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The Influence of Confirmation, Intimacy and Engagement
on Parents' Reports of Health Communication Satisfaction with Their Children

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Abstract

This study analyzed parents' self-reported measures of intimacy, confirmation, engagement and satisfaction in communication about health with their minor children (N=220). Results indicated that a significant correlation exists between reported intimate communication about health and communication satisfaction ($r = .40$), and between confirming communication and satisfaction ($r = .45$). Results also indicated that engagement in communication strongly predicts reported satisfaction among parents ($R^2 = .63$, $F(1,218) = 377.67$, $p < .001$).

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INTRODUCTION

Considerable recent research has been conducted on the relationship between parental involvement in their children's health education and health outcomes for adolescents. In particular, scholars have been interested in discovering how communication between parents and adolescents can reduce teens' risky behaviors including sexual contact and the abuse of addictive substances. However, less research has been conducted on specific parent-child communication processes and health risk factors. Indeed, Jaccard and Dittus (1993) argue that research on the communication processes between parents and teens needs to be conducted to understand the influences on health risk factors, and that such study needs to be conducted from the perspective of the parents as well as the teens.

The relevance of such studies may be a matter of defining such communication processes and what qualifies as effective communication between parents and children. According to Lytle, Birnbaum, Boutelle, and Murray (1999), health risk factors may be reduced through effective communication between parents and teenage children. Additionally, Greenwald (1989) posits that measures of effective family communication and interaction significantly predict children's social well-being. What qualifies as effective communication may include supportive interactional behaviors by parents. Gotcher (1993) found that interactions with immediate family members which demonstrated emotional support was a strong predictor of health-related adjustment, and that such interactions were also related to satisfaction in health-related communication. The purpose of this study is to investigate what types of communicative

behaviors are related to relational satisfaction and whether parental involvement in the lives of their children through communication of health related topics predicts relational satisfaction.

REVIEW OF LITERATURE

Previous studies have investigated family communication about health in relation to its effects on adolescent behavioral outcomes. For example, Barnes and Farrell (1992) found that parental support predicts adolescent behavior. In many studies, parental support has been defined as involvement in children's issues through communicative behaviors. According to Hartos and Power (2000), maternal monitoring of mother-child communication can reduce the harmful effects of adolescent stress. Those stressors in the lives of children often involve the daily routines of emotional and psycho-social development including the development of friendships and movement into adulthood.

Such development into adulthood by adolescents involves pressure to engage in risky health behaviors including sexual contact. Warren and Neer (1986) found that a strong family orientation toward communication about sex seems to facilitate openness in communication between children and their dating partners. However, it is the perceived quality of the relationship between parents and children which may assist adolescents in navigating the stressors of their development. In fact, Rask, Astedt-Kurki, Paavilainen, and Laippala (2003) found that adolescents' perception of a high level of mutuality and stability in the family predicted adolescent satisfaction. Furthermore, the authors found that poor parental relationships predicted a high level of adolescent distress.

It is the quality of the relationship which seems to be the important predictor of adolescent health and engagement in unhealthy behaviors. From a parental perspective, involvement in the lives of children has benefits for both parents and children. Ritblatt, Beatty,

Cronan, and Ochoa (2002) discovered significant relationships between parental involvement in adolescent school activities and perceptions of sensitivity, familiarity and support of their children. In a recent study, Meschke, Bartholomae, and Zentall (2002) found that parenting efforts are related to adolescent sexual behavior; that greater interaction relates to reduced risky behaviors. In support of that conclusion, Miller (2002) found that parent-child closeness and connectedness decreased the risk of adolescent pregnancy. As well, Miller, Norton, Fan, and Christopherson (1998) found that parent-adolescent communication quality was positively related to adolescent values which ultimately influenced sexual behaviors. However, Somers and Paulson (2000) discovered that higher levels of communication closeness between parents and adolescents did not significantly influence adolescent sexual behavior.

Closeness or connectedness in parent-adolescent interaction may be a function of several factors including gender of the parent, gender of the child, cultural expectations of the relationship, and context of the health-related issue. For example, Noller and Bagi (1985) found that adolescents tended to communicate more openly with mothers than fathers and that mothers were more accurate at predicting their children's responses. In another study, Romo, Lefkowitz, Sigman, and Au (2002) found that in Latino families, maternal communication influenced adolescents' perception of openness and the likelihood of engaging in risky sexual behaviors.

In terms of the context of the health related issue, how the topic is broached and by whom may also influence both parents' and children's perceptions of the interaction. If the parent or parents broach the subject of their child's health, the perception of the interaction may be considerably different than if the topic of the parent's health is discussed. Often the topic may occur within the context of a visit to the physician. In one recent study, Ma and Meeuwesen

(2000) discovered that in physician-parent-child interaction, parents typically control the communication of their children regarding the child's health, regardless of the child's age.

When such topics should be discussed is often related to what topics are discussed. For example, discussion about the parent's health may occur only when the parent's health is at risk. Miesfeldt, Cohn, Jones, Ropka, and Weinstein (2003) discovered that parents who are cancer survivors believe that discussions about cancer risk should occur before their children are 18 years of age. Discussion regarding the child's health may occur as a perceived preventive measure. Yet, such discussions can impact perceptions regarding the quality of the relationship. That is, both parents and children may perceive that openness in discussion about health-related issues is important for the relationship. However, King and Lorusso (1997) argue that parents may underestimate what topics their children are comfortable discussing.

Discussing health-related topics in the family often is influenced by the parental roles of socialization and protection. Miesfeldt and colleagues (2003) discovered that, overwhelmingly, parents believe the information source should be themselves. Jordan, Price, and Fitzgerald (2000) found that parents believe that the majority of sexuality education should occur in the family and then be supplemented by the school system. Additionally, Kelly, Comello, and Hunn (2002) discovered that teenagers perceive their parents as credible sources of information about drug use and that discussions between teenagers and their parent are correlated to teen drug use.

Birch, O'Toole, and Kanu (1997) found that the most important topics for discussion between parents and children regarding children's health included sex, drugs, alcohol and HIV/AIDS. Hutchinson (2002) discovered that earlier discussion between parents and their children about sex was associated with later initiation of sexual contact by their children and more likelihood of use of condoms. DiClemente and colleagues (2001) found that less

communication between parents and adolescents was associated with less frequent use of contraceptives and less communication between adolescents and their sexual partners. Ennet, Bauman, Foshee, Pemberton, and Hicks (2001) found that parent-child communication about substance abuse related health issues was influenced by parental substance abuse and educational level of the mother. Interestingly, Hutchinson (2002) discovered that Latina respondents reported fewer conversations about health-related issues with their parents than other ethnic groups.

Conversations between parents and their children about the health of the parents follow similar patterns but include different topics. Birch and colleagues (1997) found that the most important topics for discussion regarding parents' health included family relationships, physical fitness and stress management. Barnes and colleagues (2000) discovered that the most consistent reason mothers gave for not discussing a diagnosis of the mother's illness was to avoid questions from the children, particularly regarding death.

The research outlined above suggests that communication about health-related issues between parents and their children, regardless of specific topic, may accomplish specific tasks. Indeed, Ennet and colleagues (2001) identified three domains of communication between parents and children regarding health related issues: rules and discipline, consequences and circumstances, and Media influences. From the parents' perspective, their role as socializer and protector of their children may influence what topics are discussed and how those topics are broached. Yet, for both parents and children the purpose of communication about health may include other less tangible but nonetheless important relational goals. For example, King and Lorusso (1997) found that parents and adolescent disagree on the meaningfulness of their mutual discussions about sex, but that parents' recollections of meaningful communication about sex with their parents was associated with their children's perception of meaningfulness.

Meaningfulness of communication about any topic within the context of a family may influence perceptions about the relationship.

Previous research in family communication satisfaction demonstrates the importance of meaningful interaction. For example, Noller and Fenney (2002) demonstrated that satisfaction is directly related communication patterns in marital relationships. Communication patterns may involve how individual family members deal with conflict and/or express relational commitment. Stanley, Markman, and Whitton (2002) discovered that higher levels of reported commitment as demonstrated through communication and conflict patterns was associated with higher levels of greater relational satisfaction in marital couples. As well, Feeney (1994) found that mutually constructive communication was a strong correlate of satisfaction in marital couples across the life cycle.

The correlation between communication and satisfaction can be seen in parent-child relationships as well. Raffaelli, Bogenschneider, and Flood (1998) found that both parent and teen attitudes about the relationship were most strongly predictive of satisfactory communication about sex and health. Barnes and Olson (1985) found that families with effective parent-adolescent communication reported higher levels of relational satisfaction. Indeed, Jackson, Bijstra, Oostra, and Bosma (1998) found that effective family communication was associated with adolescents reports of relational satisfaction.

Family members' reports of relational satisfaction may be related to what each member expects of his or her communication within the context of the family. Caughlin (2003) found that expectations regarding ideal communication in the family was related to individual reports of relational satisfaction. Those expectations may include the perception of connectedness and

closeness as they are demonstrated through everyday interactions or through interactions about personal information such as health-related talk.

LeBlanc (2000) demonstrated that interaction between parents and adolescents can be described as involving confirmation and intimacy inducing communication behaviors by both parents and adolescents. LeBlanc (2000) found that confirming and intimacy inducing communication behaviors were strongly correlated, and that these constructs included the sharing of personal information such as friendships, daily activities and sex. In order to demonstrate that communication satisfaction about health-related issues in parent-child communication is related to how parents and children interact, the following hypotheses are proposed:

- H₁ Parents will report a positive relationship between the communication of intimacy and health communication satisfaction with their children.
- H₂ Parents will report a positive relationship between confirming communication and health communication satisfaction with their children.
- H₃ Parents' reported health communication satisfaction with their children will be influenced by their engagement in communication.

METHOD

Respondents

The sample for this study was randomly selected from residential households in a large southwestern city. A total of 2,925 households were called of which 257 were eligible (having a minor child at home) and responded to the survey. After eliminating responses which had missing data, a total sample size of 220 was achieved. The sample consisted of 147 females (66.8%) and 73 males (33.2%). Other characteristics of the sample included: a) mothers (58.2%), fathers (28.2%), stepmothers (7.7%), stepfathers (3.6%), and other parent type (2.3%); b)

married/remarried (75.9%), divorced/separated (20.5%), and other marital status (3.6%); c) Latino/Latina (34.1%), African-American (13.6%), Asian-American (4.5%), Caucasian/European-American (44.5%), and other race/ethnicity (3.2%); and d) some high school (2.3%), high school graduate (31.4%), some college (35.9%), college graduate (27.7%), and other educational attainment level (2.6%). The mean age of study participants was 40.2 ($s = 9.82$), with the minimum reported age as 22, and the maximum reported age as 81. Participation was voluntary and anonymous.

Measurement

The Family Health Communication Assessment survey was developed based on previous studies which investigated levels of reported confirmation and intimacy between parents and their adolescent children (see LeBlanc, 2000). As well, items were selected and revised for the current context to measure health communication satisfaction and engagement from a previous study which investigated patients' perceptions of health communication with their physicians (see LeBlanc, 2002).

The constructs of confirmation and intimacy were measured using 7-item Likert-type scales with a higher number representing a more positive response. A factor analysis using principle components extraction and varimax rotation was conducted to affirm which survey questions measured each of the constructs. The .50 loading rule was used to determine which items clustered by factor. The range of loading for items on the intimacy factor was .56 - .80, and the intimacy factor accounted for 31.5% of the variance. Reliability for the intimacy factor was measured using Cronbach's alpha with a resulting measure of $\alpha = .77$. The range of loading for items on the confirmation factor was .66 - .84, accounting for 26.3% of the variance. Reliability measure for the confirmation factor was $\alpha = .79$.

On the survey, six items measured the satisfaction construct using a 7-item Likert-type scale, also with a higher number corresponding to a more positive response. Reliability for the satisfaction construct was $\alpha = .78$. As well, six items measured engagement using the same 7-item scale as the satisfaction construct with a resulting reliability of $\alpha = .81$.

RESULTS

In general, support for all three hypotheses was found. Moderate to strong relationships were found between satisfaction with health communication and intimacy, confirmation and engagement as reported by parents.

For all study participants, the degree of association between the communication of intimacy and health communication satisfaction (H_1) was measured using the Pearson product-moment correlation procedure. Strength of the relationship was in the moderate range, $r = .40$, $p < .01$. When controlling for gender, the strength of the relationship increased slightly for females ($r = .41$, $p < .01$), but decreased slightly for males ($r = .39$, $p < .01$).

For all study participants, the strength of association between confirming communication and health communication satisfaction (H_2) was also in the moderate range, $r = .45$, $p < .01$. When controlling for gender, the strength of the relationship increased for females ($r = .46$, $p < .01$), but decreased slightly for males ($r = .42$, $p < .01$).

As suggested by LeBlanc (2000), a post-test was conducted to determine the strength of the relationship between intimacy and confirmation. A strong relationship was demonstrated to exist between two factors for this sample, $r = .74$, $p < .01$.

The relationship between engagement in health related communication and satisfaction with health communication reported by parents was strong, $r = .80$, $p < .01$. When controlling for gender, the strength of the relationship between engagement and satisfaction was increased for

females ($r = .820, p < .01$), but decreased for males ($r = .74, p < .01$) although was still strong. However, relational satisfaction is typically viewed as an outcome variable for communication behaviors within personal relationships. To test this hypothesis (H_3), a linear regression analysis was performed and revealed that engagement in communication strongly predicts reported satisfaction among parents ($R^2 = .63, F(1,218) = 377.67, p < .01$).

Post-tests were conducted to determine whether engagement was related to either confirmation or intimacy in parents' reports of their communication with their children about health. Results indicate that a moderate relationship exists between engagement in communication and confirmation, $r = .47, p < .01$. When controlling for gender, the strength of the relationship between confirmation and engagement increased for females ($r = .49, p < .01$), but decreased for males ($r = .40, p < .01$).

A slightly weaker relationship exists between engagement and intimacy, $r = .40, p < .01$. Gender also influenced the strength of the relationship between engagement and intimacy where females reported a stronger relationship ($r = .42, p < .01$), whereas males reported a weaker relationship ($r = .37, p < .01$).

Several other post-tests were conducted on the data to determine whether demographic characteristics of the sample influenced the results. An independent samples t-test was conducted to determine if significant differences existed by gender on the intimacy or confirmation factors or on the satisfaction or engagement measures. Results indicated that no significant differences were found between males and females on any of the factors or constructs. Therefore, other characteristics of the sample may have influenced the results.

Parental status was taken into account to determine if mothers, fathers, stepmothers, stepfathers, or other parents might differ in reports regarding their communication with their

children about health. ANOVA were conducted to compare different parental status groups by each of the constructs (intimacy, confirmation, satisfaction and engagement). As expected, significance was found between groups on confirmation, $F(4,215) = 5.05$, $p < .01$, $\eta^2 = .06$. This difference was attributable to significant differences between biological parents ($M = 4.01$, $s = 1.17$) and other non-step parents ($M = 5.92$, $s = 1.07$), $t(193) = -3.32$, $p < .01$, $\omega^2 = .05$.

Significant differences on reports of confirmation were also found between step parents ($M = 3.61$, $s = .91$) and other non-step parents ($M = 5.92$, $s = 1.07$), $t(28) = -5.03$, $p < .01$, $\omega^2 = .45$.

When controlling for parental status, results indicated a moderate correlation between confirmation and satisfaction for biological parents ($r = .39$, $p < .01$, $n = 190$). The strength of the relationship was considerably stronger for step-parents ($r = .65$, $p < .01$, $n = 25$), but non-significant for other non-step parental types.

Parental status also influenced results on the intimacy factor: $F(4,215) = 3.30$, $p < .01$, $\eta^2 = .06$, attributable to significant differences between biological parents ($M = 3.67$, $s = 1.13$) and other non-step parents ($M = 5.12$, $s = .95$), $t(193) = -2.82$, $p < .01$, $\omega^2 = .03$. Significant differences on the intimacy factor were also found between step parents ($M = 3.23$, $s = .90$) and other non-step parents ($M = 5.12$, $s = .95$), $t(28) = -4.25$, $p < .01$, $\omega^2 = .36$. Results indicated differing degrees of correlation between satisfaction and intimacy depending on parental status. For biological parents, level of reported intimacy was moderately correlated with satisfaction ($r = .35$, $p < .01$, $n = 190$). The correlation results were higher for step parents ($r = .45$, $p < .03$, $n = 25$), and higher still for other non-step parents ($r = .92$, $p < .03$, $n = 5$).

Further, parental status influenced results on both engagement and satisfaction measures. For the engagement measure, significant differences were found between biological parents ($M = 5.13$, $s = .92$) and step parents ($M = 4.31$, $s = 1.07$), $t(213) = 4.10$, $p < .01$, $\omega^2 = .07$, with results

indicating differing correlations between satisfaction and engagement for biological parents ($r = .79, p < .01, N = 190$), step parents ($r = .73, p < .01, n = 25$), and other non-step parents ($r = .99, p < .01, n = 5$). Significant differences on the satisfaction measure were also found between biological parents ($M = 5.08, s = .86$) and step parents ($M = 4.59, s = .85$), $t(213) = 2.65, p < .01, \omega^2 = .03$.

Marital status was also taken into account and appears to have influenced the results for the intimacy factor, $F(4,215) = 3.08, p < .01, \eta^2 = .05$. This difference was attributable to significant differences between married/remarried parents ($M = 3.53, s = 1.08$) and divorced/separated parents ($M = 3.98, s = 1.21$), $t(210) = -2.42, p < .02, \omega^2 = .02$. The difference was also attributable to significant differences between married/remarried ($M = 3.53, s = 1.08$) and single/never married ($M = 4.64, s = 1.12$), $t(170) = -2.27, p < .03, \omega^2 = .02$. When controlling for marital status, differences in correlation results for the intimacy factor were found between married/remarried ($r = .34, p < .01, n = 167$), and divorced/separated ($r = .61, p < .01, n = 45$) parents.

Marital status also influenced the results for the confirmation factor, $F(4,215) = 3.00, p < .02, \eta^2 = .05$. These results were attributable to significant differences between married/remarried ($M = 3.88, s = 1.13$) and divorced/separated ($M = 4.33, s = 1.27$) parents, $t(210) = -2.29, p < .03, \omega^2 = .02$, and between married/remarried ($M = 3.88, s = 1.13$) and single/never married ($M = 5.28, s = 1.05$) parents, $t(170) = -2.73, p < .01, \omega^2 = .04$. When controlling for marital status, differences in correlation results for the confirmation factor were found between married/remarried ($r = .34, p < .01, n = 167$) and divorced/separated ($r = .74, p < .01, n = 45$) parents.

Reports of intimacy and confirmation were also influenced by ethnicity of the subject, $F(4,215)=4.07$, $p < .01$, $\eta^2 = .07$. The differences by ethnicity for the intimacy factor, however, only applied to comparisons between Latino/Latina parents ($M = 3.93$, $s = 1.18$) and Caucasian/European-American parents ($M = 3.39$, $s = 1.04$), $t(171) = 3.21$, $p < .01$, $\omega^2 = .03$. Interestingly, the correlation between intimacy and satisfaction was higher for Latino/Latina parents compared to the sample as a whole ($r = .59$, $p < .01$, $n = 75$). For Caucasian/European-American parents, the correlation between intimacy and satisfaction was non-significant.

Results indicate that confirmation scores differed by ethnicity: $F(4,215) = 3.00$, $p < .02$, $\eta^2 = .05$. These results were attributable to significant differences between Latinos/Latinas ($M = 4.19$, $s = 1.12$) and Caucasian/European-Americans ($M = 3.73$, $s = 1.14$), $t(171) = 2.65$, $p < .01$, $\omega^2 = .03$, as well as between Asian-Americans ($M = 4.48$, $s = .68$) and Caucasian/European-Americans ($M = 3.73$, $s = 1.14$), $t(106) = 2.03$, $p < .05$, $\omega^2 = .03$. When controlling for ethnicity, the correlation between satisfaction and confirmation differed for each of these groups: a) Latinos/Latinas ($r = .61$, $p < .01$, $n = 75$), b) Caucasian/European-Americans ($r = .21$, $p < .04$, $n = 98$), and c) Asian-Americans ($r = .84$, $p < .01$, $n = 10$).

Educational level was also taken into consideration for comparison of reported confirmation, intimacy, satisfaction and engagement. Results indicate that education level did no significant differences between groups. However, significant differences in reported satisfaction were found between those who did not complete school regardless of level ($M = 5.19$, $s = .872$) and those who did complete school regardless of level ($M = 4.95$, $s = .875$), $t(212) = 1.98$, $p < .05$, $\omega^2 = .01$.

Finally, age was considered as a possible correlate to reported health communication constructs. Weak but significant correlations were found for all four of the constructs. Results indicate a weak, negative correlation between age and intimacy ($r = -.18, p \leq .01, N = 220$), and a weak but positive correlation between age and satisfaction ($r = .14, p < .04, N = 220$).

DISCUSSION

These results suggest that how health-related issues are communicated between parents and children is important to relational satisfaction. Indeed, it is the communication of intimacy and confirmation in discussions about health that contribute to perceptions of communication satisfaction in the parent-child context. Additionally, parental engagement in the process of communication about health-related issues with their children is predictive of relational satisfaction. As discussed previously, effective communication between parents and children may influence health outcomes, where relational satisfaction may indicate effective communication.

These findings have implications for parents, teachers, counselors and health care providers. For example, Barnes and colleagues (2000) discovered that few parents were given much help from physicians about how to broach the subject (of health) with their children, although these parents expressed a desire to receive such help. Jordan and colleagues (2000) also found that parents wanted assistance in communicating with their children about sex. DiClemente and colleagues (2001) suggest that physicians and other clinicians may be able to facilitate increased communication between parents and their children regarding health related issues. Finally, Barnes, Kroll, Lee, Jones, and Stein (1998) posit that family coping strategies for health related issues can be improved through family communication training.

To improve the outcome of such training may require further research into the relationship between specific relationship enhancing communication behaviors and health-related

communication between parents and children from the child's perspective. The current study was limited due to its examination of only the parent's perspective of parent-child health communication. Future studies might investigate the child's perspective of the relationship between the communication of intimacy and confirmation and relational satisfaction for health-related communication. A stronger case might be made if further studies involved paired samples of parents and children from within the same family. Regardless, individuals interested in promoting healthy behavior might consider how emphasis on the quality of communication between parents and children could serve such a purpose.

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