child relationship was negatively associated with symptoms of hyperactivity and emotional difficulties. Negative educational practices were positively correlated with behavioral problems, symptoms of hyperactivity, emotional and behavioral problems. Entangled family functioning had greater repercussion on symptoms of behavior problems and issues in relating with peers. Results suggest that different types of child's emotional and behavioral problems are influenced and influence family dynamics differently. Findings show that family functioning is associated with the child's mental health.
Keywords: family functioning, coparenting, child, mental health, family psychology.

Introduction

It is currently known that when children are exposed to many stressful situations, they are likely to present some sort of mental suffering, due to their lack of resources to cope with such situations and understand the facts, which can have long-lasting repercussions. Mental disorders that begin in childhood and are not treated can result in functional impairment during adult life (WHO, 2001). Achenbach and Edelbrock (1979) distinguish two categories of behavior problems: internalizing and externalizing. Internalizing behavior problems are those characterized by excessive worry, withdrawal, sadness, shyness, insecurity and fear, often manifested in disorders such as depression, social isolation and anxiety, i.e., they are symptoms of emotional problems. Externalizing behaviors are those involving impulsiveness, physical or verbal aggression, agitation and teasing, which are mentioned as behavior problems. Childhood mental health includes behavioral and emotional problems. Epidemiological data on child and adolescent mental health in Brazil indicate a high prevalence of psychiatric disorders (Murray, Anselmi, Gallo, Fleitlich-Bilyk & Bordin 2013).

Studies on family relationships are usually based on the Family Systems Theory. The set of characteristics of a family group, which encompasses understanding, flexibility, affectivity and forms of communication,

is called family functioning, although its structure is multidimensional (Olson, Gorall & Tiesel, 2011). A family is defined as a system in constant interaction and transformation whose functioning is governed by its own rules, standards and functions, also considering each one of its members (Minuchin, 1990). According to structural systems theory (Minuchin, 1990), adaptive family functioning is based on the following criteria: clear generational boundaries, and definitions of roles and functions that take gender and power differences into account. The author considered an adequate family functioning as the one in which there are clear boundaries between subsystems. Based on this criterion, he pointed out that the two extremes are indicators of pathology, i.e., families in which boundaries are diffuse, enmeshed families, and disengaged families in which boundaries are rigid. Thus, the appearance of emotional or behavioral problems in children can be seen, from the systems theory perspective, as a response to the difficulties in coping with stressors that affect the family throughout its life cycle, impacting relational dynamics and family functioning.

The researchers sought to identify the risk factors for childhood behavior problems present in the Brazilian family environment (Murray, et al., 2013, Sá, Bordin, Martin & Paula, 2010). The risk factors identified by the authors were: domestic violence experiences, use of physical punishment, suicidal ideation of the

mother, severe physical marital violence against the mother, drunkenness of the father/stepfather, influence of parents and friends to use drugs, family relationship difficulties (parents and siblings), low caregiver education, low emotional support at home during childhood, parents who use alcohol, divorce of parents, and lack of closeness with the mother. The risk factors for the development of behavioral problems are higher among children/adolescents raised in the absence of the father or when there is violence between the couple and/or toward children (Bordin, Martin & Paula, 2010).

Vilhema and Paula (2017) conducted a literature review on childhood/adolescent conduct disorders (CD) and observed that, in Brazil, the prevalence indicates high rates of CD in Brazilian children and adolescents, with an average of 3.6% for Conduct Disorder (CD) and 3.5% for Oppositional Defiant Disorder (ODD). A study carried out with a clinical population in Brazil characterized the difficulties of 59 parents/caregivers who sought psychological care for their children with behavior problems. It revealed that the main difficulties faced by parents/caregivers were related to the skills involved in establishing limits and in communication (they use spanking as an educational practice and lack consistency) (Bolsoni-Silva, Paiva & Barbosa, 2009). Another study carried out in the children's mental health service in Brazil showed that 63.2% of the children had symptoms of stress, most of which were in the alarm phase. And 73.7% of these children presented psychological stress with a depressive component (Lena, 2012).

Studies on this topic seek to understand the associations between family functioning and children's behavior problems (Ma, Yao & Zhao, 2013). The authors suggest that there is a two-way relationship between the variables family functioning, parental psychopathology (depression and alcohol abuse) and behavior problems among children (Wang, Pan, Zhang & Yi, 2014; Burstein, Stanger & Dumenci, 2012). Lamela and Figueiredo (2016) investigated whether parents' marital status influenced the mental health of children, and observed that divorced parents who presented more depression symptoms made more use of physical punishment, and these factors were correlated with greater damage to the mental health of children. This result confirms that the correlation of several family factors predisposes children to behavioral problems.

Research has demonstrated the interdependence between marital and parental subsystems (Bolze, 2016, Bergman, Cummings & Warmuth, 2016, Bigras & Paquette, 2000). Children who have witnessed marital conflicts with violence may develop externalizing and

internalizing behavior problems (Keller, Cummings, Peterson, & Davies 2009). Boas, Dessen, and Melchiori (2010) believe that identifying the family processes responsible for the appearance and continuity of marital conflicts associated with damage to children can help promote mental health and quality of life for families. Lindahl & Malik (2011) observed that children who witnessed marital conflicts in the family environment with high levels of dispute, disengagement, and chaos, may present emotional difficulties because they feel threatened and guilty. The results of this study have shown that family cohesion worked as a moderator of marital conflicts.

This perspective broadens the understanding of family relationships, as it encompasses parenting and marital subsystem tasks, facilitating the child's learning of solidarity, respect and empathy skills. In this sense, it is important to consider the concept of coparenting, defined as the joint and reciprocal involvement of parents/caregivers in the education of children, and the degree of mutuality in decision-making and guidance regarding the child (Feinberg, 2003). Coparenting is one of the family variables related to the mental health of children and parents, and to family functioning. A meta-analysis study by authors Teubert and Pinquart (2010) found that coparenting is related to child adjustment. The researchers concluded that coparenting is one of the predictors of children's psychological adjustment. A study with parents in the post-divorce stage revealed significant positive associations between coparental conflict and behavior problems, symptoms of anxiety, depression and somatization in children. The specific dimensions of coparenting (coparental support, cooperation, and agreement) showed significant positive associations between overall mental health, self-esteem, and academic performance of children (Lamela & Figueiredo 2016).

The literature mentioned above suggests that there is a relationship between internalizing and externalizing behavior problems, family functioning, coparenting and marital relationship, but few studies aimed at discussing this phenomenon have been conducted (Boas et al. 2010; Keller et al., 2009). Given this context, this study aimed to identify the associations of the variables family functioning, coparenting and marital conflict, with emotional and behavioral problems of children aged 5 to 11 years, according to the perception of mothers. Therefore, the results of this study may contribute to the understanding of the family factors associated with childhood mental health problems, and help in the development of treatment and prevention programs that address the insertion of children into the family dynamics.

Method

This is a scientific and technological research study, conducted with a clinical population, with a quantitative, exploratory, descriptive and cross-sectional design. Families were recruited in institutions that provide psychological assistance to children, using a convenience sample of different socioeconomic levels in a city of the South Region of Brazil.

Participants

In order to meet the objectives of the present study, interviews were conducted with mothers of children diagnosed with emotional and behavioral problems who were receiving psychological counseling at Reference Public Health Services, at the Child and Youth Psychosocial Care Center (CAPSI), and at a Non-governmental Organization (NGO). Two institutions that provided psychological care to children aged 5 to 11 years were selected. Among the families assisted by the institutions, only 50 mothers met the research inclusion criteria. They were invited to answer questions about family functioning and the mental health of their child (ages 5 to 11), referred to as focal child. The criteria for inclusion of the families were: a) being a nuclear, single-parent or remarried family, b) the biological mother resided with the child undergoing psychological treatment. In order to compose a more homogeneous sample and reduce variables that might interfere with the analyses, it was decided to conduct interviews with mothers of children who had not been diagnosed with neurological problems and intellectual disabilities (autism, schizophrenia, and others). A study shows that the parental practices of families of children with atypical development are different, when compared to families of typical children, and family functioning and parental stress influence such practices (Minetto, 2010). Children with Attention Deficit/Hyperactivity Disorder, disruptive behavior disorders and emotional disorders were included.

Instruments

1. *Interview to describe family organization***.** Based on the instrument developed by Maria-Mengel and Linhares (2007), it contains the following items: family and child identification data, socio-demographic characterization of the family, and questions regarding family routine and description of the reasons for psychological counseling. In the version developed for this research, two extra questions were formulated and added: the first, to identify the perception of mothers

about their relationship with their child, and the second, about the father's participation in school life, friendship and child's health matters (assessed through a Likert scale ranging from 0 to 5 points).

2. *Strengths and Difficulties Questionnaire (SDQ)*. Developed by Goodman (1997), it is used for assessing the mental health of children. The authors, Woerner et al., (2004) briefly described the psychometric data on the validity and reliability of SDQ in Brazil, defined by the calculation of Cronbach's alpha and by test-retest (clinical sample of 17 participants and mean interval of 20 days between applications). For the internal consistency index, Cronbach's alpha displayed, for the three versions used, values close to 0.80 (values for the total difficulties score), while for test-retest, the result was 0.79. Results indicated that the SDQ presented adequate psychometric properties assessed for the Brazilian population. This instrument is a questionnaire applied to parents and teachers in order to track mental health problems in children. It consists of 25 items divided into five areas: a) prosocial behavior problems, b) hyperactivity, c) emotional problems, d) conduct problems and e) peer relationship problems, with five items in each subscale. The sum of each scale and the total sum allow child classification into three categories: normal (ND), borderline (BD) or abnormal (AD) development. For each of the five subscales, the score ranges from 0 to 10, and the points of the total difficulties score are generated by the sum of the results of all subscales, except for prosocial behavior, which ranges from 0 to 40 points. The cut-off point for the total difficulties score established for the population of England, where the original SDQ standardization studies were conducted, was 17 for the parent version and 16 for the teacher version. In the prosocial behavior subscale, the higher the score, the lower the number of complaints. In the other subscales (hyperactivity, emotional problems, conduct problems and relationship problems), the higher the score, the higher the number of complaints.

3. *FACES IV. The Family Adaptability and Cohesion Evaluation Scale* is an instrument for the assessment of family functioning (Olson & Gorall, 2003, Olson et al., 2011). It is composed of 62 items, divided into three scales: Family Self-Perception Inventory, Family Assessment Device and Family Satisfaction Scale. The items are statements answered by means of a five-point Likert scale (1 = strongly disagree, 5 = strongly agree) for the first two scales of the Inventory; and (1 = very dissatisfied, 5 = extremely satisfied) for the third scale. In a study by Minetto (2010), the instrument was adapted using translation, back translation, and semantic

adaptation, and Cronbach's subscale indexes varied from 0.79 to 0.84. The indices found suggest that FACES IV is a reliable instrument for research use in Brazil, although it has not been validated for this population.

4. *Sources of conflict between the couple and in the child's presence* - is one of the subscales of the Marital Harmony Questionnaire - Floreal. Developed by researchers at the *Laboratório de Psicologia da saúde, família e comunidade/UFSC-Brazil* (Research Laboratory in Health, Family and Community Psychology) and by Canadian researchers. The instrument is composed of five dimensions, but only the fourth dimension was used for the purposes of the present research, since it is the only one of interest for this study. It assesses the sources of marital conflict, and conflict that occurs in the child's presence. It addresses 45 items through a Likert scale ranging from 1 (never) to 5 (very often). The items investigate misunderstandings, arguments or fights related to family, religious, and financial matters, and also regarding the education of children, personal and sexual habits, physical and verbal aggression, among others. This part of the instrument was based on the American questionnaire named O'Leary-Porter Scale (Overt Hostility), which investigates how often different types of inter-parental conflicts take place in front of children. Cronbach's alpha for the Floreal, which has already been used in Brazilian samples, was 0.88, which is a good reliability coefficient for the correlation between the responses (Bolze, 2011).

5. *Coparenting Relationship Scale (CRS)*. Developed by Feinberg, Brown and Kan (2012), is a measurement instrument based on Feinberg's Theoretical Model of Coparenting (2003). It consists of 35 items that evaluate the following components: coparenting agreement, coparenting closeness, exposure to conflict, coparenting support and undermining, endorse partner parenting, and division of labor related to the child. The Scale's psychometric study has demonstrated excellent internal consistency, with *Cronbach's alphas* between 0.91 and 0.94, for the full version (35 items); and 0.81 and 0.89 for the reduced version of the scale (14 items). An excellent correlation was found between the complete and reduced versions, with a correlation of 0.97 for mothers and 0.94 for fathers. In general, results indicated that the instrument has good psychometric properties: internal consistency and correlation between versions, strong stability and construct validity (Feinberg et al., 2012).

6. *Parent Perception Inventory*. Developed by Hazzard, Christensen and Margolin, (1983), this instrument has 20 questions that describe educational practices and is composed of two dimensions: positive and negative. Responses

are evaluated through a Likert scale ranging from 0 to 5 (0 never, 1 a little, 2 sometimes, 3 often, 4 pretty much and 5 a lot). The positive dimension includes the following behaviors: positive reinforcement, establishment of dialogue, child's involvement in decision-making, time parents spend with the child, expression of affection, praising and caring attitudes. The negative dimension is composed of: privilege removal, criticism, physical punishment, neglecting, yelling, threatening, nagging, and ignoring. Souza, Pinto and Carvalho (2014) conducted an adaptation study of this instrument with the Brazilian version, and the results of the preliminary analysis partially met the reliability criteria. Although the sample was small, 50 fathers and 50 mothers, all positive items were significantly correlated (mother and father), with correlations ranging from 0.4 to 0.83. All negative items were also significantly correlated (mother and father), with correlations ranging from 0.34 to 0.72. Cronbach's alpha was also calculated for each of the subscales: mother positive: 0.84; mother negative: 0.78; father positive: 0.88; father negative: 0.80. On the other hand, it is necessary to reflect on the usefulness of this instrument, considering that it is easy to apply and includes the dimensions of encouraging and punishing/inhibiting behaviors, used by parents of children in the age group corresponding to this research. In order to evaluate educational practices, three items of the positive dimension and four items of the negative dimension were included in this study. These questions were meant to include the variable "educational practices", which was not present in the other instruments, and it was decided that the items most closely related to the objectives of the study would be chosen.

Procedure

The mothers were selected based on healthcare service records, considering the following criteria: being over 18 years old, having overall physical and mental health conditions that allowed them to freely provide information, and being able to understand the nature of the research and its procedures. Subsequently, they were contacted by phone to schedule the interviews, which were usually conducted during the times when the child was receiving psychological counseling. Free and Informed Consent Forms were read and signed by mothers before the beginning of each interview. Then, the instruments were applied in the following order: Family Identification Interview, Strengths and Difficulties Questionnaire (SDQ), Instrument to evaluate family functioning (FACES IV), Subscale Sources of Conflict in the child's presence of the Floreal Questionnaire, Coparenting Relationship Scale,

and Parent Perception Inventory**.** All the instruments were applied through interviews to facilitate their understanding, even though the mothers were literate. Data collection occurred according to participants' availability.

Data Analysis

The data were analyzed through the *Statistical Package for Social Sciences-SPSS* 21.0. The CRS, the SDQ, the subscale of the Floreal Questionnaire and FACES IV were analyzed according to the standards established by the authors of the instruments. Data from the Family Identification Interview and Parent Perception Inventory were analyzed through descriptive statistical analysis to study frequency distributions and percentages for categorical variables. Continuous variables (sociodemographic data, SDQ, FACES IV, Floreal and CRS) were analyzed through their means and standard deviations. Subsequently, correlational analyses were performed through nonparametric statistics, using the Spearman test (with significance level $p < 0.05$). The nonparametric test was chosen because the data of some variables did not present a normal distribution and because the sample was small and heterogeneous (Dancey & Reidy 2006).

Ethical considerations

The project of this study was approved by the Ethics Committee in Research with Human Beings of the university to which the study is linked, under opinion number 987.433, of March 2015. An informed consent form was obtained from all the participants in this study. The authors declare that there is no conflict of interest.

Results

The information collected during the interview that aimed to describe family organization is presented below. Regarding their educational level, 13 mothers had completed high school, 12 had incomplete primary

Table 1

Frequency and percentage of occurrence of childhood mental health problems according to SDQ scores

SDQ	Total	Non-clinical group	Clínical group
	f (%)	f (%)	f (%)
Total Score SDQ	50 (100 %)	15 (30 %)	35 (70 %)
Emotional Problems	50 (100 %)	28 (56 %)	22 (44 %)
Hyperactivity Symptoms	50 (100 %)	13 (26 %)	37 (74 %)
Conduct Problems	50 (100 %)	20 (40 %)	30 (60 %)
Peer Relationship	50 (100 %)	35 (70 %)	15 (30 %)
Prosocial	50 (100 %)	44 (88 %)	6 (12 %)

Note. f=frequency, % percentage.

education, seven had incomplete high school education, five had completed primary education, seven had started higher education, but not finished, and only four had completed higher education, one of them completed a graduate course and another one had incomplete primary education. Many were gainfully employed, 30 of them, and their average family income was R$ 2,359.90, the minimum amount was R$ 788.00 and the maximum R$ 10,000.00 (SD=R$ 1,528.2). They had two children on average (SD=.9). Their minimum age was 24 years and the maximum 49 years (M=35.2 years, SD=6.2).

Regarding family composition, 25 were nuclear families, 19 were single-parent families and 6 were remarried families. Mothers reported that fathers had little participation in the education of children (M=2.5, SD=2.0). They evaluated their relationship with their child as excellent (M=4.5, SD = 1). Parent Perception Inventory results for the dimension negative educational practices varied widely, the minimum score was 0 and the maximum was 4 (M=1.7, SD=1), showing that some mothers made little use of physical punishment, yelling, or spanking, but others mentioned making use of punishment and spanking. In the positive educational practices dimension, the data showed that most mothers expressed affection, praised and listened to their children (M=4.1, SD=0.9).

Most children were male, 34, and their average age was 8.2 (M=8, SD=1.7). According to the mothers' reports, the most frequent reasons for their children's referral to psychological care were: aggressiveness/lack of limits (n.22), emotional difficulties and anxiety (n.22), and hyperactivity symptoms (n.6). In order to analyze the distribution of children according to the scale indicators that assess behavioral /emotional problems and prosocial behavior (SDQ), they were divided into a clinical group, for those that showed more signs of emotional and behavioral problems, and a non-clinical group, for those with less signs of these problems (Table 1).

It was found that, according to the mothers' perception, 35 children who were receiving psychological care

Table 2.
Mean and standard deviation of mothers' responses regarding family functioning (FACES IV)

	Balanced			Unbalanced		
	Cohesion	Flexibility	Disengaged	Enmeshed	Rigid	Chaotic
M	3.7	3.3	2.5	2.9	3	2.4
SD	.7	.5	.6	.6	.5	.6

Note. M = Mean, SD = Standard deviation

displayed symptoms of mental health problems, classified in the clinical group. Most of them presented symptoms of hyperactivity (n.37), conduct problems (n.30), emotional problems (n.22) and peer relationship problems (n.15). The children in the clinical group showed more symptoms of hyperactivity and conduct problems. In the prosocial dimension, which evaluates social skills, the majority (n.44) obtained a good index, and only 6 were classified within the clinical indexes.

The assessment of family functioning was performed through the Family Adaptability and Cohesion Evaluation Scale, and will be presented in Table 2.

Analyses indicated high levels for the cohesion (M = 3.7, SD = 0.7) and balanced flexibility (M = 3.3, SD = 0.5) subscales. As for the unbalanced, disengaged and chaotic subscales, values are within the mean (M=2.5, SD=0.6), while rigid (M=3.0, SD=0.5) and enmeshed subscales (M=2.9, SD=0.6) presented high scores. These families tend to present rigid and enmeshed functioning, according to the mothers' perception. During the application of the FACES IV scale, most mothers took into consideration their relationship with their children and their family of origin (especially their own mother) when assessing their family relationship, even those who were living with their spouse. *I don't do anything without my mother's opinion. Oh, I'm very protective... (M.22). I feel abandoned if my children are away from me (M.50). My mother wants to control everything (M.49).* Other comments from the mothers reinforced this statement, as they claimed to have difficulties in dialoguing with their spouse: *When my husband comes home everything changes, it's impossible to talk near him (M.48). He does not agree with anything, he is absentminded (M.37). I survive and take everything (referring to conflicts with the husband) for the sake of my children (M.46).* These reports denote that mothers have a very close relationship with their child, while fathers probably have a peripheral participation in the family, and therefore are not included in the family relationship.

The quality of marital relationships is an important factor for good family functioning. This aspect was evaluated by the instrument named Sources of conflict

between the couple and in the child's presence (Floreal subscale). Results showed the existence of marital conflict and conflict in the child's presence. The mean scores for each dimension were: marital conflict (M=2.0, SD=0.6) and child's exposure to conflict (M=1.4, SD=0.6), which demonstrates the existence of marital conflict in both dimensions, but at low levels. In order to identify the existence of aggression in the marital relationship, the questions that specifically evaluated the presence of violence were calculated: the first about the existence of physical hostility, and the second, about verbal hostility. It was found that physical hostility occurred in 34% (n.17) of the couples, and all the children witnessed this event. Regarding the second question, 70% (n.35) of the couples experienced verbal hostility and 80% (n.28) of the children witnessed it, according to the mothers' perception. Mothers also stated that 60% (n.21) of these children showed signs of behavioral problems.

The results of the Coparenting Relationship Scale indicated that the mother has a positive perception of their partner's role in educational tasks. She feels that there is closeness, support and agreement in decision-making, but she mentioned difficulties in division of labor (Table 3).

Data on the negative dimensions of coparenting, i.e., Exposure to Conflict (M=1.0, SD = 1.8) and Undermining (M=1.4, SD=1.5) presented low scores, but indicating that mothers' responses varied greatly in both dimensions. As for the other positive dimensions, Closeness (M=3.3, SD=1.8), Endorse Parenting (M=3.3, SD = 1.1) and Support (M=3.1, SD=1.5), scores presented above-average results. Coparenting Agreement (M=2.8, SD=1.6), Division of Labor (M=2.6, SD=1.6), Exposure to Conflict (M=1.7, DP=1.8) and Undermining (M=1.7, SD=1.5) presented below-average scores.

In order to check if the variables related to family aspects had an impact on the mental health of the children, a correlation analysis of the total scores and subscales of the SDQ, with the total scores of the scales that evaluated educational practices, paternal involvement, mother-child relationship, family functioning, marital relationship, and coparenting was conducted (Table 4).

Table 3.
Coparenting Relationship Evaluation presented in terms of means and standard deviation

	Agree-ment	Closeness	Endorse Parenting	Support	Division of labor	Exposure to conflicts	Undermining
M	2.8	3.3	3.3	3.1	2.6	1.0	1.4
SD	1.6	1.8	1.1	1.5	1.6	1.8	1.5

Note. Mean and standard deviation of Coparenting Relationship Scale (CRS) dimensions M = Mean, SD = Standard deviation

Table 4
Correlation between indicators of symptoms of childhood mental health problems and variables related to family aspects

SDQ	Variables	r
Total SDQ	Unbalanced/Enmeshed	0.440**
	Negative Educational Practices	0.370**
Hyperactivity Symptoms	Negative Educational Practices	0,286*
	Mother-child Relationship	-0,302*
Conduct Problems	Unbalanced/Enmeshed	0,328*
	Negative Educational Practices	0,377**
Peer Relationship Problems	Unbalanced/Enmeshed	0,285*
Emotional Symptoms	Mother-child Relationship	-0,314*
	Negative Educational Practices	0,294*

***$p < 0.001$ **$p < 0.01$ and *$p < 0.05$, *r = correlation coefficient*

Enmeshed families, i.e., those with fused emotional involvement, have children with more mental health problems (r=0.440**), which are mostly symptoms of conduct problems (r = 0.328*) and peer relationship problems (r=0.285*). The symptoms of emotional problems were positively correlated with negative educational practices (0.294*), and negatively correlated with good mother-child relationship (r=-0.314*), i.e., the lower the frequency of negative educational practices and the better the mother-child relationship, the less the signs of emotional problems presented by the child. Negative educational practices (use of spanking, criticism, ignoring and screaming/yelling at the child) were also correlated with hyperactivity symptoms (r=0.286*) and conduct problems (r=0.377**). The sample size probably interfered with the analyses, which presented low correlations in some aspects.

Discussion

Research conducted in the context of child psychopathology has emphasized the role of the family environment where the child develops, and the interactions established in it, as encouraging or limiting factors to the process of

development of mental health in children. The objectives of this study were to describe the perception of mothers of children aged 5 to 11 years regarding family functioning, marital relationship, coparenting, behavior and emotional problems in children, and identify the associations between family variables and children's behavioral problems. According to the mothers' perception, these families tend to have a rigid and enmeshed functioning. Enmeshed families, which display fused emotional involvement, were associated with the group of children with more mental health problems, specifically symptoms of conduct and peer relationship problems. Based on the analyses of the mothers' reports, one of the hypotheses considered was that this type of enmeshed functioning would happen between some family members, such as mothers with their family of origin and their child, for instance. This family dynamics puts the father in a peripheral position, and probably hinders paternal involvement in family and educational matters. The enmeshment of a mother with her children is directly related to the emotional distance between her and her husband (Nichols & Schwartz, 2007). The less attention she receives from her husband, the more attention she will need to receive from her children; the more involved with her children, the less time and energy she will have for her husband. Minuchin (1990) points

out that this form of family functioning compromises differentiation and the exercise of autonomy of its members. Enmeshed subsystems have diffuse boundaries, and convey a greater sense of support at the cost of independence and autonomy (Nichols & Schwartz, 2007). Enmeshed parents are loving and caring, but their children tend to be dependent and may have difficulty relating to people outside the family. For Minuchin (1990), one of the signs of a "healthy" family functioning is the fact that the couple can fulfill the task of separating themselves from their family of origin, and negotiate a different relationship with their parents and relatives. For this to happen, the couple must be committed to their marriage, i.e., build conflict resolution strategies, and the families of origin must accept and support the couple's initiative.

In addition, this result suggests that the mothers were more closely linked to their family of origin and to their children, indicating the existence of undisclosed conflict between the couple. Marital relationship analyses found below-average results for the presence of marital conflict, but when evaluating the questions about the existence of physical and verbal hostility, 17 of the mothers stated that they had already experienced physical aggression situations, and 35 had already experienced verbal aggression situations. It can be hypothesized that the result regarding the low level of marital conflict occurred due to the fact that some women reported avoiding arguments, so that their children would not feel uncomfortable, and also not to increase their husband's violence. One of them reported that her husband was very aggressive, so she avoided arguing: - *Talking is useless, better not to argue. It's good not to argue to avoid fighting, I think about the children.* The participant reported that she used to argue before, which had resulted in physical aggression from him in front of the child, who became very upset. Some couples use avoidance to maintain marital harmony, according to Bolze, Crepaldi, Schmidt and Vieira (2013). These authors observed that women, more than men, use negative reciprocity and avoidance. The mother also said that: *"Now, when I realize my husband is very angry, I go to my father's house and leave the children there with their grandparents".* Once again, there is a search for support in the family of origin. Mothers feel unprotected and do not know how to deal with these conflicts, so they turn to their own parents for emotional support and for help in taking care of their children.

Total score averages showed that children had low exposure to marital conflict. However, when evaluating the percentage, it was found that among the 28 children who witnessed verbal hostility between their parents, 21 showed indicators of mental health problems. Children

who witness destructive marital conflict between parents and expression of negative parental affection are more likely to exhibit aggressive behavior (Keller et al., 2009). For Pires, Silva and Assis (2012), children are emotionally affected when they witness violence in the family. Children in this situation are more likely to exhibit aggressive behavior and ADHD symptoms. Verbal aggression perpetrated by parents toward the children was found to be associated with ADHD. Children who experience adverse psychological situations in the domestic setting may also present intellectual, language, attention and other difficulties in cognitive functions (Oliveira, Scivoletto & Cunha, 2010), besides emotional difficulties, since they feel threatened and guilty (Lindahl & Malik 2011).

Cummings and Davies (2010) found an interconnection between marital conflict, parental psychopathology and child adjustment, thus pointing to the importance of conducting more research on behavioral problems in children, including a systemic and interdisciplinary perspective in the analysis of family risk factors. The perspective of current studies on family relationships aims to identify the processes responsible for the appearance and continuation of marital conflicts, associated with damages to the development of children (Cummings and Davies, 2010; Bergman, Cummings & Warmuth, 2016).

A good marital relationship gives couples the satisfaction of their intimate needs and also provides emotional support and assistance in the education of their children (Bergman, Cummings & Warmuth, 2016). When there are conflicts in the marital relationship, they can be transferred to the coparenting relationship and negatively interfere with the parents/child relationship and the child's mental health. Research has demonstrated the interdependence between the marital subsystem and the parental subsystem (Bigras & Paquette 2000). Boas et al. (2010) have mentioned that there are few works published focusing on the implications of marital conflicts for the development of children, and concluded that it is necessary to collect results of Brazilian studies, seeking to understand the functioning of these families and the implications of marital conflicts for the development of children.

The study also investigated the association between mental health problems in children, the mother-child relationship, and paternal involvement in day-to-day activities. Correlational analyses showed that emotional symptoms were negatively associated with the mother-child relationship, but paternal involvement was not correlated with any indicator of children's emotional and behavioral problems, according to the mothers' perception. A positive mother-child relationship can be considered as a protective factor for child development.

But it is important to evaluate whether other variables are mediating this result.

The dimensions coparenting, agreement, and division of labor showed below-average scores, revealing that the mother and her partner have different ideas on how they should raise their child, and are not able to share educational tasks, which indicates a conflicting coparenting relationship between them, as the following report illustrates: *He is more rigid, and I am more protective; so he wants me to be like him*. On the other hand, in positive dimensions, the mother believes that her partner supports her in educational tasks. Thus, she tends to value her husband's involvement in educational matters and also reports that there is closeness in their coparenting relationship. However, the coparenting relationship data did not show any association with mental health problems in children, but the dimensions that assessed the child's exposure to marital conflict and undermining were very scattered, revealing that some participants evaluated this aspect positively and others negatively, which caused this distribution to interfere with the analyses.

Negative educational practices were associated with more symptoms of hyperactivity, emotional and conduct problems. These results are in line with those of Alvarenga, Magalhães and Gomes (2012), who found that physical punishment was related to externalizing behavior problems in a population of preschool children. Some of the most studied risk factors related to mental health and behavioral problems in children are inadequate parental educational practices (Bolsoni-Silva, Loureiro & Marturano, 2011). However, it is important to note that the correlations were low in the present study, indicating that other variables may be influencing this result.

The study showed the importance of family relationship aspects to children's mental health. One of the characteristics of a healthy family environment is that it favors the quality of the marital relationship, and consequently, it is interconnected with parenting, facilitating child development. Marital relationship and coparenting were also described in this study as variables that indirectly affected children's mental health. Therefore, institutions that provide care for children with emotional and behavioral problems might want to evaluate family functioning, parental practices, and coparenting, in order to develop psychological care strategies aimed at building possibilities for agreement, support and cooperative closeness between parents. They may also suggest that health professionals work with parents on the dimensions of coparenting and marital relationship. The diversity of family factors involved in the behavioral and emotional difficulties of children was identified in

this study, and it was evident in the scores of the scales on negative educational practices and in the negative dimensions of coparenting (exposure to conflict and undermining). Further studies with a case study design should be conducted, as they could specifically check these relationships and deepen the analyses carried out.

Among the limitations of this study, related to the intended analyses and clarification of the associations between variables, it is worth mentioning: sample size, convenience sample, the use of adapted instruments not validated for the Brazilian population, such as FACES IV, and the heterogeneous characteristics of the families. It is also suggested to carry out new studies that can investigate whether these results appear in other types of family arrangements referred to community health services, as well as comparative studies between paternal and maternal perceptions on the variables discussed here. The identification of family factors associated with emotional and behavioral problems in children may favor the implementation of interventions toward this population. Some authors (Solís-Cámara, Medina Cuevas, & Díaz Romero, 2015; Rea-Amaya, Acle Tomasini, Rueda & Méndez, 2014) noted that parents of children with behavior problems who received guidance regarding educational matters have made less use of harsh parenting practices. A family intervention program that includes the learning of positive educational practices, positive coparenting and resolution of marital conflicts, while building strategies to facilitate father involvement in educational matters, and fostering more flexible and cohesive family relationships, can prevent mental health problems in children.

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