The Relationship between Family Communication Patterns and Mental Health in Adolescents

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Abstract

Background and object: The purpose of this study was to investigate the relationship between family communication patterns and mental health disorders in adolescents in the city of Mashhad and the prevalence of mental disorders among them.

Materials and Methods: Methodology is descriptive and correlational. The study sample consisted of 507 people who were chosen using stratified cluster sampling method. The data were collected using Family Communication Patterns of Ritchie and Fitzpatrick questionnaire, and the Strengths and Difficulties questionnaire (SDQ), and then was analyzed by SPSS 18 software using regression and Pearson correlation tests.

Results: Results showed 48% of adolescents with moderate mental health, 44% with desirable mental health and 8% with very low mental health. There is a significant positive correlation between mental health and conversation aspect of family communication patterns and a significant negative one between mental health and conformity aspect, and orientation of conversation against conformity is a stronger predictor of mental health of adolescents. Also according to family, mental health divisions of adolescents respectively from top to bottom were in pluralistic, consensual, easygoing and protective families.

Conclusion: Family communication patterns and its dimensions are significantly associated with mental health. So adopting appropriate measures and actions for training families to improve the mental health of adolescents and reduce the damage caused by it is necessary.

Keywords: family communication patterns, mental health, the prevalence of mental disorder.
Introduction

Mental health is one of the issues that had existed since the creation of the human and has always preoccupied the human mind. World Health Organization (WHO) knows mental health as something more than the absence of mental disorders, including mental well-being, perceived self-efficacy, autonomy, competency, adult dependency, and self-actualization of intellectual and emotional potentials [1]. Mental health is a public health issue. According to the declaration of WHO, more than 0.5 milliard people throughout the world suffer from weak and severe mental illness and this rate among the Iranian population over 15 years has been reported equal to 21% (25.9% females and 14.9 males) and in population over 18 years equal to 17.10 percent (23.4 females and 10.8 males) [2]. Meanwhile, the current generation of people aged 10-24 years (adolescence ages) almost includes a quarter of the world’s population and just about 90 percent of them live in low or medium-income countries, where there are most of the population because of the much higher fertility rates than high-income countries [1].

The fact is that 20% of adolescents experience a mental health problem (mainly depression and anxiety) each year, and suicide is a leading cause of death among them. On the other hand, 75 percent of mental disorders appear before the age of 24 and 50 percent appear before the age of 14 [3].

World Health Organization experts have stated that more than 1,500 people in the world suffer from psycho-neurological and socio-neurological disorders and these disorders are one of the reasons for the inability in the ages 10-24 years and self-immolation is the second cause of death in these ages [4]. Around the world, the three main reasons for the age modified years based on disability in the age group of 10-24 years are nerve-psychiatric disorders (45%), unintentional events (12%) and infectious and parasitic diseases (10%) [5].

Mental health is very important for good quality of life. Happy and high confident adolescents are more likely to be happy and confident adults that in turn contribute the health and well-being of the nations. Mental health of adolescents has consequences such as self-esteem, school attendance, and academic success, social cohesion, life chances, and future health [6] and the adolescents and youth with mental health have the dexterities such as problem-solving skills, social abilities, and sense of purposefulness. These assets help them grow at difficult conditions, avoid risky behaviors and generally continue a productive life [7].

On the other hand, mental disorders have different consequences. For children and adolescents these consequences include low academic achievement, higher risk of suicide, substance abuse, antisocial behavior and early pregnancy, and are associated with a wide range of health outcomes in adulthood, such as higher rates of mental illness, low levels of employment, low income, marital problems and criminal activities [8].

Chau-Hang (1991) classifies the factors effective on mental health into six categories, including physical deprivations, psycho-social factors, familial bad patterns, familial maladaptive
structure, pressures caused by new industrial life, and social-cultural factors. Among these factors, the family and the atmosphere governing it has a decisive and effective role in psychological development, the formation of personality and mental health of family members, especially children [9]. So far, among all human societies the family has been the most fundamental social institution and the infrastructure of communities and the origin of cultures, civilizations and human history. Family is the most effective transmitters of culture and the fundamental pillar of society which has mutual interaction with cultural and social factors in different situations. Human beings achieve their entities and personal growth and reach spiritual and moral development in healthy and matured families. The family is the fundamental unit of Islamic society [Islamic Republic of Iran’s constitution, Article 10] and no society can claim to be healthy without having healthy families [10]. Some events may occur in the family, which affect family members. The exclusion of the father is one the particular conditions of a family, which may be an important environmental variable that directly or indirectly has special effects on overall growth and various aspects of child behavior, particularly in the field of mental health, physical health and academic performance [8]. Mental illness of parents, social isolation, substance abuse, domestic violence and disorderly living conditions are family risk factors that all of them are associated with negative outcomes for children, especially with externalized behaviors [11]. In particular, low mental health of parents increases the risk of emotional disorder, and behavioral disorder up to 4 to 5 times, and lack of parental employment also increases the risk of emotional disorder and behavioral disorder in childhood up to 2 to 3 times. The overall agreement is that the family plays an important role in the development of children’s behavioral disorders [12].

Family experience of tremendous events affects children’s psychological functioning. Low socio-economic conditions of the family operate as a risk factor for mental health of adolescents. Addiction is one of the risk factors. Addiction negatively affects family relations. Addiction of father influences the sociability functioning of society, his economical and supporting role and social relations of the family members [13].

Health of adolescents and young adults has been widely neglected in global public health, because this age group is considered as an healthy group [8] and more than 90 percent of the world’s countries deprive from a comprehensive policy of mental health that considers children and young people and 30 percent of these countries do not have a clear plan for mental health [14], while they youth and adolescents’ need for guidance is more than before because of unsafe social environment and their options are limited in this regard. This issue is more important in Third World countries due to the lack of division of labor, non-trustable and unsociable institutions, and the risk of distortions caused by higher anomie and the considerable number of young people, the role of family in education, training, and guiding them [15]. On the other hand, most mental illnesses begin before adolescence and often continue throughout the life. Promotion of mental health in early life reduces disparities, promotes physical health and reduces health risk behaviors and increases life expectancy, economic production, social functioning and quality of life [16]. Also, identification of the family risk factors of mental health in adolescents will be helpful to provide a comprehensive prevention program in this regard. In addition, the growing worldwide focus on mental health is an important opportunity to target adolescents’ health. Considering these subjects, this study was done to investigate the relationship between family communication patterns and mental disorders in adolescents.
Materials and methods

The present study is a fundamental one in terms of object and also a descriptive-correlative one considering the lack of involvement of researcher in the creation of data. The research population consisted of all high school students in the city of Mashhad in the academic year 2014-2015 which includes 82685 students. According to Morgan table that is commonly used in descriptive studies, the sample size was selected as 382 people using the combinational method of stratified cluster random method. Since, one of the goals of this study was to investigate the prevalence rate of mental health problems, the sample size was increased to 570 people; and finally because of some incomplete questionnaires and eliminating them, the final number of study subjects was determined as 507 people. The questionnaires were administered in 18 male and female high schools in districts 2, 4 and 5 in Mashhad city by receiving permission of the authorities of Education Department.

To collect data, two questionnaires of Ritchie and Fitzpatrick’s (1990) family communication patterns and strengths and difficulties questionnaire (SDQ) which was standardized in Iran, were used.

1. Family Communication Patterns Questionnaire: It is a self-evaluation questionnaire which was designed by Ritchie and Fitzpatrick (1990) and measures the rate of the respondents’ agreement or disagreement on the status of his/her family communication with 26 items in 5-point scales. Score of 4 shows strongly agree or score of zero shows strongly disagree. The first 15 items are related to the orientation of conversation and the next 11 items are related to the conformity orientation. Each subject acquires two scores from this instrument. The higher score in every scale means that the subject perceives higher conversation or conformity orientation on his/her family. Kiers Mayer-Alkin’s coefficient equal to 0.852 indicates the sampling adequacy of matrix content of information correlation. Kroit-Bartlett’s test coefficient was equal to 498.2319 which was significant at the level of P>0.0005. The revised instrument of family communication pattern enjoys content validity [17].

Investigation of the reliability of this instrument by Cronbach’s alpha and test-retest method indicated the reliability of the instrument. Cronbach’s alpha was obtained equal to 0.87 for conversation orientation scale, and equal to 0.81 for conformity orientation scale [18].

2. Strengths and Difficulties Questionnaire (SDQ): It is a short-form questionnaire is completed by parents and teachers of children 4 to 16 years old and children of 11 to 16 years. This questionnaire helps to identify the areas of common emotional and behavioral problems and also to determine whether the informed person thinks that the child has difficulty in any of these areas or not and if there are such problems, whether these problems cause distress or social dysfunction, or not.

The questionnaire consists of 25 items that measures the emotional and behavioral problems. The subject selects one of the options for each item, including “not true”, “partially true” and “certainly true” for each studied child. Along with each answer sheet, there are a number of itemsthat help determine the severity of the child’s problem and the impact of problems on him/her and his/her
entourages. Due to this reason, the self-reporting version of SDQ was designed for 11-16 year old adolescents. Total scores of the child show the possibility of his/her catching with important problems. Total scores of some of the items can be calculated to obtain subscales of social behavior, hyperactivity, emotional symptoms, conduct problems and peer problems.

Overall in scoring, it can be said that the items received scores 0, 1 or 2. The answer “partially true” is always scored 1, but the responses “not true” and “certainly true” depending on the item that is the weakness or strength are assigned a score of 0 or 2. The higher score in overall score or any of the subscales (except the sociability subscale) indicates a high probability of disorder in the individual and the need to further investigation of them. The lower score on each of the above subscales does not reject the existence of psychiatric disorders. In evaluating the reliability of SDQ, Goodman (2001) reported Cronbach’s alpha for different scales equal to 0.73 that the similar numbers have been reported for this coefficient in other studies in the same area. Convergent and divergent validity of SDQ has been measured compared with the Child Behavior Check-List (CBCL)[19]. This scale was standardization in Iran and the validity and reliability of its Persian translation has been approved.

Findings

The study was done on 507 adolescents aged 15-18 years, with mean age of 15.7±1. Descriptive analysis of demographic data of respondents shows that 51% were male and 49% were female. The analyses on job status shows that 85.3% of their mothers were housewives and 23.8% of fathers were employed, 52.16% were self-employed and 77.6% of them had moderate to good economic situation.

| Table 1. Descriptive findings on research variables |
|---------------------------------|----------------|----------------|----------------|
| Statistical indicators         | No.  | Mean  | Standard deviation |
| Scale                          |      |       |                  |
| Mentalhealth                   | 507  | 21.92 | 11.14            |
| Orientation of conversation    | 507  | 34.34 | 12.20            |
| Conformity orientation         | 507  | 21.92 | 9.43             |

In order to examine the relationship between family communication patterns and mental health, the Pearson correlation coefficient was used. The results obtained from the correlation matrix showed that there is a significant negative correlation between mental health problems in adolescents and the aspects of family communication patterns, i.e. conversation (-0.417), and there is a significant direct correlation between mental health problems in adolescents and confirmatory orientation (0.355) (n=507; p<0.0001). The results are shown in Table 2.
Table 2. The results of the correlation between family communication patterns and psychological problems

<table>
<thead>
<tr>
<th></th>
<th>Mental health problems</th>
<th>Conversation</th>
<th>Conformity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td>1.000</td>
<td>0.417</td>
<td>0.355</td>
</tr>
<tr>
<td></td>
<td>Conversation</td>
<td>-0.417</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>Conformity</td>
<td>0.355</td>
<td>-0.389</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Conversation</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Conformity</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>N</td>
<td>507</td>
<td>507</td>
<td>507</td>
</tr>
<tr>
<td></td>
<td>Conversation</td>
<td>507</td>
<td>507</td>
</tr>
<tr>
<td></td>
<td>Conformity</td>
<td>507</td>
<td>507</td>
</tr>
</tbody>
</table>

To answer the question that what aspects of family communication patterns and mental health are the appropriate predictors for adolescents’ mental health, the simultaneous multiple regression analysis method was used. By this model, a significant model was obtained (adjusted R-squared = 0.215; p<0.05; and F(2,507) = 70.261) which shows that family conversation orientation is the positive predictor of mental health of adolescents and the conformity is its negative predictor; and the family conversation orientation is a stronger predictor than conformity for mental health. The results of this analysis are shown in Table 3.

Table 3. Table of coefficients (parameters) regression based on the method

<table>
<thead>
<tr>
<th>Variables</th>
<th>R</th>
<th>R²</th>
<th>F</th>
<th>P</th>
<th>β</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversation</td>
<td>0.467</td>
<td>0.218</td>
<td>70.261</td>
<td>0.000</td>
<td>-0.329</td>
<td>7.687</td>
<td>0.000</td>
</tr>
<tr>
<td>Conformity</td>
<td>0.228</td>
<td>0.326</td>
<td>326.5</td>
<td>0.000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Classification of mental health scores for boys and girls has been done in three categories: those with low mental health, those with moderate mental health, and those with high mental health. By combination of the two types of family orientation patterns, two types of family are emerged: the consensual family that obtains high score in both aspects of the conversation orientation and conformity orientation, and the pluralistic family that obtains high score in conversation orientation, and low score in conformity orientation; that is, the supportive family that obtains high score in conversation orientation and low score in conformity orientation, and the easygoing family that obtains low score both in conversation orientation and conformity orientation [20]. The results are shown in Table 4.
Table 4. Investigation of the prevalence of mental health

<table>
<thead>
<tr>
<th>Division based on gender</th>
<th>2-20</th>
<th>21-39</th>
<th>40-58</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High mental health</td>
<td>moderate mental health</td>
<td>Low mental health</td>
</tr>
<tr>
<td>Girls</td>
<td>103</td>
<td>120</td>
<td>24</td>
</tr>
<tr>
<td>Boys</td>
<td>121</td>
<td>123</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>224</td>
<td>243</td>
<td>40</td>
</tr>
</tbody>
</table>

Types of families

<table>
<thead>
<tr>
<th>Types of families</th>
<th>Frequency</th>
<th>Percent</th>
<th>Mean of abilities and problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Supportive</td>
<td>147</td>
<td>29%</td>
<td>29</td>
</tr>
<tr>
<td>2-Easygoing</td>
<td>69</td>
<td>13.5%</td>
<td>24</td>
</tr>
<tr>
<td>3-Consensual</td>
<td>140</td>
<td>27.5%</td>
<td>21</td>
</tr>
<tr>
<td>4-Pluralist</td>
<td>151</td>
<td>30%</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>507</td>
<td>100%</td>
<td>22.75</td>
</tr>
</tbody>
</table>

Discussion

The purpose of this study was to investigate the prevalence of mental health in adolescents in the city of Mashhad. The findings of this study were based on classification of mental health scores in three categories: those with low mental health, those with intermediate mental health, and those with high mental health. Based on this classification, of the total 507 adolescents responded to the questionnaire, 243 people (48%) had the intermediate level of mental health, 223 people (44%) had good mental health, and 40 people (8%) had too low mental health. A total of 56% of the sample population are already suffering from mental disorders or are prone to psychological problems. These findings are consistent with those of previous studies, including Lambert et al., [21], Ghobari Banab et al., [22], Ghiyasie et al., [23], Khushabiet al., [24], Rajait et al., [25] and Khoddam [26] that studied the status of mental health in primary school children. Also these results are in agreement with those of Rahimian Bogar et al., [27] that examined the mental disorders in secondary and high school students of Khorasan province. The obtained results are in contrary to the results of studies that have reported high rates of mental health.

High rates of mental health problems derived from this study show the necessity of studying the effective roots and factors that arise, and providing appropriate solutions to mitigate these problems. Since the family has an important role in mental health, the present research examined the possible relationship between family communication patterns and mental health. The results of the present study are congruent with findings which indicate mental health has a significant positive relationship with conversation aspect of family communication patterns, and a significant negative correlation with the conformity aspect of it.

This result is consistent with the finding by Rahimi [28] that states the orientation of the educational objectives is a consequence of family communication patterns, and also is consistent with finding by Tajali and Latifian [29].
Another finding of the study wasthe predictability power of mental health through the aspects of family communication patterns. The results of regression analysis showed that both aspects of family communication patterns are good predictors of mental health, which among these two variables, conversation is considered a stronger predictor of mental health than conformity. This predictability was not unexpected with regard to the proposed theoretical foundations. This finding can also be explained so that the orientation of conversation is an effective factor to express ideas and feelings in adolescence. In a family that the orientation of conversation is very high, this family somehow modifies conformity orientation, or more clearly, the orientation of conversation is a modifying factor of conformity orientation in adolescents and explains it more generally. In other words, the orientation of conversation somehow encompasses the conformity orientation, which is congruent with findings by Tajallian and Latifian [28].

Based on the classification of the families according to the questionnaire of family communication patterns[18, 29], 27.5% of families were compatible, 30% pluralistic, 29% supportive, and 13.5% were easygoing families. Adolescents’ mental health patterns in family patterns from top to bottom are pluralistic family, compatible family, easygoing family and supportive family. The findings of the present research showed that most families had pluralistic communication pattern, which is consistent with the results obtained by Jawkarand Rahimi[30], Kouroshnia and Latifian [20], and Shahraki Sanavi [31]. Mental health in pluralistic family patterns was higher than other families, which was not unexpected with respect to the provided theoretical foundations. In this pattern, the adolescent obtains high score in the conversation aspect and low score in conformity aspect[20], which by considering high mental health in the pluralistic family pattern, other findings of this research, that is, the positive correlation of mental health with conversation aspect and negative relationship with conformity aspect is approved. The pluralistic family has the properties of openness and development of serious and competitive communications. In this family, the children in addition to respect the parents’ views are independent and autonomous. In explaining about the other families, it can be said that the consensual families reflect the conflict between discovering ideas among the open relations, exchange and pressure for agreement and supporting the familial hierarchies [17]. In the pattern of easygoing family, the family members are not often committed to each others in conversations and unlike the pluralistic families, the parents are not interested to the decisions made by children in communication and contact with them [32]. In the sportive family, as the last family pattern in terms of mental health, the communications and performances are needed for obeying and performing the family norms [17]. In this type of family, the obedience of the source of power (father and mother) is emphasized [17]. Therefore, the findings indicate that the family environment and open and wide communications are very effective in encouragement of adolescents in expressing their ideas and feelings, and helps their mental health. These findings are consistent with those of Kouroshnia and Latifian [20], Koemer and Fitzpatrick [17] and Shahraki Sanavi et al., [31] that studied the frequency of the type of families and the quality of life.

At the end, it is recommended that in future researches the mental health in adolescents is studied indifferent strata of the community and at regional and national levels. In terms of application, it is recommended that the experts of mental health try to promote the level of mental health in adolescents by providing appropriate grounds and measures to create a proper atmosphere for training families, and performing training activities in schools, and following it, help the
improvement of mental health in families and adolescents to achieve consequences such as self-esteem, school attendance, academic success, social coherence and chance of life in future and in general help the fruitful life of adolescents.

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References


