

Family dynamics and the psychosocial well-being of adolescents: A cross sectional study

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ABSTRACT

Background: Family dynamics play a pivotal role in shaping the psycho-social well-being of adolescents, particularly in Saudi Arabia (KSA), where cultural, social, and religious factors intertwine to influence the way families interact and raise their children. Significant emotional, cognitive, and social development characterize the adolescent years, and a young person's family environment greatly influences how they navigate these changes.

The aim of the study: To assess family dynamics and the psycho-social well-being of in-school adolescents, with a view to determining the association between family dynamics and the psycho-social well-being of in-school adolescents. This provided a basis for planning family-oriented support services to improve the psycho-social health status of in-school adolescents.

Study design: A descriptive cross-sectional design.

Methods: Three hundred and thirty-five school-adolescents from public and private secondary schools in KSA were selected using the proportionate systematic random sampling technique. Data was collected with the Family Assessment Device questionnaire and Youth self-reported Pediatric Symptom Checklist and analyzed using descriptive and inferential statistics.

Results: Findings showed that 53.7% of the participants had unhealthy family dynamics while 16.0% had impaired psycho-social status. There is a significant negative association between family dynamics in problem solving dimension and psychosocial health status with a Beta coefficient (-1.120), Odds ratio=0.326 (95% CI 0.171 to 0.624).

Conclusion: Majority of in-school adolescents had unhealthy family functioning pattern and one in six adolescents had impaired psychosocial health. There was a negative but significant association between the problem-solving dimension of family dynamics and psycho-social health. Community health professionals should carry out preventive interventions among parents and adolescents in the community with adequate attention to all the dimensions of family functioning.

Keywords: family, dynamics, psycho-social well-being, adolescents, school

INTRODUCTION

Adolescence is widely recognized as a critical and transformative period of human development, bridging childhood and adulthood. It is a time when individuals undergo profound physical, psychological, and social changes that lay the foundation for a healthy, successful adulthood⁽¹⁾. The onset of puberty marks the beginning of this transition, accompanied by rapid physical growth, cognitive maturation, and the development of emotional and social competencies. This period of life is characterized by a search for identity, an increase in autonomy, and significant shifts in relationships with peers, family, and society⁽²⁾.

The changes that adolescents experience are not only biological but are deeply intertwined with their psycho-

social development, as they form their sense of self, make critical life choices, and begin to navigate the complexities of adulthood^(1, 2). It is during this time that young individuals confront challenges that will have lasting impacts on their mental health, interpersonal skills, and life trajectories. As they begin to assert their independence and explore their potential, adolescents require a supportive environment to guide them through this transformative stage. Family dynamics, peer influences, and cultural norms all play pivotal roles in shaping the way adolescents experience these changes and prepare for their future⁽³⁾.

Adolescents in school frequently deal with the challenges of adjusting to school life while also dealing with the physiological changes that accompany adolescent growth and development⁽⁴⁾. Adolescent schoolchildren also adapt to the emotional, social, familial, and scholastic challenges that come with their developmental stage, in addition to physical and physiological changes. This might be stressful, which raises the possibility that they will adopt unhealthy habits⁽⁵⁾.

Adolescents with psychosocial health issues are more likely to experience mental health issues, academic failure, and antisocial conduct⁽⁶⁾. The key source of a strong support system for the in-school teenager to move through the phase with fewer negative health outcomes has been the family. The adolescent's transition depends on how they engage with their family members in an environment where they are performing at their best. Adolescent development and psychosocial health have been shown to be impacted by family dynamics, interaction patterns, and functioning patterns^(7, 8).

Family dynamics refers to the multifaceted interactional pattern between family members in communicating, performing their roles and connecting emotionally as they carry out their daily routines^(9, 10, and 11). Additionally, family dynamic helps families to develop functioning relationships that help in continuous shaping of the values and behaviors of family members^(12, 13).

The McMaster Family Functioning Model is a well-regarded theoretical framework used to assess the overall functioning of a family system. Developed by Dr. Marilyn B. Epstein and colleagues in the early 1980s, this model integrates various concepts from family systems theory and family therapy. It provides a structured approach to understanding the dynamics within a family and how these dynamics affect the well-being of individual family members, particularly in the context of psychological health and adjustment^(14, 15). This model identifies six key dimensions of family functioning: problem-solving, communication, roles, affective responsiveness, affective involvement, and behavior control. These dimensions provide a structured approach to evaluating how families function and interact, offering insights into the potential impact of family dynamics on the emotional and psychological development of family members, especially adolescents^(14, 15).

In many cultures, the family is the central unit of socialization, offering emotional, psychological, and practical support for its members. In the case of KSA, family life is deeply rooted in traditional values, cultural norms, and religious teachings, all of which influence how family members interact, perform roles, and engage in key tasks. Given the strong familial ties, patriarchal family structure, and the growing influence of modernization and global interconnectedness, it is essential to explore how family dynamics in Saudi Arabia align with, or differ from, frameworks such as the McMaster model⁽¹⁵⁾.

The functioning habits of families may be impacted by the recent trend of changing family types, which includes a variety of contemporary family forms and structures. This could have an effect on the teenagers' mental health^(16, 17). Unhealthy parental interaction patterns can both cause and worsen harmful behavioral patterns in young people⁽¹⁸⁾.

The legal recognition of the traditional family structure in Saudi Arabia upholds norms such as fatherhood as the primary source of authority, gendered roles, and the importance of family loyalty and unity. This framework influences all aspects of family life, from marriage and child-rearing to the distribution of family responsibilities and resources. As a result, family functioning within Saudi Arabia is shaped by both societal expectations and legal mandates that emphasize the importance of maintaining social cohesion, respect for authority, and adherence to Islamic teachings⁽¹⁹⁻²¹⁾.

Allen et al. examined the relationship between secure attachment and multiple domains of adolescent psychosocial functioning. Mother-adolescent secure attachment was linked to low levels of depression and behavioral problems among young people⁽¹⁹⁾. Abbas and Al Buhairan carried out a study with Saudi adolescents and young adults aged between 10 and 24 years. They found that insecure parent-adolescent relationships and family conflict contributed to higher rates of mental health problems in young life⁽²⁰⁾. Similarly, Raheel found that depression was more prevalent among Saudi girls who had insecure attachments to their family, lived with a single parent, had low monthly income, and were exposed to emotional abuse⁽²¹⁾.

Therefore, the aim of this study to assess family dynamics and the psycho-social well-being of in-school adolescents, with a view to determining the association between family dynamics and the psycho-social well-being of in-school adolescents. This provided a basis for planning family-oriented support services to improve the psycho-social health status of in-school adolescents.

METHODS

Design: A cross-sectional descriptive research design was adopted and samples of adolescents were selected

from public and private secondary schools to participate in the study.

Setting: Study was conducted in KSA. Saudi Arabia is a large country with diverse regions. To ensure geographic diversity:

- Stratify the sample by region (e.g., Western, Eastern, Central, Northern, and Southern regions).
- Randomly select schools from each region to ensure coverage across all parts of the country.

Study population and selection of participants

The target population for the study was school-adolescents aged 12 years and above from public and private junior and senior secondary schools in KSA. Multi-staged sampling technique was used at two levels of selecting schools and selecting sample units at the school levels. At the levels of selecting schools, four (4) public schools out of 10 were selected and five (5) out of the 16 private schools were also selected adopting the simple random sampling. Sample size was calculated with the Cochran formula (335). Proportionate sampling was adopted considering the population and gender by school to select 335 secondary school students from the nine schools.

Instrument for data collection

Family Assessment Device (FAD) ⁽²²⁾ and Pediatric Symptom Checklist (Y-PSC) ⁽²³⁾ psychosocial assessment checklist for adolescents ⁽²⁴⁾ were used to collect data. The self-administered questionnaire for data collection was divided into sections. Section A covered the demographic characteristics and family history of respondents. Section B consists of the FAD. The FAD is a 60-item self-reported structured measure of family functional pattern. Only 48 items out of the 60 items were used in data collection. The 12 items on general functioning which is the overall measure of the six dimensions of family functioning were excluded; this was done in order to make filling the questionnaire less cumbersome for respondents based on their age. Family functioning was measured on a 4-point Likert scale (strongly agree = 1, agree = 2, disagree = 3 and strongly disagree = 4).

Participants were asked to rate each of the 48 statements according to the description of their family. Six dimensions (subscales) of family functioning were measured covering: problem solving capabilities (ability to solve problems that affect the integrity and function of the family); communication (effective exchange of information within the family); family roles (efficiency of practices used by the family to distribute and perform tasks); family affective involvement (quality of interest, attention, and investment of family members towards each other); family affective responsiveness (strategies adopted by the family members to initiate proper emotional responses, whether positive or negative feelings); behavior control (expression, maintenance and patterns of behavior standards).

The FAD was scored by adding the responses (1-4) for each scale and dividing by the number of items in each scale. The scale score ranges from 1.0 (best functioning) to 4.0 (worse functioning) ⁽²⁵⁾. The FAD was described as a good measure of family functioning with excellent internal consistency among all the subscales ($\alpha = 0.72 - 0.90$) ⁽²⁶⁾. Section C consisted of questions that assessed respondent's psychosocial status using Self-Report Pediatric Symptom Checklist (PSC-17) ^(27, 28). The PSC-17 contained 17 questions with responses ranked on 3-point likert scale (never = 0, sometimes = 1, often = 2). Items on PSC-17 were arranged into 3 subscales (Internalizing behavior, externalizing behavior, and attention). According to the use of PSC17 tool, items that were left unanswered were ignored. With four or more items left unanswered, the questionnaire was considered invalid. The scores of the 17 items were summed up to get the total score. A score ≥ 15 indicated that respondents had a level of emotional and behavioral impairment. Based on recommendation on the use of this instrument, students with a score suggestive of psychosocial impairment were referred through their parents to mental health expert for further assessment. Both FAD and PSC-17 was pilot tested among participants with similar characteristics with study population. Cronbach's Alpha was 0.81 and 0.79 respectively.

Method of data collection

An initial visit was made to the schools involved in the study, the research purpose was explained to head teachers, class teachers and students and the need for their collaboration was discussed. On another visit, students were met in their various classes after class sessions before another class engagement and the self-administered questionnaires were distributed. Simple random technique was used to select respondents using the class register. Students who were less than age 12 years were not included. The instrument was self-administered but assistance was readily available where necessary. Students were instructed to read carefully each item on their questionnaire and rate the extent to which those statements described their family and their feelings. The adolescents were allowed to ask questions, and such questions were attended to for clarity as necessary. Questionnaires were retrieved few minutes after completion.

Ethical consideration

Ethical approval was taken from relevant educational authorities in KSA (e.g., Ministry of Education). Consent of parents were taken with letters sent through the respondents, the letter described the study and requested them

allow their child/ward to participate in the study. School adolescents who returned signed consent forms from their parents/guardian were included in the study after obtaining assent from them also. Maintain confidentiality and adhere to ethical standards for data collection and analysis.

Data analysis

Data entry was done with Statistical Package for Social Sciences (SPSS) software version 28.0 using both descriptive and inferential statistics. Respondent's family functioning and psychosocial status was analyzed using frequency and percentage, median, mean and standard deviation. FAD was scored by summing up the responses (1-4) for each subscale (note all negatively worded items were reversed). The computed scores were then divided by the number of items in each scale, the cut-off (mean) for each dimension were computed. If an adolescent school child scored smaller than the cut-off point, then the family functioning was considered healthy in that dimension, and if the resulting score was larger or equal to cut-off point, then the family functioning was considered unhealthy in that dimension. Relationship between dependent and independent variables were analyzed using regression analysis and Kruskal Wallis Chi-square. Level of significance was considered at $p < 0.05$ for 95% confidence interval.

RESULTS

Table (1) showed respondents varied socio-demographic characteristics. Majority 74.3% clustered around ages 15 through 19; with the Mean age of 15.4 ± 1.6 .

Table 1: Socio-demographic characteristics of respondents

Socio-demographic Characteristics	Characteristics	Frequency(n=335)	Percentage(%)
Age group	12-14years	83	24.8
	15-17years	248	74
	18-20years	4	1.2
Sex	Female	166	49.6
	Male	169	50.4
Present class	Juniorclass	8	2.4
	Seniorclass	327	97.6
Position at home	First	70	20.9
	Second	94	28.1
	Third	66	19.7
	Fourth	54	16.1
	Fifth	27	8.1
	Sixth	23	6.9
	Seventh	1	0.3
Family types	Monogamy	299	89.3
	Polygamous	36	10.7
Family marital status	Divorced	6	1.8
	Married	289	89.3
	Separated	11	3.3
	Widowed	29	5.7
Fathers' academics	No education	4	1.2
	Primary	3	0.9
	Secondary	44	13.1
	Tertiary	284	84.8
Mothers' academics	No education	7	2.1
	Primary	11	3.3
	Secondary	51	15.2
	Tertiary	266	79.4
Father alive	Yes	316	94.3
	No	19	5.7
Mother alive	Yes	325	97
	No	10	3

Table (2) showed the distribution of family functioning among respondents. Majority had unhealthy family functioning pattern in Communication (57.6%, Mean 2.75 ± 0.14), Role (50.7%, Mean 2.86 ± 0.18), Problem solving (61.2%, Mean 3.43 ± 0.28), Affective responsiveness (51.9%, Mean 2.66 ± 2.50), Affective involvement

(56.7%, Mean 2.98 ± 0.33) and Behavior control (60.6, Mean 2.79 ± 0.23). Family functioning is worst in roles, problem solving and affective involvement (2.86 ± 0.18 , 3.43 ± 0.28 and 2.98 ± 0.33 respectively). The overall result of respondents showed that majority (53.7%) had unhealthy family functioning pattern.

Table 2: Frequency distribution of participants based on the mean scores of family functioning dimensions among respondents

Dimensions		n=335(%)	Mean \pm SD	Median	Max	Min
Communication	Unhealthy	193(57.6)	2.75 \pm 0.14	2.7	3.2	2.6
	Healthy	142(42.4)	2.38 \pm 0.12	2.4	2.5	2
Roles	Unhealthy	170(50.7)	2.86 \pm 0.18	2.8	3.5	2.7
	Healthy	165(49.3)	2.84 \pm 0.14	2.5	2.6	2
Problem-solving	Unhealthy	205(61.2)	3.43 \pm 0.28	3.33	4	3.17
	Healthy	130(38.8)	2.79 \pm 0.29	3	3	1.5
Affective responsiveness	Unhealthy	174(51.9)	2.80 \pm 0.31	2.66	3.5	2.5
	Healthy	161(48.1)	2.15 \pm 0.20	2.16	2.33	1.33
Affective involvement	Unhealthy	190(56.7)	2.98 \pm 0.33	2.85	4	2.57
	Healthy	145(43.3)	2.06 \pm 0.27	2.14	2.43	1.43
Behavior control	Unhealthy	203(60.6)	2.79 \pm 0.23	2.77	3.67	2.56
	Healthy	132(39.4)	2.22 \pm 0.21	2.22	2.44	1.33
Overall family functioning	Unhealthy	180(53.7)	2.77 \pm 0.18	2.74	3.2	2.27
	Healthy	155(46.3)	2.57 \pm 0.21	2.55	3.28	2.11

Table (3) showed the distribution of the psycho-social health status of respondents. In the internalizing subscale, more than one third of the respondents sometimes "feel sad, unhappy" (47.2%), "seem to be having less fun" (41.8%), and "worry a lot" (41.5%). In the attention subscale, there were more than one third of the respondents sometimes "daydream too much" (34.9%), "have troubles concentrating" (36.1%) and "distract easily" (35.5%). Also, more than 1 out of 10 (11.0%) were "fidgety and unable to sit still" often. In the externalizing subscale, more than 1/3rd sometimes "refuse to share" (35.5%), "do not understand other people's feelings" (39.1%), "blame others for their troubles" (35.8%), "do not listen to rules" (30.7%) and "tease others" (39.7%). in addition, more than 1 out 10 (14.6%) "Do not understand other people's feelings" often do not listen to rules (10.4%) and tease others (18.5%). The overall mean score was 8.47 ± 5.64 , respondents that scored above mean were grouped as 'not impaired', respondents that scored above mean were grouped 'impaired'. In the overall, about 1 out of 6 respondents (16.0%) had impaired psychosocial health.

Table 3: The distribution of the psycho-social health status of respondents

	Never N (%)	Sometime N (%)	Often N (%)
Internalizing Subscale			
Feel sad, unhappy	140(41.8)	158(47.2)	37(11.0)
Feel hopeless	222(66.3)	97(29.0)	16(4.8)
Down on yourself	238(71.0)	78(23.3)	19(5.7)
Seem to behaving less fun	161(48.1)	140(41.8)	34(10.0)
Worry a lot	167(49.9)	139(41.5)	29(8.7)
Attention Subscale			
Fidgety, unable to sit still	202(60.3)	96(28.7)	37(11.0)
Day dream too much	196(58.5)	117(34.9)	22(6.6)
Have troubles concentrating	186(55.5)	121(36.1)	28(8.4)
Act as if driven by motor	237(70.7)	86(25.7)	12(3.6)
Distract easily	188(56.1)	119(35.5)	28(8.4)
Externalizing Subscale			
Refuse to share	198(59.1)	119(35.5)	18(5.4)
Do not understand other people's feelings	155(46.3)	131(39.1)	49(14.6)
Fight with other children	254(75.8)	70(20.9)	11(3.3)
Blame others for your troubles	194(57.9)	120(35.8)	21(6.3)
Do not listen to rules	197(58.8)	103(30.7)	35(10.4)
Tease others	140(41.8)	133(39.7)	62(18.5)
Take things that do not belong to you	254(75.8)	66(19.7)	15(4.5)

Table (4) showed association between respondents' psychosocial health status and their family functioning pattern using logistic regression analysis. Result showed a significant negative association between family functioning in problem solving dimension and respondent's psychosocial health status with a Beta coefficient (-1.120), Odd ratio=0.326 (95% CI 0.171 to 0.624). This showed that respondents with unhealthy family functioning in the dimension of problem solving do not have an impaired psycho-social status.

Table 4: Association of family functional pattern and psychosocial health status of respondents

Family functioning of Adolescent	Psychosocial health status of adolescents							
	B	S.E	Wald	df	Sig	Exp(B)	95% CI for EXP(B)	
							Lower	Upper
Communication	0.161	0.318	0.256	1	0.613	1.174	0.63	2.189
Role	-0.282	0.322	0.764	1	0.382	0.754	0.401	1.419
Problem solving	-1.12	0.331	11.458	1	0.001	0.326	0.171	0.624
Affective responsiveness	-0.123	0.332	0.138	1	0.71	0.884	0.462	1.694
Affective involvement	-0.421	0.337	1.562	1	0.211	0.656	0.339	1.27
Behavior control	0.456	0.348	1.71	1	0.191	1.577	0.797	3.122

Table (5) showed relationship between respondent's family functioning pattern and socio-demographic characteristics. There are significant association between family functioning pattern and age ($X^2 = 10.777$, $p=0.005$); Family type ($X^2 = 20.039$, $p=0.001$) and mother alive or dead ($X^2 = 5.408$, $p=0.020$).

Table 5: Relationship between respondents' socio-demographic variables and family functioning pattern

Socio-demographic Characteristics	N	Mean(±SD)	Mean Rank	Statistics index
Age ***				
12-14 years	83	2.75(±0.23)	196.58	X ² =10.777 Df=2 p-value=0.005
15-17 years	248	2.66(±0.20)	159.43	
18-20 years	4	2.49(±0.27)	106.63	
Sex:				
Female	166	2.70(±0.22)	177.45	X ² =3.136 Df=1 p-value=0.077
Male	169	2.65((±0.21)	158.71	
PresentClass				
Junior class	8	2.61(±0.15)	142.63	X ² =0.563 Df=1 p-value=0.453
Senior class	327	2.68(±0.22)	168.62	
Positionat home:				
First	70	2.65(±0.19)	159.39	X ² =7.906 Df=6 p-value=0.245
Second	94	2.68(±0.23)	170.3	
Third	66	2.66(±0.18)	163.34	
Fourth	54	2.66(±0.17)	160.44	
Fifth	27	2.72(±0.27)	183.72	
Sixth	23	2.80(±0.27)	204.54	
Seventh	1	2.23(±0.00)	5	
Family types***				
Monogamy	299	2.52(±0.19)	99.74	X ² =20.039 Df=1 p-value=0.001
Polygamous	36	2.70(±0.21)	176.22	
Family Marital status:				
Divorced	6	2.78(±0.07)	234.33	X ² =0.563 Df=1 p-value=0.453=5.607 Df=3 p-value=0.132
Married	289	2.67(±0.22)	165.8	
Separated	11	2.78(±0.20)	212.64	
Widowed	29	2.64(±0.19)	155.79	
Fathers' Educational Status				
Noeducation	4	2.59(±0.14)	132.88	X ² =20.039 Df=1 p-value=0.001=5.914
Primary education	3	2.64(±0.11)	153.67	
Secondary education	44	2.60(±0.18)	137.25	

Tertiary	284	2.69(±0.22)	173.41	Df=3 p-value=0.116
Mothers' Educational Status				
No education	7	2.67(±0.02)	172.64	X ² =1.271 Df=3 p-value=0.736
Primary education	11	2.66(±0.19)	158.36	
Secondary education	51	2.71(±0.22)	181.52	
Tertiary	266	2.67(±0.22)	165.68	
Father alive				
Yes	316	2.68(±0.22)	168.73	X ² =0.320 Df=1 p-value=0.572
No	19	2.64(±0.19)	155.79	
Mother alive***				
Yes	325	2.53(±0.15)	97.85	X ² =5.408 Df=1 p-value=0.020
No	10	2.68(±0.22)	170.16	

DISCUSSION

The aim of this study was to assess family dynamics and psycho-social well-being of in school adolescents and determine if their family dynamics influenced their psycho-social well-being. The In-school adolescent family dynamics was measured based on the self-report of the adolescents. Majority of respondents in this study were within the age group of 16-19 years (mean age 15.41 ± 1.65 years). More than half were Senior Secondary School, with an almost equal number of both genders with 50.4% of the total sample identifying as male.

Family dynamics of the respondents from the findings of this study showed that majority of the participants had unhealthy family functioning pattern in all the dimensions. This finding synchronized with the finding in a study of relationship between family functioning and aggression among school adolescents by Dabaghi et al., (2018)⁽²⁹⁾ where majority of participants had unhealthy family dynamics. The percentage of families with unhealthy family functioning pattern in this study were considered high with the need for urgent attention in view of its implications on the psycho-social health status of school adolescents.

The high percentage of dysfunctional families in Saudi Arabia (KSA) could indeed be influenced by a variety of current social, economic, and cultural challenges. These factors, which reflect both broader societal issues and specific local conditions, may contribute to family dysfunction in different ways. Below are some key challenges in KSA that could be linked to the increasing incidence of dysfunctional families.

Dai & Wang., (2015)⁽¹⁴⁾ in their review acknowledged that father's employment status, living condition and financial status may influence family dynamics. Other factors include the stage of the family, for example families with teenagers. All of these factors must be planned into interventions to improve family dynamics. Unhealthy functioning in any of the family dynamics dimensions may result in physical and emotional stress and may aggravate psycho-social problems in the school adolescent.

Also, approximately 1 out of 6 (16%) of the respondents had impaired psycho-social status. This finding is consistent with the findings in a similar study by Timalsina et al., (2018)⁽²⁸⁾ where 12.9% of school adolescent had impaired psychosocial status. In another study by Bista et al., (2016)⁽⁴⁾ 17.3% of school adolescents had impaired psycho-social impairment. Adolescents have unique and specific needs which must be well taken care of in the parenting process. Inadequate attention to the psycho-social health status of school adolescents may have an adverse influence on their academic performance. A study revealed that higher psycho-social impairment was seen in children with poor performance in class⁽³⁰⁾. Poor performance in the classroom may eventually affect ability to achieve or attain high educational level in future. Apart from the implication of impaired psycho-social status of school adolescents on their academic performance, impaired psychosocial status may result in mental health problems, which may limit the economic productivity of the adolescents in future.

This study also showed that there was a negative association between the problem-solving dimension of family function and psycho-social health of respondents. This finding is contrary to findings in past studies that reported positive association of family functioning with psycho-social well-being of adolescents^(16, 31, and 33). Another study reported association of general family dynamics with psychological symptoms⁽³⁴⁾. Variance in the findings from this study may be as a result of the self-report nature of data collection.

Furthermore, the impact of poor family functioning may not be significantly felt on the psycho-social health status of older adolescents when they relate and spend more time with friends outside the family. This is with the understanding that the school adolescent spends more time in the school than home. However, the family remains an important social setting for the adolescents' well-being. A healthy functioning family is crucial to reduce the risk of psychopathology amongst adolescent^(34, 35).

Parents should develop the ability to resolve problems that emanate through family member's daily interactions;

most especially those related to feelings and emotions or those that threaten the integrity or the functioning capacity of the family. Generally, parents and other members of the family must show appropriate affection and demonstrate adequate emotional sharing. Open expressions of feelings and concerns must be encouraged among family members while appropriate boundaries are set to prevent over-involvement. Parents should be flexible with rules and ensure satisfaction of all family members. All of these serve as protective factors that promote adolescent psychological functioning. These should also be incorporated into the interventions for improving family dynamics. In view of the fact that the school adolescents stay more in school than home except during holidays; school teachers must show love and provide a safe and supportive environment for the adolescents. Adolescents should be helped to accept defeat and failures and be assisted to cope with stressful life situations (36, 37).

CONCLUSION

Overall, the majority of school-age teenagers exhibited unsatisfactory family functioning status in the areas of affective involvement, problem resolution, and family responsibilities. Among school-aged teenagers, problem-solving skills and psychosocial health were significantly correlated negatively. One key tactic for addressing emotional and behavioral issues in school-aged adolescents is to focus on strengthening family functioning patterns. The study's conclusions point to areas that require more research on the complex aspects of family functioning. Future studies should include community health nurses to carry out community-based preventative treatments in conjunction with educators to quickly identify adolescents who may be at risk for psychosocial health issues related to family functioning.

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