

Resident and Parental Perceptions of Adolescent Problems and Family Communications in a Low Socioeconomic Population

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This cross-sectional survey of a low socioeconomic patient group was designed to determine the prevalence and severity of parentally perceived behavioral problems in adolescents as well as to investigate the correlation between such problems and single parenting, family communications, and medical care delivered. The sample population consisted of 79 parents and 121 teenagers selected from a family practice center. The medical record and telephone interview were the sources of information. Results include a parental perception of a high prevalence of problems with school grades (48 percent), school attendance (38 percent), and household problems (chores and sibling rivalry). Of low prevalence but high severity were perceived problems related to suicidal ideation, running away, sexual activity, and gang membership. Single-parent homes had a threefold higher incidence of behavioral problems, a greater degree of communication, and a lower use of community resources than two-parent families. None of the approximately 400 perceived behavioral problems listed by parents was found in the family physicians' master problem list. The results indicate the need for physician education of low socioeconomic and single-parent patients with regard to communication and coping style. In addition, it appears that training programs should provide more education in the care of adolescents.

Teenagers make up a significant percentage of the United States population. However, teenagers continue to be a major segment of the medically

underserved American population.¹ Of all stages in the life cycle, the least studied and understood stage is that of adolescence.²

The purpose of this study was to determine (1) the parental perception of the prevalence and severity of common behavioral problems in adolescents of low socioeconomic status, (2) the relationship among the perception of such problems, the presence of both parents in the home, and

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family communications, and (3) the number of these perceived adolescent behavioral problems that had been addressed by the family physicians of these families.

Methods

The study population consisted of all families with teenagers cared for at the McKee Family Health Center in San Bernardino, California. This family health center, one of four within the residency training program of the San Bernardino County Medical Center, typically attracts patients using public-assistance programs, who represent a low socioeconomic group. Only families with teenagers aged 13 to 18 years were eligible for study.

Information was collected about families through both medical record review and telephone interview. Information collected from the medical record abstract included any problem listed in the patient's master problem list (which should include any temporary or chronic medical condition identified by the physician), visits made in the prior 12 months, and demographic characteristics of family members.

Telephone interview was utilized to obtain information on respondent and family demographic characteristics, physician visits made by teenagers during the prior 12 months, and the parent's perception of the severity of 18 common behavioral problems in each of the family's teenagers during the prior 12 months. Respondents were asked to grade the severity of the perceived problems from no problem (scored as 0) to severe problem—cannot handle it (scored as 4). Thus, the individual teenage problem-severity score could range from 0 to 72. From the individual responses for each perceived problem and each teenager in the family, a total perceived family-teenager behavioral score was constructed as the sum of the severity of all perceived teenage problems in the family.

In addition, for information on parent-adolescent communication styles and for identification of problem-solving approaches used by families, two standard questionnaires were used.³ The Parent-Adolescent Communication Questionnaire was used as a measure of the degree of communication between parent and adolescent, with questions focusing on the degree of actual and emotional information flow between these family members.

The higher the score, the higher the degree of communication.

The second questionnaire used was the F-Copes (Family Coping Strategies) questionnaire. This 29-item questionnaire measures effective problem-solving approaches and behaviors used by families in response to problems or difficulties. Five subscales are present within the questionnaire as follows: (1) the use of supportive personal relationships, (2) the use of positive redefinition of problems to make them manageable, (3) the use of religious support mechanisms, (4) the use of community resources, and (5) the use of denial mechanisms. Higher scores on these subscales represent higher use of the particular coping strategy.

Standard univariate statistical tests used to determine associations included Student's *t* test (two-tailed for difference in means), chi-square test (for independence of frequency data), and deviation of the Pearson product-moment correlation coefficient (r^2) from zero.

Results

In all, 211 families were identified as eligible for study. Of these, 103 (48.8 percent) were not reachable by telephone (no telephone, wrong number, message telephone). Seventy-nine (71.3 percent) of the remaining 108 families were reached by telephone and completed the interview. In comparison with respondents, nonrespondents were of similar age, were somewhat overrepresented with nonwhites, and had a similar number of teenagers in the household. Respondents who were mothers of teenagers showed much greater utilization of the Family Health Center than nonrespondents ($P < .01$).

General demographic characteristics of families ($n = 79$) responding to the interview are found in Table 1. Almost always (96 percent) the respondent was the mother.

The most prevalent behavioral problems perceived by the parents were school grades and attendance (48 percent and 38 percent, respectively). Following these two problems in prevalence were the household problems of failing to do chores (36 percent) and sibling rivalry (34.2 percent). Defiant behaviors were next most prevalent (lying, verbal defiance), with approximately three out of ten teenagers exhibiting these behaviors.

Table 1. Characteristics of Families Completing Interview (n = 79)

Characteristic	
Age of responding parent (mean)	41.9 yr
Number of visits to physician by respondent in prior 12 months (mean)	6.76
Relationship of responding parent	No. (%)
Mother	75 (96)
Father	4 (4)
Families with only one parent at home	49 (63)
Child support obtained	19 (38.8)
No visitation by missing parent	28 (60)
No discipline from missing parent	31 (65)
Ethnicity of respondent	
White	50 (64)
Hispanic	18 (23)
Other	11 (13)
Income of respondent	
<\$5,000	20 (26)
\$5-10,000	23 (30)
\$10-15,000	19 (25)
\$15,000+	15 (19)

The next most frequent problems were those associated with peer-group activities (staying out late, sexual activity, pregnancy, violence, drug use, problems with legal authorities), averaging 10 to 15 percent. Relatively rare were problems of suicidal ideation, running away, having no friends, and gang membership. However, when present, the most severe problems were those of low prevalence including pregnancy, gang membership, problems with legal authorities, suicidal ideation, no friends, and sexual activity (Table 2).

Only the F-Copes total score was significantly correlated with the family-teenager behavioral score ($r^2 = -.28, P < .005$) (Table 3).

In comparing the sample with regard to the presence of both parents in the home, the family-teenager behavioral score was threefold higher in one-parent households. In addition, one-parent

households scored higher on the Parent-Adolescent Communication Questionnaire. However, except for the ability to use community resources, which was lower in the one-parent household, no significant differences were shown in coping strategy.

Finally, with regard to medical problems and utilization of health services, the median number of visits to physicians in the prior year was 2.45 and 6.76 for teens and respondents, respectively. Approximately two thirds of these physician visits were to the family physician. No relationship was found among communication characteristics, family coping style, and the presence of 14 of the most common reasons for visits to physicians. In fact, of the approximately 400 perceived behavioral problems listed as present in the teenagers of this sample, not one appeared on the master problem list of the patients.

Discussion

The results of this study should not be generalized to patient groups outside the low socioeconomic setting. In addition, as less than one half of the identified sample was interviewed, and as the inability to reach a household was related to ethnicity and utilization of the family practice center, caution should be observed in extrapolating the findings because a selection bias could have created the observed findings. Moreover, one must remember that the problems identified in this study are only those perceived by the parents and may represent underreactions or overreactions to true behavioral problems. However, results similar to those of this study have been shown by others when the respondents were the teenagers themselves.^{4,5}

With these limitations in mind, comparison of this low socioeconomic status group with a national sample of couples and families who took the same Parent-Adolescent Communications Scale and F-Copes Scale is remarkable.³ The sample mean parent-adolescent communication score in this study group was at less than the tenth percentile in comparison with the national sample. In addition, sample means were in the following percentiles for the F-Copes subscales: personal relationships (50th percentile), redefinition (less than 7th percentile), religious support (less than the 5th

Table 2. Respondent Perceived Behavioral Problems in Teens (n = 120)

Behavioral Problems	Prevalence of Problem No. (%)	Mean Severity of Problem	
		When Present	In Total Sample
School grades	58 (48.3)	2.07	1.00
School attendance	45 (37.5)	2.20	0.83
Sibling rivalry	41 (34.2)	1.87	0.64
Doing chores	43 (35.8)	1.67	0.60
Lying	38 (31.6)	1.68	0.53
Defiance	37 (30.8)	1.68	0.52
Peer group	30 (25.0)	1.87	0.47
Staying out late	19 (15.8)	2.16	0.34
Sexual activity	18 (15.0)	2.28	0.34
Pregnancy	12 (10.0)	3.42	0.34
Violence	15 (12.5)	2.07	0.26
Illicit drug use	13 (10.8)	2.08	0.23
Problems with law	9 (7.5)	2.67	0.20
Alcohol use	11 (9.2)	1.91	0.18
Suicide ideation	6 (5.0)	2.50	0.13
Running away	10 (8.3)	1.60	0.13
No friends	7 (5.8)	2.14	0.13
Gang membership	3 (2.5)	3.00	0.08

Table 3. Correlation Among Family-Teenager Behavioral Score, Communication Characteristics of the Family, and Family Coping Strategies (F-Copes)

Communication and Coping Characteristic	Sample Mean No.	Correlation With Family-Teenager Behavioral Score r^2
Parent-Adolescent Communication (n = 78)		
Total score	50.48	.20
F-Copes (n = 78)		
Personal relationship	28.15	-.22
Redefinition	17.94	-.06
Religious support	10.00	-.20
Community resources	11.37	-.26
Denial mechanisms	14.25	.03
Total score	81.71	-.28*

*P < .05

percentile), community resources (35th percentile), and denial mechanisms (97th percentile). Thus, unless accounted for by a selection bias, this

low socioeconomic-status sample appears to have very low communication levels with adolescents as well as very low use of problem redefinition and

religious support as a means of coping with problems. However, denial as a means of coping is extremely high in the group. Coping styles represented in this last subscale include luck, watching television, waiting for problems to go away, and feeling that no matter what you do, you will have difficulty with the problem. As the family physician's role includes educating patients in coping with problems, these results may give an area of focus for those who care for patients of low socioeconomic status.

School grades, attendance, and helping around the household were found to be perceived as prevalent problems by parents in this sample. As expected, these problems were much less severe in nature than the rare problems of suicidal ideation and gang membership. For the family physician, these data suggest that intervention strategies directed toward these seemingly minor problems may be needed, as they may be masking more serious physical and mental health problems of the family.⁶

The positive correlation between greater communication ability and the magnitude of the perceived family-teenager behavioral score is noteworthy. While superficially one may deduce that greater ability to communicate leads to more behavioral problems, this seems unlikely. Rather this finding may indicate that increased communication results in the parent's increased awareness of behavioral problems.

These results also give insight into problems facing one-parent families of low socioeconomic status. The threefold increase in perceived problem family-teenager behavioral score in this sample could not have resulted from differences in the number of teenagers (the number was equal in the two groups). In addition, these one-parent families had a lower ability to cope with problems. This difference in coping ability was statistically significant in only their ability to use community resources, suggesting that social isolation is a problem in one-parent families.

Finally, a disturbing finding in this study was that none of the 400 perceived behavioral problems reported by parents had been noted in the family physician's master problem list of either the parents or teenagers. Assuming that these perceived behavioral problems are real, two major possible problems become evident: (1) family physicians in training do not consider these behavioral

problems significant enough to make note of them in the medical record, or (2) patients do not disclose these behavioral problems to their physician. Marks et al⁷ have recently shown that the majority of teenagers would not choose to go to a physician for care related to sexuality, substance abuse, or emotional upset, giving evidence that the lack of care is patient centered. However, 66 percent of recent graduates of pediatric residency programs indicate that their training in adolescent medicine is insufficient,⁸ providing support for a provider-centered problem. In either case, as Strausburger has espoused, "Not only pediatric programs but also internal medicine and family practice programs need to be restructured so that more about adolescence is taught and all physicians learn how to care for and cope with teenagers."⁹ Family physicians are uniquely situated to address the problems of adolescents even in the absence of visits by teenagers (only 30 percent of the total), as problems may be addressed during visits with parents.

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