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Original Article

Impact of Family Conflict on the Psychosocial Behaviour in Male Adolescents

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Abstract

Introduction: Accepting and supportive family relationships during childhood and adolescence may have long-term associations with psychosocial functioning into adulthood. Cross-sectional studies provide evidence by which positive family relationships promote adolescent health by increasing the likelihood of positive outcomes including higher educational and occupational attainment and reducing the risk for negative outcomes including suicidal behaviour and poor health. **Materials and Methods:** The sample consisted of 500 male adolescents from the urban and rural field practice areas in the vicinity of Sri Guru Ram Das Medical College Amritsar. Cross sectional study was conducted to examine the relation between familial conflict problems and psychosocial/behavioural disorders in adolescents. **Results:** Almost one third (33%) adolescents were having parental and family dispute problems. These problems were significantly higher in middle adolescence (14-16 years), adolescents of large extended families (>8 members) and in lower socioeconomic status. Residence had no significant relation to family problems in the adolescents. On correlation, poor and unhealthy family atmosphere had more chances in adolescents of having greater academic problems, depression, suicidal thoughts, substance abuse and more sexual activity. **Conclusion:** Family involvement, family structure, parental values, parental monitoring and parent-child communication are important factors influencing critical life choices in teens. The family support and communication should be improved through these education programs to develop healthy psychosocial and sexual attitudes and counteract unsafe behaviours in the adolescents. Future research is needed to identify additional pathways underlying this association, and the extent to which these factors are modifiable.

Key words: Adolescent, Familial conflict, Psychological stress

Introduction

Adolescence is characterized by a number of cognitive, emotional, physical and attitudinal changes which can be a cause of conflict on one hand and positive personality development on the other. Adolescents who have a good relationship with their parents are less likely to engage in various risky behaviours such as smoking, drinking or fighting. Conflict is a common component of the parent-young adolescent relationship[1,2].

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Children and teenagers in our society are not spared from the evil of domestic violence. In fact, this form of violence is second in terms of number of reported cases after the violence against women. According to the WHO, in 2002, 31,000 children younger than 15 years died as a result of domestic violence globally[3]. Child exposure to domestic violence or "intimate partner violence" is a term encompassing a wide range of experiences for children whose caregivers are being abused physically, sexually or emotionally by an intimate partner. Kernic et al(2002) evaluated the association between children's exposure to maternal intimate partner violence (IPV) and behaviour problems and found that children exposed to maternal IPV were more likely to have externalizing (i.e., aggressive, delinquent) and internalizing (i.e., anxious, depressed) behaviours[4].

Lepisto et al in Finland found out that sixty-seven per cent of adolescents had experienced parental symbolic aggression, 55% mild violence and 9% serious violence and they reported deterioration in self-rated health, life satisfaction, adolescent depression and suicidal ideation and approval of corporal punishment[5]. Sprah reported among young adolescents in Slovenia that victims of domestic violence displayed aggressiveness, anger, posttraumatic stress symptoms, anxiety, depression and suicidal thoughts that could be linked with their violence experience in dysfunctional family environment[6]. Fergusson et al found increasing frequency of depression to be associated with declining education and economic outcomes in adolescent age[7].

Bricker et al showed that the influence of parents' smoking was substantial for most of the adolescents. In contrast, the influence of close friends smoking was strongest for trying smoking and did not significantly change (all $p>0.05$) for any of the smoking transitions as the adolescent became older[8]. Choquet et al found that a negative relationship existed between parental control and substance use but this relationship was more marked for tobacco and cannabis as compared to alcohol[9].

Lammers et al did a survey in USA to study the risk factors associated with early onset of sexual intercourse among adolescents and found that lower levels of sexual activity was associated with dual-parent families, higher socioeconomic status (SES), rural residency, better school performance, greater religiosity, absence of suicidal thoughts, parents looking after the adolescents needs and high parental expectations[10].

As adolescents face the challenges of second decade of life, a little help can go a long way in channelling their energy towards positive and productive paths. Over the years, many studies have been carried out in different parts of the world to assess the problems of adolescence. Most of the epidemiological surveys on school going children and adolescents have reported a wide variation (20-33%) in the prevalence of psychosocial problems[11]. Individual studies illustrated the prevalence of psychosocial problems ranging between 10-40%[12,13,14].

The rapidly changing social, political and economical scenario in the world has not left Indian family untouched. It is going through structural and functional modifications that have a bearing on adolescent's socialization and parent child relations. Weakening of social support from kinship, movement of women empowerment, exposure to media, increasing competitive demands of the market economy and higher standards of achievement are a few aspects that have changed the family dynamics in the recent past[15].

Adolescents across all sections of the society thus have a family as an 'anchor' that supports them to cope with challenges of transition to adulthood. Family as an institution in India therefore, has a potent role in influencing adolescents. Capacity building of its members to provide timely support and monitoring signs of dangers to save adolescents from slipping into risks can be an important strategy/approach. Involvement of parents has increasingly now been used in planned interventions of governmental and voluntary sectors. So, this study was planned to assess the impact of family problems on psychosocial behaviour in male adolescents aged of 12-18 years in Amritsar.

Materials and Methods

A cross-sectional study was conducted in schools and colleges located in rural and urban field practice areas of Department of Paediatrics, Sri Guru Ram Das Hospital, Amritsar. Three schools and two colleges were randomly selected for inclusion in the study. A total of 500 male adolescent students from age 12-18 years were selected by the method of systemic random sampling so that 250 males were from rural areas and 250 were from urban areas. Students were selected both from Punjabi as well as English medium schools and colleges. The objectives of the study were to study impact of family problems on psychosocial behaviour in male adolescents aged 12-18 years in Amritsar.

A verbal consent of principals of schools and colleges selected for the study was obtained prior to the study. The study tool consisted of self developed, pretested, semi structured Performa containing questions regarding adolescents' socio demographic background and adolescents' school, family, psychosocial and personality problems and history of substance abuse and sexual activity. A face to face interview was done in a large room and seating was arranged in such a manner that each participant had privacy in responding to the interviewers. A descriptive study design was planned.

The questionnaire consisted of the following parts:

I. *Informed consent:* Every adolescent was included in the study only after taking written informed consent in their vernacular language. Before commencing the study, a brief explanation of the purpose of the study was given to the school students. Participation in the study was entirely voluntary. All participants were reassured about the anonymity during the administration of questionnaire. The interview was conducted in the vernacular language of adolescents and parents

of the students were informed about this study for their affirmation. The purpose of gathering the information was fully explained and students were reassured that the information provided by them will be kept confidential and would be used for research purpose only.

II. *General information:* Name, age, sex, class, school/ college, residential area, parents name, age, education, occupation, income of the family, number of siblings and total family members were recorded as per the Performa.

Age: The male adolescents were divided into 3 groups based on age.

Group I 12 year to 14 years
Group II 14 year to 16 years
Group III 16 year to 18 years.

Education and occupation: Details were asked about the education status and occupation of both the parents.

Family income: The families of adolescents were divided into 3 groups based on total family income/ month

Group I <4000 rupees/month
Group II 4000 -8000 rupees/month
Group III >8000 rupees/ month

Total family members: The families of adolescents were divided into 3 groups based on total family members.

Group I < 4 family members
Group II 4-8 family members
Group III >8 family members

Socio-economic status: It was evaluated on the basis of Kuppuswamy's socioeconomic index which is an important tool in hospital and community based research in India[16].

KUPPUSWAMI'S CLASSIFICATION

It is based on Education, Occupation and Income of Family Head.

A. EDUCATION

Professional degree, PG and above	7
Graduate	6
Intermediate or Post High School Diploma	5
High School Diploma	4
Middle School Completion	3
Primary School Completion	2
Illiterate	1

B. OCCUPATION

Profession	10
Semi Profession	6
Clerk, Shop Owner, Farm Owner	5
Skilled Worker	4
Semi Skilled Worker	3
Unskilled	2
Unemployed	1

C. PER CAPITA INCOME (rupees per month)

1500 or above	>12
750-1499	10
565-749	6
375-564	4
225-374	3
75-224	2
Below 75	1

The total score is graded as follows

Upper (I)	26-29
Upper Middle(II)	16-25
Lower Middle (III)	11-15
Upper Lower(IV)	5-10
Lower (V)	<5

The male adolescents in our study were divided into three groups by modifying Kuppuswasmi's socioeconomic index.

Upper socioeconomic status → Class I
Middle socioeconomic status → Class II+III
Lower socioeconomic status → Class IV+V

III Specific information and problems: All the students were evaluated covering the following aspects of the adolescents

1. School problems
2. Family problems
3. Psychosocial and personality problems
4. Substance abuse
5. Sexual problems

The data was collected and analysed using SPSS-17 (statistical package for the social sciences software). Analysis of association between socio demographic profile of adolescents and school, family, psychosocial and personality problems, substance abuse, sexual activity was done using chi square test and analysis of variance (ANOVA). Multivariate analysis of association was also done between school, family, psychosocial, substance abuse and sexual activity among themselves using chi square test. For all statistical tests, a p-value of >0.05 was considered non significant, a p-value of <0.05

was considered significant and a p-value of <0.001 was considered highly significant.

Results

The present study was undertaken for 12 months from April 2009- March 2010 on 500 male adolescents of age group 12-18 years, taken equally among rural and urban areas of district Amritsar. All the adolescents were divided into groups based on age, educational institution, residence, total family members, total family income and socioeconomic status.

Age groups: It is seen that maximum number of adolescents were in age group 14-16 years (40%). Age group 12-14 years (29%) and age group 16-18 years (31%) were having almost equal number of adolescents. Educational institution: 69.2% of adolescents were studying in schools and 30.8% were from colleges. Residence: Adolescents were equally selected (50% each) from both rural and urban areas. Total family members: Maximum number of adolescents (51.4%) was from middle sized family of 4-8 members. Only 20.6% adolescents were from small sized family of less than 4 family members. Total family income: Maximum number of adolescents (46.8%) was from low income families having family income of less than rupees 4000/month. Only 20% adolescents were from good family income of more than rupees 8000/month. Socioeconomic status: Maximum number of adolescents (43%) was from middle socioeconomic status and 36.8% adolescents were from lower socio economic status. Only 20.2% adolescents belonged to upper socio economic status.

33% adolescents were having parental and family dispute problems and 29.4% parents were not taking care of the needs of their children. Only 68.4% adolescents were receiving pocket money and majority of them (49.5%) were getting between 100-500 rupees / month. 29% adolescents experienced domestic violence in their family. 38.2% adolescents did not have any close friends and most of them (43.6%) were having one or two friends. Majority (54.6%) of the adolescents were not sharing their problems with their friends.

Age group: Maximum number of family problems (39.5%) were in adolescents in age group 14-16 years in comparison to age group 12-14 years (27.5%) and this was statistically significant ($p<0.05$). Residence: Family problems were in 30% urban adolescents and 36% rural adolescents and this was not significant statistically ($p>0.05$). Total family members: Maximum family problems were in families with family size >8 members (52.8%) as compared to family size <4 members (18.4%) which was statistically significant ($p<0.001$) Socioeconomic status: Maximum family problems were in lower socioeconomic status (65.7%) as compared to upper (18.8%) and middle (11.6%) socioeconomic status. p value was highly significant ($p<0.001$)

Family problems were higher in adolescents with academic stress ($p<0.05$), depression ($p<0.001$) and suicidal thoughts ($p<0.001$). Substance abuse ($p<0.001$) and sexual activity were also significantly related to family problems ($p<0.001$).

Table 1: Sociodemographic profile of male adolescents in the study group

Variable of adolescents	Sub group	Number of adolescents	Percentage %
Age group(in years)	12-14 years	145	29.0
	14-16 years	200	40.0
	16-18 years	155	31.0
Educational institution	School	346	69.2
	College	154	30.8
Place of Residence	Urban	250	50.0
	Rural	250	50.0
Total family members (in numbers)	<4	103	20.6
	4-8	257	51.4
	>8	140	28.0
Total family income (in INR per month)	<4000	234	46.8
	4000-8000	166	33.2
	>8000	100	20.0
Socio economic status	Upper SES	101	20.2
	Middle SES	215	43.0
	Lower SES	184	36.8

Table 2: Distribution of family problems of male adolescents in study group

Variable	Subgroup	Number of adolescents	Percentage %
Parental/family dispute (n=500)	Yes	165	33
	No	335	67
Parents taking care of needs like books, clothes (n=500)	Yes	353	70.6
	No	147	29.4
Pocket money (n=500)	Yes	342	68.4
	No	158	31.6
If yes, how much pocket money (n=342)	<100/month	120	35
	100-500/month	169	49.5
	>500/month	53	15.5
Domestic violence	Yes	145	29
	No	355	71
Close friends	None	191	38.2
	1-2	218	43.6
	≥3	91	18.2
Sharing problems with friends	Yes	227	45.4
	No	273	54.6

Table 3: Socio demographic profile of male adolescents with family problems

Variable	Subgroup	Number of adolescents with family problem	Percentage %	Statistical analysis
Age group	12-14 years (n=145)	40	27.5	S
	14-16 years (n=200)	79	39.5	
	16-18 years (n=155)	46	29.6	
Residence	Urban (n=250)	75	30	NS
	Rural (n=250)	90	36	
Total family members	<4 (n=103)	19	18.4	HS
	4-8 (n=257)	72	28.0	
	>8 (n=140)	74	52.8	
Socioeconomic status	Upper SES (n=101)	19	18.8	HS
	Middle SES (n=215)	25	11.6	
	Lower SES (n=184)	121	65.7	

Table 4: Association of family problems with other adolescent problems

Variable	Sub group	Number of adolescents with family problem (n=165)	Percentage %	Statistical analysis
Academic problem	Yes (n=319)	118	36.9	S
	No (n=181)	47	25.9	
Depression	Yes (n=198)	95	47.9	HS
	No (n=302)	70	23.1	
Suicidal thoughts	Yes (n=103)	103	100	HS
	No (n=397)	62	15.6	
Substance abuse	Yes (n=94)	55	58.5	HS
	No (n=406)	110	27.0	
Sexual activity	Yes (n=78)	62	79.4	HS
	No (n=422)	103	24.4	

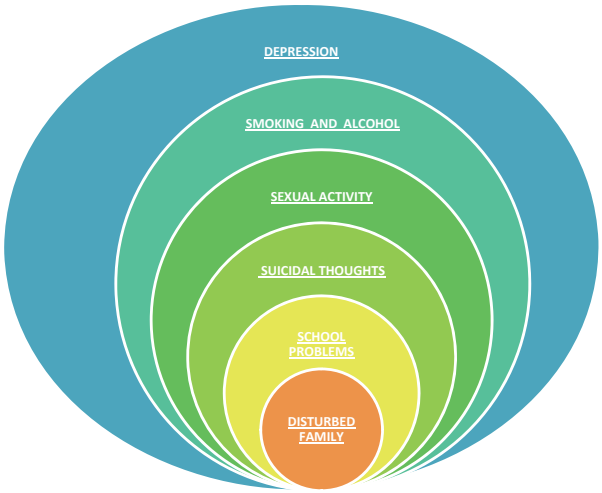

Figure 1

Discussion

Adolescence has been defined by WHO as the period spanning between the age of 10-19 years[17]. It is the period whereby an individual makes gradual transition from childhood to adulthood. These adolescents suffer from psychosocial problems at one time or the other during their development. The term psychosocial reflects both the under controlled, externalizing or behavioural problems such as conduct disorders, educational difficulties, substance abuse etc. and the over controlled, internalizing or emotional problems like anxiety, depression etc. The emotional problems have been relatively neglected compared with behavioural problems because these are not easy to be detected by the parents or teachers.

Table 1 show the socio demographic profile of the male adolescents in the study group. Maximum number of males was from 14-16 years constituting 40% of the adolescents followed by 31% and 29% in age group of 16-18 and 12-14 years respectively with 69.2% of adolescents studying in schools and 30.8% in colleges. Maximum number of adolescents (51.4%) were from middle sized families of 4-8 members and majority (46.8%) of them were from low income families having family income of less than rupees 4000/month. 43% adolescents were from middle socioeconomic class (II and III) and 36.8% adolescents were from lower socio economic status (IV and V). About 20.2% adolescents belonged to upper socio economic status (I).

Table 2 shows that 165 (33%) adolescents were having parental and family dispute and there was no family dispute in 335 (67%) male adolescents. Family conflicts affect children by creating an aversive home environment due to inter parental separation and similar findings were shared by Ganesh and Magdalin (2007) in children of disrupted and non disrupted families[18]. Parents were taking care of teens needs in 353(70.6%) males as compared to 147(29.4%) parents who were indifferent to the needs of youngsters. About 158 (31.6%) adolescents were not getting any pocket money from the parents and those who were getting, majority (84.5%) of them got less than 500 rupees/month. Giving pocket money to the adolescents has several advantages as it inculcates in them a sense of responsibility and teaches them how to manage money which will come in handy throughout their lives. It has been seen that those teenagers who are not getting any pocket money develop deviant behaviours like stealing adding to the behavioural problems in the adolescents.

Table 2 further shows that 145 (29%) adolescents had experienced domestic violence which was higher than that seen by Sprah (18.7%) in Slovenia (2008)[6]. Teenagers and adolescents are not spared from the evil of domestic violence in our society and possible reasons could be disobeying parental advises and debating with parents and other family members. About 191 (38.2%) adolescents had no friends and those who were having, majority (43.6%) had just one or two friends. Most (54.6%) of the adolescents were not sharing their problems with friends which can be aggravating cause for increase in adolescent problems as peer relationships in childhood and adolescence are believed to play an important role in desirable and undesirable developmental outcomes. Information on whether a child has friends, the quality of the child's peer relationships and the identity of the peers all contribute to understanding the developmental implications of peer relationship experiences[19].

Table 3 shows the socio demographic profile of adolescents with family problem. Only 27.5% adolescents in 12-14 years of age had family problems in contrast to 39.5% adolescents in later age of 14-16 years. One possible reason could be that adolescents in earlier age are hesitant to discuss their family environment in comparison to later years. Both rural (36%) and urban (30%) adolescents faced family problems in high numbers. The rates of unemployment, low educational attainment, marital discord and economic stress occur equally in both rural and urban settings making adolescents vulnerable to dysfunctional family atmosphere irrespective of their residence. 52.8% adolescents from extended families faced family problems in comparison to just 18.4% adolescents from small sized nuclear families which may be due to availability of less resources and more mental stress in care providers of large families.

Maximum numbers of family problems were found in adolescents of lower socio economic status (65.7%) in comparison to upper (18.8%) and middle (11.6%) socioeconomic status which may again be linked to

lower employment rates and illiteracy in family members of low SES.

Table 4 shows the association of family problems with other adolescent problems. On multivariate analysis, family problems had a statistical association to low academic performance (36.9% v 25.9%), depression (47.9% v 23.1%) and suicidal thoughts (100% v 15.6%) along with substance abuse (58.5% v 27%) and pre marital sexual activity (79.4% v 24.4%). It is seen that adolescents with family dispute where parents are not taking care of the basic needs like books and clothes are more vulnerable to school and academic problems which is in accordance to study done by Arun and Chavan (2009)[20]. Poor inter parental relationships and stressful family environment with lack of parental supervision and intellectual stimulation negatively affects the school performance in adolescents as was also found by Munni and Malhi (2001) in their study in Chandigarh adolescents[21]. These adolescents with unhealthy family atmosphere may internalize their psychological response as pointed by Sprah (2008) in Slovenian schools where dysfunctional family environment led to depression and suicidal thoughts in adolescents[6]. Adolescent depression may affect the teen's socialization, family relations and performance at school often with potentially serious long-term consequences.

Substance abuse has also been shown to be common outcome of early maltreatment in uncordial family atmosphere. Children exposed to parental separation during childhood had elevated risks of a range of adolescent problems, including substance abuse or dependence, conduct or oppositional disorders, mood and anxiety disorders, and early-onset sexual activity[22].

Family structure, parental values and monitoring along with parent-child communication are important factors influencing critical life choices like experimentation with drugs, delay in the onset of sexual intercourse and more consistent use of contraception by sexually active teens. Low parental support and involvement has been related to sexually permissive attitudes of teens as found by Lammers et al (1988) who advocated enhancement of family and education programs in preventing teen pregnancy[9]. Sexual activity was more in adolescents who had family dispute, poor family support, and feeling of not being cared and poor communication with the parents. Felton and Bartoces (2002) pointed that males who had strong family support and good communication with the parents tend to delay sexual intercourse[23].

To sum up, as seen in Figure 1, it was observed that the disturbed family structure is the core cause of majority of psychosocial problems in adolescence and leads to negative behaviour during these crucial years. Youth based programs should be oriented on family participation to recognise the diversity of youth age group spanning between the age of 12 -18 years who vary by age, schooling, residence, family size and socioeconomic status. Involvement of family can help address the need of our target group comprising of rural boys belonging to extended families of low socioeconomic status.

Conclusion

Remedial measures were taken in the form of giving consolation and advice to the affected students at the time of filling the Performa providing awareness regarding various factors observed during the study wherever possible. Adolescents having psychosocial problems were referred to the psychiatry department. Parent/teacher meetings were advised and teachers were made responsible to contact parents to alleviate adolescent problems.

Improving the health of young people is complex and difficult and relatively few adolescent focussed programs have been tried on large scale. The delivery of health care to adolescents must be based on the analysis of the problems identified in different surveys in various parts of the country.

Family involvement, family structure, parental values, parental monitoring and parent-child communication are important factors influencing critical life choices in teens. The family support and communication should be improved through education programs to develop healthy psychosocial and sexual attitudes and counteract unsafe behaviours in the adolescents

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