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The Effect of Parent Adolescent Communication on Psychological Well-Being Among Haitian

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Abstract

Many individuals during adolescence may go through a transitional period of feeling misunderstood due to difficulty with expressing themselves. As the adolescent goes through identity development, there may be tension between the parent and the adolescent. This study specifically addresses adolescents of Haitian descent. Individuals of Haitian descent may have their own unique cultural practices and norms that impacts communication between the children and parents. This in turn may contribute to poor communication, especially as the Haitian children born in the United States assimilate into the Western culture. This assimilation may lead to negative psychological outcomes. Most of the research done on PAC has examined the impact that lack of communication has on adolescent behavior and failed to address the impact this lack of communication may have on psychological well-being.

The purpose of this research is to explore the relationship between parent-adolescent communication (PAC) and psychological well-being of adolescents of Haitian descent. The participants in this study included 99 middle school students (44 males and 55 females) of Haitian descent (ages 10 to 15 with a mean of 12.28). It was hypothesized Open PAC and would predict lower depression, lower anxiety, and higher self-esteem among adolescents and Problem PAC and would predict higher depression, higher anxiety, and lower self-esteem. Correlations were conducted to determine if the variables of interest were related. Next, linear regression analyses were conducted to determine whether open parent adolescent communication (PAC) and depression, anxiety, and self-esteem would predict lower depression, lower anxiety, and higher self-esteem among adolescents and whether problem PAC would predict higher depression, higher anxiety, and lower self-esteem.

The findings showed that the variables were related. Findings revealed that there was a strong positive correlation between open communication and self-esteem, $r(99) = .504$, $p < .01$. A Pearson Correlation was performed to determine the relationship between open communication and depression. The results revealed that there was a strong negative correlation between open communication and depression, $r(102) = -.463$, $p < .01$. Further, the findings revealed that open parent-adolescent communication predicted lower depression among adolescents of Haitian Descent F (1, 94) =25.589, $p < .000$), with an R^2 of .206. Open parent-adolescent communication predicted higher self-esteem F (1, 90) = 30.609, $p < .000$), with an R^2 of. 245. Open-parent adolescent communication did not predict lower anxiety among Haitian Adolescents F (1, 96) = 1.725, $p = .192$ with an R^2 of .007. Problem communication predicted higher depression F (1, 95) = 28.748, $p <. 000$), with an R^2 of .232. And lower self-esteem F (1, 92) = 12.248, p = .001, with an R^2 of .117. Problem communication did not predict higher anxiety F (1, 98) = 3.726, $p = .056$, with an R^2 of .037. Results of this study supported the notion that open PAC predicted lower depression and higher self-esteem and problem PAC predicted higher depression and lower self-esteem. However, open PAC and problem PAC predicting lower and higher anxiety was not supported. The results of these findings have implications for educators, parents and other professionals working with adolescents of Haitian descent.

Introduction

Adolescence is a period that can significantly impact the later stages in a person's life. Protective factors can contribute positively to an adolescent's development. On the other hand, some elements may impede an adolescent's progress. These factors are called risk factors. Risk and protective factors may occur at the individual level. Risk and protective factors may also occur at the environmental level such as family cohesiveness, neighborhood, and parent-adolescent communication (Youth.Gov, n.d.).

Risk factors can be defined as "a characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes (Youth.Gov, n.d.). Risk factors are characterized as conditions that increase the probability of an undesirable outcome. Risk factors among adolescents may include, low self-esteem, anxiety, and severe temperament. These risk factors may cause adolescents to engage in sexual risk behaviors that can result in unintended health outcomes. For example, among U.S. high school students surveyed in 2015, 41% had ever had sexual intercourse (Youth.Gov, n.d.). In addition, 30% of adolescents have had sexual intercourse during the previous three months, and, of this 43 % did not use a condom the last time they had sex (Youth.Gov, n.d.). However, 14% of adolescents did not use any method to prevent pregnancy. Twenty-one percent of adolescents' drunk alcohol or used drugs before last sexual intercourse (Youth.Gov, n.d.).

Protective factors can be interpreted as "a characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes" (Youth.Gov, n.d.). Protective factors are factors or attributes that help individuals to

defend against undesirable consequences. The protective factors among adolescents include high self-esteem, emotional self-regulation, good coping, and problem-solving skills. Furthermore, adolescents may need more socio-emotional space as they navigate through the changes that are happening in their lives. During this time, adolescents are also gaining new physical and cognitive capacities and developing new social interests. As adolescents emerge into adulthood, they must learn to handle these challenges with independence and responsibility.

Children change during adolescence and the formation of an independent identity often emerges. Adolescents are more likely to seek out new experiences and engage in more risk-taking behavior. Adolescents are still developing control over their impulses and may be influenced more by their peers. Their peers can influence them to engage in sex, use drugs, or skip school. Further, during this period adolescents may go through emotional changes. Young individuals become more advanced when it comes to processing other individuals' emotions as they develop. While they are developing these skills, they can sometimes misread facial expressions or body language. They may be easily offended by the actions of others. Effective communication with parents can help the adolescent navigate these changes.

Barnes and Olson (1985) stated that communication is the mechanism that families utilize to share their changing preferences, needs, and feelings. This means that while positive connection facilitates movement to different levels of a family organization, a lack of communication skills or negative communication is believed to inhibit the family system's ability to change levels of cohesion and adaptability (Barnes & Olson, 1985). Open communication between parents and adolescents helps reduce the adolescents' chances of negative outcomes such as depression, substance abuse, sexual behavior, and delinquency (Barnes & Olson, 1985).

Parent-adolescent communication improves the parents' understanding of their child's changing preferences, needs, and feelings.

Purpose Statement

Most of the research done on parent adolescent communication (PAC) has examined the impact that lack of communication has on risky behavior in adolescents. Few, if any studies have examined whether or not poor PAC leads to psychological problems in adolescents (e.g. effects their psychological well-being). Yet, one in every four to five youth in the general population meet criteria for a lifetime mental disorder that is associated with severe impairment and distress (11.2 percent with mood disorders, 8.3 percent with anxiety disorders, and 9.6 percent behavior disorders; Youth.Gov, n, d). A national and international literature review found that an average of 17 percent of young people experiences an emotional, mental, or behavioral disorder (Youth.Gov, n, d). Substance abuse or dependence was the most commonly diagnosed group for young people, followed by anxiety disorders, depressive disorders, and attention deficit hyperactivity disorder. The rate of severe mental illness was higher for 18 to 25-year-olds by 7.4 percent in 2008 (Youth.Gov, n, d,). Further, the onset of 50 percent of adult mental health disorders occurs by age 14, and 75 percent of adults by age 24. If the lack of parental communication is a factor that contributes to poor mental health, then more research in this area is needed.

The remainder of this paper will critically review research conducted on parent-child relationships. This literature review will focus on research that examines the relationship between parental involvement, parental monitoring, parent-adolescent communication, and psychological well-being in adolescents. The literature review will first examine studies

exploring parental involvement, adolescent risky behavior, and psychological well-being. Next, this review will include studies on parental monitoring, adolescent risky behavior, and psychological well-being. Finally, the literature review will narrow its focus to research regarding parent-adolescent communication and its impact on adolescents' psychological well-being; particularly ethnic minorities. Following this section Bronfenbrenner's Ecological Systems Theory will be discussed as the theoretical framework for a study that will be proposed. The proposed study will include the hypotheses and the rationale for the study as well as the method section.

Literature Review

Parental Involvement

Pearson, Muller, and Frisco (2006) explored how parental involvement that better represents dynamics between maturing teens and their parents influences their sexual initiation. The study addressed how parental availability and household organization influenced prosocial behaviors, such as academic achievement and decreased participation in risk-taking activities. Results show that parents being at home for dinner in the evening may signal that parents are there to offer guidance and structure without the more explicit behavior control that is negatively associated with outcomes for older teens. Adolescents who share meals with their parents are engaged in fewer behavior problems, possibly because a shared mealtime indicates a more stable and organized family life. This study's researchers found that being available during dinnertime impacts adolescent sexual decision-making. Many parents share such activities as attending events (e.g., sporting events, movies, or concerts), religious services, or shopping with their sons and daughters. This form of involvement is more likely to take place outside the home and may

provide an opportunity for family interaction. This type of involvement may also help parents to take out the time to share everyday experiences with their children. In addition, parental supervision and discipline reduces the likelihood that a teenager will initiate sex.

Hysing et al. (2014) reported that socioeconomic disadvantage in childhood is related to both immediate and persistent impairments in their mental health and well-being. This means that children and adolescents who grow up in families from lower socioeconomic status (SES) have more internalizing symptoms such as anxiety and depression, and externalizing traits such as aggressiveness, opposition, and hyperactivity, as compared to those raised in more affluent families (Hysing et al., 2014). Their findings suggest that parents from lower socioeconomic statuses may not have the time to devote to be their child's life. Parents often work long hours and when home they are too exhausted to provide quality involvement in their child's life.

One of the leading perspectives on the pathways mediating the association between SES and child mental health is the family process model. This model suggests that the family's economic status affects the children's socioemotional development by influencing the psychological well-being of parents and thereby their parenting practices (Hysing et al., 2014). Parents that lack warmth and involvement, and who engage in harsh and erratic discipline creates aggressiveness, hostility, opposition, anxiety and depression in adolescents. These findings acknowledge the importance of parent-child relationships such as parent-child closeness, parental knowledge of children's whereabouts, and the home environment to adolescent outcomes.

Hysing et al. (2014) also found that the parents work life may significantly impact the child's mental health. The shift in which parents' work may have significant implications on the

time, energy, and resources that parents can draw upon to raise their children. Parents' experiences at the workplace may spill over to the home by influencing their well-being, which in turn may impact how involved they are in the children's lives. Stressful job conditions associated with working a nonstandard schedule may, in turn, lead to less positive family dynamics, including reduced time spent with children, lower parental knowledge of children's whereabouts, and lower quality home environments. In addition, even if parents can find the time to spend with their children, parents that work evening or night hours may not have the energy to foster a positive parent-child relationship. Thus, the effect of work stress on the family and home environment further impacts the adolescent's psychosocial functioning (Hysing et al., 2014).

Wang and Sheikh-Khalil (2014) examined the effects of different types of parental involvement on high school students' academic achievement and depression. In this study, researchers hypothesized that parental involvement was positively associated with achievement and negatively associated with depression. They also hypothesized that parental involvement would promote adolescent achievement and reduce depression by enhancing student behavioral and emotional engagement in school. Finally, Wang and Sheikh-Khalil (2014) hypothesized that the associations between parental involvement and adolescent outcomes would vary by ethnic background and family SES, although similarities might also exist. For instance, it was expected in this study that African American parents would have less school-based involvement than European American parents, but that both ethnic groups would benefit from school-based involvement similarly.

The different types of parental involvement included, "school-based involvement", "home-based involvement", and "academic socialization". School based involvement included, parent–

teacher communication, attendance at school events, and volunteering at school. Home-based involvement included, provision of structure for homework time, leisure time (e.g., having a set time or location to do homework, visiting museums), and monitoring of schoolwork. Furthermore, academic socialization referred to the communication of parental expectations about schoolwork, importance of education, encouragement of career goals, and making preparations with adolescents that support their future goals. Participants consisted of 1,056 tenth graders from ten high schools. The classes consisted of approximately 66% European American students, 26% African American students, and 8% other racial minority students. Student achievement was based on GPA (Wang & Sheikh-Khalil, 2014). Adolescent depression was measured using the Children's Depression Inventory.

Wang and Sheikh-Khalil (2014) found that parental involvement in 10th grade improved not only educational but also emotional functioning among adolescents by the time they were in the 11th grade. However, the effects of parental involvement on achievement and depression varied by the type of participation in which parents engaged. For instance, among the types of parental involvement, academic socialization had the most positive association with achievement. African American parents reported more home-based involvement and less school-based involvement than European American parents. However, there were no ethnic differences in academic socialization found between European and African American parents.

Parental Monitoring

Parental monitoring is described as a "set of parenting behaviors aimed at paying attention to and tracking the child's whereabouts, activities, and adaptations" (Dishion & McMahon, 1998). It is often considered a protective factor and research supports this claim.

Dittus et al. (2015) performed a meta-analysis to assess the magnitude of the association between parental monitoring and adolescent sexual intercourse, condom use, and contraceptive use. This meta-analysis examined the relationship between parental supervision and adolescent sexual behavior. This study also evaluated whether specific types of parental monitoring such as global knowledge of activities or enforcement of sexual behavior rules, and overall parental tracking have a differential effect on adolescent sexual intercourse, condom use, and contraceptive use. The meta-analysis focused on adolescents aged 10 to 19 years old. This meta-analysis examined the association between parental monitoring and one of the following: adolescent sexual risk behaviors such as whether or not the adolescent has ever engaged in sexual intercourse, condom use, contraceptive use, intention to engage in sexual intercourse, frequency of sexual intercourse, number of sexual partners, and sexually transmitted infection and pregnancy outcome.

This study found that higher levels of parental monitoring were associated with lower likelihood of adolescents ever having engaged in sexual intercourse and a higher risk of sexually experienced adolescents using both condoms and contraceptives. Additionally, Dittus et al. (2015) found that parental enforcement of rules about friends and dating (sexual behavior–control) was more strongly associated with delaying adolescent sexual intercourse than was parental knowledge of friends, whereabouts, and activities (global parental monitoring). However, enforcement of rules was not associated with condom or contraceptive use. Lastly, parental monitoring effects were robust across age, gender, and sexual experience. This suggested that parents can positively influence the sexual risk behavior of boys as well as girls, for older as well as younger adolescents and for adolescents who have or have not initiated sexual intercourse (Dittus et al., 2015).

Parent-Adolescent Communication

Parent adolescent communication is communication that affects adolescent identity formation and behaviors. There are two types of communication: "Open" and "problem" communication. Open communication is the quality of exchanging information and investigates freedom in communication, comprehension and satisfaction with communication (Barnes & Olson, 1985). Problem communication is communication that focuses on barriers to parent–adolescent communication such as the presence of negative feelings about communication, absence of sharing feelings and selectivity of subjects (Barnes & Olson, 1985).

Prado et al. (2012) found that open parent-adolescent communication about sex is associated with engagement in fewer HIV risk behaviors. Several indicators of open parent-adolescent discussion about sex, in turn, may promote positive condom use attitudes, parental norms, and control beliefs (Prado et al., 2012). Adolescents who openly communicate about sex with parents have a greater perception that their parents approve of condom use. Adolescents who talk about sex with parents are also more likely to have positive attitudes about condoms, including that condoms are reliable and protect against sexually transmitted diseases.

Harris, Sutherland, and Hutchinson (2012) examined the influence of parental marital status, parent-child sexual communication, and parent-child closeness on the HIV-related knowledge, safer-sex intentions, and behaviors of late adolescent urban African American males. The investigators found that adolescent boys reported higher PCSC (Parent-Child Communication) with their mothers compared to fathers.

There has been a limited amount of research dealing with parent-adolescent communication and mental health. The research has primarily focused on risky behavior and

parent adolescent communication. However, it is important to determine if adolescents experience psychological impairments as a result of poor PAC.

Psychological Well-Being and Subjective Well-Being

There are two types of well-being; psychological (eudaimonic) and subjective well-being (hedonic). Psychological well-being is a combination of positive affective states such as happiness and functioning with optimal effectiveness in individual and social life (Deci & Ryan, 2008). Psychological Well-Being (PWB) is multifaceted in nature and is commonly measured using the Ryff scale which include six different dimensions. These six dimensions are self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy (Ryff & Singer, 2008). Psychological well-being is about life going well. It is the combination of feeling good and functioning effectively (Huppert, 2009). People with high PWB report feeling happy, capable, well-supported, and satisfied with life (Huppert, 2009).

Subjective well-being is an individual's perspective regarding their mental health. In addition, subjective well-being is an individual's evaluation of certain areas of their life such as work, relationships, etc. (Diener, Lucas, & Oshi, 2002). When working with adolescents, separate constructs are often used to measure subjective well-being such as depression, anxiety, and self-esteem. Since the population in this study are adolescents, subjective well-being and not psychological well-being will be the focus. Thus, the aforementioned constructs regarding depression, anxiety, and self-esteem will be used to measure subjective well-being. Prior to going into detail about the proposed study, an overview of the theoretical framework will be provided.

Theoretical Framework

The ecological systems theory was developed by psychologist, Bronfenbrenner (1979). Ecological systems theory states that there are five external systems that may influence an individual's life. The systems are organized from the most intimate level to the broadest. These systems include the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem. The individual's microsystems include any immediate relationships or organizations the individual interacts with, such as their immediate family and school (Oswald, 2015). The mesosystem is the interaction of microsystems such as the parent and the school. For instance, if an adolescent's parents engage in school-based involvement, such as going to parent-teacher conferences then this will enhance the adolescent's academic achievement and possibly their well-being. The exosystem is a system that includes the other people and places that the individual themselves may not interact with as consistently but that still have a large effect on them, such as parents' workplaces, extended family members, and the neighborhood (Oswald, 2015). For instance, if a child's parent gets laid off from work, that may have a negative effect on the child. The parent may take their frustrations out on the child due to possible financial struggles. The macrosystem is a system that consists of broader cultural values, beliefs, laws, and governmental resources that affect the individual. For instance, a parent's culture which consists of shared beliefs, values, and customs may influence their parenting. The chronosystem is a system in which changes occur during an individual's life that affects their characteristics and the environment. For instance, a child may be negatively impacted by their parent's divorce. The child may develop symptoms of depression. Research on PAC clearly demonstrates that the microsystem, the mesosystem, and the exosystem may directly impact the lives of adolescents (e.g. risky behavior and psychological well-being).

Microsystem and PAC

Meschke and Juang (2014) explored the understanding of parent-adolescent communication in refugee families by examining communication obstacles among Hmong American adolescents and their parents. Participants included thirty Hmong American young adults ages 18-25 that were born in the US. The results of the study revealed obstacles that were initiated by the adolescent, parent, and community. Two adolescent-focused sub-themes (emotional discomfort and psychosocial immaturity), five parent-focused sub-themes (parental judgment, parental intimidation, no benefits of communication with parents, generational/ cultural differences, and lack of parent-adolescent bond), and two culture/ community-focused sub-themes (traditions/values and vocabulary) emerged. Participants talked about their conundrum: Children did not have a history of communicating openly and, consequently, did not have a close relationship that would facilitate communication (Meschke & Juang, 2014). Parent absence due to lack of visitation following a divorce or long parental work hours strained the parent-adolescent relationship and reduced communication.

In another study, Malcolm et al. (2012) examined the effect of family functioning on condom use intentions and behaviors through communication about sex and condom use attitudes, parental norms, and control beliefs. Participants were of Hispanic origin, were in the eighth grade, and identified as displaying problem behaviors. Problem behavior youth were identified in two steps. First, the adolescent had to be identified by school counselors as having at least “mild problems” on one of three Revised Behavioral Problem Checklist .The subscales consisted of, conduct disorder, socialized aggression, and attention problems (Quay & Peterson, 1987). Four family processes were used to assess family functioning: parent-adolescent communication, family communication, parental involvement, and positive parenting. Findings

largely supported the overall model and suggest that family functioning had an indirect effect on condom use intention and behavior through communication about sex, condom use attitudes, and control beliefs. However, family functioning, did not have an indirect effect on condom use intention and behavior through communication about sex and parental norms.

Family functioning was not directly associated with any of the study variables, except for parent-adolescent communication about sex. Higher levels of family functioning were directly associated with higher levels of parent-adolescent conversation about sex. Higher levels of parent-adolescent communication about sex also directly and positively associated with condom use attitudes, parental norms, and control beliefs. However, condom use parental norms were not significantly associated with condom use intentions. Finally, plans to use condoms were negatively and significantly associated with condom use at last sex. Therefore, as purposes to use condoms increased, so did condom use at last sexual intercourse. The association between family functioning and condom use at last sex was mediated by parent-adolescent communication about sex, condom use attitudes, and intentions. The relationship between family functioning and condom use during the last sexual encounter was also mediated by dialogue about sex, condom use control beliefs, and plans. However, it was not mediated by discussion about sex and condom use parental norms and intentions.

Cordova et al. (2016) hypothesized that discrepancies within family functioning will be linked with increased likelihood of recent-immigrant Hispanic youth engaging in HIV risk behaviors. Family functioning was assessed by including parent and adolescent reports on five indicators including, positive parenting, family cohesion, family communication, parental monitoring of peers, and parent-adolescent communication. Positive parenting was assessed using the corresponding subscale from the Parenting Practices Scale. The positive parenting

subscale measures parenting behaviors characterized by acknowledging and rewarding desirable adolescent behavior. Parent-adolescent communication was assessed using the Parent-Adolescent Communication Scale (Barnes & Olson, 1985). The findings suggest that more significant parent-adolescent family functioning discrepancies increase the risk of two HIV risk behaviors such sexual debut and lifetime alcohol use among recent-immigrant Hispanic adolescents over time (Cordova et al., 2016).

Exosystem and PAC

Jianghong et al. (2014) reviewed 23 studies that examined the influence of parents' non-standard work schedules on their children's well-being using four indicators: internalizing and externalizing problems, cognitive development, and body mass index. Work schedules present parents with both advantages and challenges in balancing work and family demands. If a parent chooses (or can choose) to work night shift schedules, this may likely moderate the effect on both family processes and child outcomes. In 21 of the 23 studies, the investigators found significant associations between nonstandard work schedules and an adverse child developmental outcome. These associations were more pronounced in disadvantaged families and were partially mediated through parental depression, low quality parenting, a reduction in parent-children interactions and closeness as well as a less supportive home environment.

Han (2008) reported a significant association between the child's cumulative exposure to parental nonstandard work schedules, mental health and behavioral problems. Han (2008) found that behavioral problems among 4-10-year-old children increased with the number of years that mothers had worked the night shift. Similarly, Han and Miller (2009) reported that the number of years' mothers worked night shifts and fathers worked evening shifts was significantly associated with higher risks of depression in children aged 13 or 14. Han (2008) found that the number of

years' mothers had worked a nonstandard schedule shift was also linked to adolescent smoking, drinking, drug use, delinquency, and sexual activity. Based on a sample of low-income families (primarily single mothers), Hsueh and Yoshikawa (2007) found that 5 to 16-year-old children whose primary caregiver worked variable nonstandard schedules had more teacher-reported externalizing behaviors but fewer parent-reported internalizing behaviors than children whose caregivers did not work such hours.

Mesosystem and PAC

Schuster, Mermelstein, and Wakschlag (2012) wanted to better characterize the relationship between depressive symptoms and risky sexual behavior in adolescents. They chose to focus on the contributions of marijuana use, family context, and gender because all have been independently associated with risky sexual behavior. Importantly, this study controlled for multiple factors that tend to co-occur with unsafe sex (i.e., age, minority status, academic achievement and alcohol use). The hypothesis in this study included how depressive symptoms and marijuana use would be positively related to sexual risk-taking (number of sexual partners and condom use), more parental control. Higher quality parent-adolescent communication was suspected to be inversely associated with risky sexual behavior and marijuana use. Researchers expected that marijuana use would mediate the relationship between depressive symptoms and risky sexual behavior. Schuster, Mermelstein, and Wakschlag (2012) anticipated that depressive symptoms would be associated directly with increased sexual risk, but that this relationship would be reduced after adjusting for marijuana use. Additionally, they believed that depressive symptoms would interact with both dimensions of parenting (parental control and parent-adolescent communication) in predicting behavioral outcomes in youth (risky sexual behavior and marijuana use). In addition, the investigators hypothesized that depressive symptoms would

be positively related to risky sexual behavior and marijuana use only when there were low levels of parental control or when parent-adolescent communication was poor.

Participants were from sixteen Chicago area high schools. Researchers measured depression using the Center for Epidemiological Studies Depression inventory (CES-D; Radloff 1977). The CES-D is a widely used 20-item measure that assesses the frequency of depressive symptoms experienced in the past week. The quality of parent-adolescent communication was assessed using the Parent-Adolescent Communication Scale (PACS; Barnes & Olson, 1985).

Depressive symptoms and marijuana use were related to risky sexual behavior. However, even though there was a relationship between marijuana use and sexual risk for both boys and girls, the association between depressive symptoms and risky sexual behavior was contingent on gender. More depressive symptoms were associated with more partners and more frequent use of marijuana nine months later among boys. The depressive symptoms were related to the less frequent use of protection among girls. The results in this study did not suggest that either parental control or parent-adolescent communication is relevant towards moderating the relationship between depressive symptoms with marijuana use and risky sexual behavior. Better quality of communication was associated with fewer partners for boys, but not for girls. The investigators discovered that better quality of communication at was associated with an increased likelihood of using protection among girls only. However, quality of communication was not related to frequency of marijuana use among either boys or girls (Schuster, Mermelstein, & Wakschlag, 2012).

In a longitudinal study Smokowski, Bacallao, Cotter, and Evans (2015) sought to determine if prior and current year parenting would influence adolescent mental health. Participants in this current study included 4,000 middle school students in two rural counties

within the Southeastern United States. In county 1, the sample included all middle school students in public schools and in county 2, they used a random sample of 40 % of public middle school students.

This study used the School Success Profile (SSP) which is a 220-item youth self-report survey to measures attitudes and perceptions about school, friends, family, neighborhood, self, and health/well-being. The current study also used a modified version of the SSP, the SSP which measures internalizing behaviors (i.e., depression and anxiety) and externalizing behaviors. A modified version of the Rosenberg self-esteem scale, and the Conflict Behavior Questionnaire (CBQ) was used to measure parent–child conflict as well.

The investigators found that authoritative parenting was positively associated with healthy adolescent outcomes (self-esteem, future optimism, school satisfaction). Parent support, parent–child future orientation, and parent educational support were all significantly related to self-esteem, future optimism, and school satisfaction. Authoritative parenting was significantly associated with indicators of positive adolescent psychological health; but unrelated to adolescent mental health difficulties. This study discussed how positive parenting, seen in the authoritative parenting style, may be a promotive factor (i.e., advancing positive outcomes), but not a protective factor (i.e., interacting with risk to decrease negative outcomes). This suggests that authoritative parenting may promote positive psychological processes while having little influence on negative adolescent mental health processes.

The hypothesis regarding authoritarian parenting (negative parenting), in the form of parent–child conflict was supported. Parent–adolescent conflict was positively associated with anxiety, depression, and aggression, and inversely associated with self-esteem and school satisfaction. This shows that parent–child conflicts are often precipitated by authoritarian

parenting styles which is characterized by low levels of nurturance, high levels of control, and a lack of parent support. In addition, conflicts occur over adolescent autonomy within family systems that do not support independence.

Problem Statement

Few if any studies have examined whether or not poor PAC leads to psychological problems in adolescents of Haitian descent (e.g. effects their psychological well-being). Individuals of Haitian descent may have their own unique cultural practices and norms that impact communication between the children and parents. This in turn may contribute to poor communication, especially as the Haitian children born in the United States assimilate into the Western culture. This assimilation may lead to negative psychological outcomes. Since research on PAC has only examined the impact that it has on risky behavior in adolescents, this study will contribute to the gap in the field by examining PAC impact on adolescent well-being.

Hypotheses

H_1: Open parent-adolescent communication will predict lower depression among adolescents of Haitian descent.

H_2: Open parent-adolescent communication will predict lower anxiety among adolescents of Haitian descent.

H_3: Open parent-adolescent communication will predict higher self-esteem among adolescents of Haitian descent.

H_4: Problem parent-adolescent communication will predict higher depression among adolescents of Haitian descent.

H_5: Problem parent-adolescent communication will predict higher anxiety among adolescents of Haitian descent.

H_6: Problem parent-adolescent communication will predict lower self-esteem among adolescents of Haitian descent.

Method

Design

This is an archival study. Data from a summer art-based research program was used to test the hypotheses. The adolescents were participants from the Haitian Empowerment Literacy Project (HELP). The HELP Summer Institute was a seven-week culturally based program that helped adolescents with their growth of cultural identity, literacy, and social skills. The purpose of (HELP) is to help increase and nurture Haitian youths' intellectual, emotional, social, physical, creative, and spiritual development. The HELP program also encouraged the adolescents to increase cultural awareness through art activities such as poetry/spoken word, visual arts, photography, dance, and drama.

Participants

The adolescents attending the culturally based program consisted of 99 middle school students residing in Miami Dade County. Participants included 55 females and 44 males, ranging in the age from 11 to 15 (M = 12.28, SD = 1.136). Participants were of Haitian descent.

Measures

Reynolds Adolescent Depression Scale-2nd edition. The RADS-2 (M = 46.23, SD = 8.385) is a 30-item scale that consists of consists of a 4-point scale that ranges from 1 (almost never) to 4 (most of the time) participants rated statements about the way they feel. Examples of some of these statements include "I feel like crying," "I feel like having fun with other students," "I feel life is unfair" and "I like eating meals." The responses are almost never, hardly ever,sometimes, and most of the time. There are four subscales which include dysphoric mood,

anhedonia or negative affect, negative self-evaluation, and somatic complaints. This scale includes individuals experiencing dissatisfaction, anxiety, and restlessness. Dysphoric mood assesses disturbances in the adolescents' mood and symptoms of depression. Anhedonia or negative affect assesses behavioral changes associated with depression, such as abstaining from previously pleasant activities. Negative self-evaluation assesses the cognitive component of depression such as thoughts of self-harm or self-denigration. Somatic complaints assess common physical complaints of depressed adolescents, such as stomachaches and sleep disturbances (Hilsenroth, Segal, & Hersen, 2004). The RADS-2 standard scores below 61 indicate clinical description within normal range; a score of 70 and above suggest severe clinical depression. The RADS-2 standards scores provide an indication of the clinical severity of the individual's depressive symptoms (Reynolds, 2004). For the purpose of this study the total depression score was used. high internal consistency. The internal consistency for this scale is *(α = .88)*. (See Appendix A. for scale).

Rosenberg Self-Esteem Inventory. This Rosenberg Self-Esteem Inventory (*M* = 33.90, *SD* = 4.059) includes 10 items to measure an individual's evaluation of their self-worth. The questions consist of five positive statements and five negative statements that are rated on a 4-point Likert scale from strongly agree, to strongly disagree (Rosenberg, 1965). Examples of statements on the Rosenberg Self-Esteem Inventory are, "I wish that I could have more self-respect for myself," "All in All, I am inclined to feel that I am a failure," "I am able to do things as well as most other people," and "I take a positive attitude towards myself". The total score is calculated by adding all the items together. Higher scores indicate a greater level of self-esteem. The scores on this scale range from 0-40 where a score less than 15 might indicate a problematic low self-esteem. The internal consistency for this scale is *(α = .70)*. (See Appendix B. for scale).

Multidimensional Anxiety Scale for Children–10 Item. The Multidimensional Anxiety Scale for Children–10 Item (M = 49.12, SD = 10.377) is a comprehensive instrument of assessment of anxiety dimensions in children and adolescents. The Multidimensional Anxiety Scale for Children uses 10 questions to measure the symptoms of anxiety that occurred over the last week. For this study the total MASC-10 score will be used to test Hypothesis 2 and 5. The total score provides an understanding regarding how children and adolescents who experience difficulty with anxiety exhibit their symptoms. Furthermore, the score of anxiety symptoms in the MASC-10 indexes can be a useful adjunct to the diagnosis of anxiety disorders. The responses are on a 4-point Likert scale. The MASC-10 is a short version of the 39-item Multidimensional Anxiety Scale for Children designed as a screening questionnaire for anxiety. The MASC-10 yields a global anxiety symptom score that includes items measuring physiological symptoms, social anxiety, harm avoidance, and separation/panic. Children rate the extent to which each of the statements is true about them on a scale from 0 (never true about me) to 3 (often true about me). The total score ranges from 0 to 30, with higher scores indicating higher levels of anxiety. There are four subscales: physical symptoms, social anxiety, separation anxiety/panic, and harm avoidance. Physical Symptoms includes tense/restless and somatic/autonomic complaints. Social Anxiety assesses humiliation/rejection and public performance fears that the adolescents may experience. Harm Avoidance consists of perfectionism and anxious coping. Separation anxiety entails adolescents refusing to attend school and avoiding participating in new activities or going places without a parent (March, Parker, Sullivan, Stallings, & Conners, 1997). The total score provides an understanding regarding how children and adolescents who experience difficulty with anxiety exhibit their symptoms. Furthermore, the score of anxiety symptoms in the MASC-10 indexes can be useful

towards detecting the diagnosis of anxiety disorders. The internal consistency for this scale is *(α = .67)*. (See Appendix C. for scale).

Parent-Adolescent Communication Scale (Adolescent Form). The Parent–Adolescent Communication Scale (PACS) was used to measure communication as perceived by adolescents. The PACS has two subscales which are comprised of 10 items. The Parent-Adolescent Communication Scale is a scale that is composed of two scales. (Barnes & Olson, 1985). The Openness of Parent–Adolescent Communication (10 items) subscale (*M* = 37.90, *SD* = 33.90) assesses the quality of exchanging information and investigates freedom in communication, and comprehension and satisfaction about communication. An example of an item is: 'it is easy for me to express all my true feelings to my father/mother'. The Problems in Parent–Adolescent Communication (10 items) (*M* = 29.09, *SD* = 7.174) identifies barriers to parent–adolescent communication such as presence of negative feelings about communication, absence of sharing feelings and selectivity of subjects. An example item is: 'when we are having a problem, I often give my mother/father the silent treatment'. The answers were given on a 5-point Likert scale, ranging from 'strongly disagree' to 'strongly agree' (possible range 10–50). This was done separately for the communication with the mother and the communication with the father. Higher scores on the Open Communication subscale indicate more open communication. Scores on the Problems Communication subscale were reversed in value, so that higher scores indicate less perceived problem communication. Adolescents answer the items twice, once as they pertain to their mother and again as they pertain to their fathers. In addition, parents respond to the items once to describe how they communicate with their adolescent. (See Appendix D. for scale).

Results

Correlations

Prior to testing the hypotheses using regression analyses, it was important to determine if the variables of interest were correlated. Thus, a Pearson Correlation was performed to determine the relationship between open communication and the total self-esteem score. The results were statistically significant. The results revealed that there was a strong positive correlation between open communication and self-esteem, $r(99) = .504$, $p < .01$. A Pearson Correlation was performed to determine the relationship between open communication and the total depression score. The results were statistically significant. The results revealed that there was a strong negative correlation between open communication and depression, $r(102) = -.463$, $p < .01$. A Pearson Correlation was performed to determine the relationship between open communication and the total anxiety score. The results were not statistically significant. The results revealed that there was a weak correlation between open communication and anxiety, $r(98) = -.133$, $p > .01$.

A Pearson Correlation was performed to determine the relationship between problem communication and the total self-esteem score. The results were statistically significant. There was a strong negative correlation between problem communication and self-esteem, $r(94) = -.343$, $p < .01$. A Pearson Correlation was performed to determine the relationship between problem communication and depression. The results revealed that there was a strong positive correlation between problem communication and depression, $r(97) = .482$, $p < .01$. However, the results revealed that there was no relationship between problem communication and anxiety, $r(100) = .056$, $p > .01$.

Regressions

Linear regression analyses were conducted to identify whether open parent-adolescent communication would predict lower depression, lower anxiety, and higher self-esteem among adolescents and whether problem parent-adolescent communication would predict higher depression, higher anxiety, and lower self-esteem.

The alternative-hypothesis that open parent-adolescent communication would predict lower depression among adolescents of Haitian descent was supported. The regression model with the predictor entered was significant, F (1, 94) =25.589, p = .000, with an R^2 of .206. The alternative hypothesis that open parent-adolescent communication would predict higher self-esteem was supported. The regression model, with the predictor entered was significant, F (1, 90) = 30.609, p = .000, with an R^2 of .245. The alternative hypothesis that open-parent adolescent communication would predict lower anxiety was not supported. The regression model with the predictor was not significant, F (1, 96) = 1.725, p = .192, with an R^2 of .007. Based on

The alternative hypothesis that problem communication would predict higher depression was supported. The regression model with the predictor was significant, F (1, 95) = 28.748, p = .000), with an R^2 of .232. The alternative hypothesis that problem communication would predict lower self-esteem was supported. The regression model with the predictor was significant, F (1, 92) = 12.248, p = .001, with an R^2 of .117. The alternative hypothesis that problem communication would predict higher anxiety was not supported. The regression model with the predictor was not significant, F (1, 98) = 3.726, p = .056, with an R^2 of .037.

Discussion

As indicated previously, few if any studies have examined whether or not poor PAC leads to psychological problems in adolescents of Haitian descent (e.g. psychological well-being). The

purpose of this study was to explore whether poor parent adolescent communication (PAC) leads to psychological problems in adolescents of Haitian descent (e.g. psychological well-being). The objective of the present study was to address if Open PAC will predict lower depression, lower anxiety, and higher self-esteem among Haitian-American adolescents and whether problem PAC will predict higher depression, higher anxiety, and lower self-esteem. The present findings clearly demonstrated that adolescents of Haitian descent who had open communication with their parents had lower levels of depression and higher levels of self-esteem. Further, they should that problem communication with parents led to higher levels of depression and lower levels of self-esteem. These findings support the research conducted by Hysing (2014) in which it was found that parents that lack warmth and involvement, and who engage in harsh and erratic discipline create aggressiveness, hostility, opposition, and depression in adolescents. Openness may be associated with greater sharing of family needs and preferences, which may increase self-esteem and decrease depression among adolescents.

With regards to open and problem communication with the parents, there were no significant relationships with anxiety. This is not consistent with other research on adolescents which suggests higher levels of anxiety amongst adolescents from different ethnicities (Smokowski et al., 2015). It is possible that these effects were not significant because of the low sample size and the low cronbach alpha on the anxiety scale *(α = .67).*

In conclusion, parent adolescent communication involves patience and understanding between the parent and adolescent. This study contributes to the existing literature on psychological well-being by focusing on the advantages of open communication and disadvantages of problem communication between parents and adolescents. This study focused on how both factors affect the psychological well-being of adolescents of Haitian descent.

Limitations

This study had some limitations. It aimed to examine the effect of parent adolescent communication and mental health among Haitian-American adolescents. This study was conducted utilizing archival data. A limitation associated with using archival data is that the researcher who analyzed the data did not collect the data. As a result, the researcher did not have control over what measures to use. Another limitation is the reliance on only subjective self-reports for measuring individual aspects. In addition, the original study was conducted in one cultural area and adolescents' view of communication with parents, roles, and expectations in the family may differ from families of different cultural backgrounds. Parenting practices may differ with respect to cultural heritage. For instance, Bornstein(2012) stated that every culture is characterized, and distinguished from other cultures, by acknowledged ideas about how one needs to feel, think, and act as a functioning member of the culture. Therefore, parents vary on how much they use verbal and nonverbal communication with their children. In addition, parents may be more comfortable using different kinds of communication strategies in different situations (Bornstein, 2012). Research also suggest that there is variation in parenting knowledge, attitudes, and practices among groups. Future research should examine other variables such as acculturation and/or parental stress on child resiliency and well-being.

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Appendix A

RADS-2

Directions: Listed below are some sentences about how you feel. Read each sentence and decide how often you feel this way. Decide if you feel this way almost never, hardly ever, sometimes, or most of the time. To answer each item, circle the number under the answer that best describes how you really feel. Remember, there are no right or wrong answers, just choose the answer that tells how you usually feel.

	Almost never	Hardly ever	Some-times	Most of the time
1. I feel happy…….	1	2	3	4
2. I worry about school……...	1	2	3	4
3. I feel lonely…….	1	2	3	4
4. I feel my parents don't like me……...	1	2	3	4
5. I feel important……	1	2	3	4
6. I feel like hiding from people…….	1	2	3	4
7. I feel sad…….	1	2	3	4
8. I feel like crying…….	1	2	3	4
9. I feel that no one cares about me…….....	1	2	3	4
10. I feel like having fun with other students……	1	2	3	4
11. I feel sick…….	1	2	3	4
12. I feel loved……...	1	2	3	4
13. I feel like running away……...	1	2	3	4
14. I feel like hurting myself…….	1	2	3	4
15. I feel that other students don't like me……	1	2	3	4
16. I feel upset……	1	2	3	4
17. I feel life is unfair……	1	2	3	4
18. I feel tired……	1	2	3	4
19. I feel I am bad…….	1	2	3	4
20. I feel I am no good…….	1	2	3	4
21. I feel sorry for myself…….	1	2	3	4
22. I feel mad about things……	1	2	3	4
23. I feel like talking to other students…….	1	2	3	4
24. I have trouble sleeping……	1	2	3	4
25. I feel like having fun……...	1	2	3	4
26. I feel worried……...	1	2	3	4
27. I get stomachaches…….	1	2	3	4
28. I feel bored…….	1	2	3	4
29. I like eating meals……	1	2	3	4
30. I feel like nothing I do helps anymore…….	1	2	3	4

Appendix B

Rosenberg Self-Esteem Scale

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle SA. If you agree with the statement, circle A. If you disagree, circle D. If you strongly disagree, circle SD.

1.	On the whole, I am satisfied with myself.	SA A D SD
2.*	At times, I think I am no good at all.	SA A D SD
3.	I feel that I have a number of food qualities.	SA A D SD
4.	I am able to do things as well as most other people.	SA A D SD
5.*	I feel I do not have much to be proud of.	SA A D SD
6.*	I certainly feel useless at times.	SA A D SD
7.	I feel that I am a person of worth, at least on an equal plan with others.	SA A D SD
8.*	I wish I could have more respect for myself.	SA A D SD
9.*	All in All, I am inclined to feel that I am a failure.	SA A D SD
10.	I take a positive attitude towards myself.	SA A D SD

Scoring: SA=3, A=2, D=1, SD=0. Items with an asterisk are reverse scored, that is AS=0, A=1, D=2, SD=3. Sum the scores for the 10 items. The higher the score the higher the self-esteem.

Appendix C

MASC-10: Multidimensional Anxiety Scale for Children-10 item

By John March, M.D., M.P.H,

Client ID: _____ Age: _____ Sex: Male Female

Date: ____/____/_____ School Grade: _____

This questionnaire asks you how you have been thinking, feeling, or acting recently. For each item, please circle the number that shows how often the statement is true for you. If a sentence is true about you a lot of the time, circle 3. If it is true about you some of the time, circle 2. If it is true about you once in a while, circle 1. If a sentence is not ever true about you, circle a 0. Remember, there are no right or wrong answers, just answer how you have been feeling recently.

Here are two examples to show you how to complete the questionnaire. In Example A, if you were hardly ever scared of dogs, you would circle1, meaning that the statement is rarely true about you. In Example B, if thunderstorms sometimes upset you, you would circle 2, meaning that the statement is sometimes true about you.

		Never true about me	Rarely true about me	Some-times true about me	Often true about me
Example A	I'm scared of dogs……	0	1	2	3
Example B	Thunderstorms upset me…….	0	1	2	3

Now try these items yourself.

1.	The idea of going away to camp scares me……...	0	1	2	3
2.	I'm afraid that other kids will make fun of me…….	0	1	2	3
3.	I try to stay near my mom and dad……	0	1	2	3
4.	I get dizzy or faint feelings……	0	1	2	3
5.	I feel restless and on edge…….	0	1	2	3
6.	I feel sick to my stomach……...	0	1	2	3
7.	I get nervous if I have to perform in public……...	0	1	2	3
8.	Bad weather, the dark, heights, animals and bugs scare me.	0	1	2	3
		0	1	2	3
9.	I check to make sure things are safe…….				
10.	I feel shy……	0	1	2	3

Appendix D

Parent-Adolescent Communication Scale (Adolescent Form)

1. I can discuss my beliefs with my mother/father without feeling restrained or embarrassed.
2. Sometimes I have trouble believing everything my mother/father tells me.
3. My mother/father is always a good listener
4. I am sometimes afraid to ask my mother/father for what I want.
5. My mother/father has a tendency to say things to me that would be better left unsaid.
6. My mother/father can tell how I'm feeling without asking.
7. I am very satisfied with how my mother/father and I talk together.
8. If I were in trouble, I could tell my mother/father/
9. I openly show affection to my mother/father.
10. When we are having a problem, I often give my mother/father the silent treatment.
11. I am careful about what I say to my mother/father.
12. When talking to my mother/father, I have the tendency to say things that would be better left unsaid.
13. When I ask questions, I get honest answers from my mother/father.
14. My mother/father tries to understand my point of view.
15. There are topics I avoid discussing with my mother/father.
16. I find it easy to discuss problems with my mother/father.
17. It is very easy for me to express all my true feelings to my mother/father.
18. My mother/father nags/bothers me.
19. My mother/father insults me when s/he is angry with me.
20. I don't think I can tell my mother/father how I really feel about some things.

Parent Form:

1. I can discuss my beliefs with my child without feeling restrained or embarrassed.
2. Sometimes I have trouble believing everything my child tells me.
3. My child is always a good listener.
4. I am sometimes afraid to ask my child for what I want.
5. My child has a tendency to say things to me that would be better left unsaid.
6. My child can tell how I'm feeling without asking.
7. I am very satisfied with how my child and I talk together.
8. If I were in trouble, I could tell my child.
9. I openly show affection to my child.
10. When we are having a problem, I often give my child the silent treatment.
11. I am careful about what I say to my child.
12. When talking with my child, I tend to say things that would be better left unsaid.
13. When I ask questions, I get honest answers from my child.
14. My child tries to understand my point of view.
15. There are topics I avoid discussing with my child.
16. I find it easy to discuss problems with my child.
17. It is very easy for me to express all my true feelings to my child.

18. My child nags/bothers me.
19. My child insults me when s/he is angry with me.
20. I don't think I can tell my child how I really feel about some things.

The internal consistency of the scores, measured by Cronbach`s alpha, were 0.87 for the openness subscale and 0.78 for the problems subscale.

Two Subscales

Degree of openness: 1, 3, 6, 7, 8, 9, 13, 14, 16, 17

Extent of Problems: 2, 4, 5, 10, 11, 12, 15, 18, 19, 20

1 = Strongly disagree

2 = Moderately disagree

3 = Neither agree nor disagree

4 = Moderately agree

5 = Strongly agree