Research Article

Perceived Parental Support and Self-Reported Psychosomatic Complaints Among Adolescents: A Cross-Sectional Analysis

Kavitha Mugesh[1] and Dr. Shaista Ahad[2]

[1]PhD Scholar, Psychology, Department of Social Sciences and Humanities, Shri Venkateshwara University, Gajraula, Uttar Pradesh. Email: kavithamugesh@gmail.com
[2]Supervisor, Department of Social Sciences and Humanities, Shri Venkateshwara University, Gajraula, Uttar Pradesh. Email: aanjlie01khan@gmail.com

Abstract

Recurrent headache, abdominal pain, backache and dizziness are common in adolescence and are often not explained by an identifiable organic cause. Such psychosomatic complaints are frequently linked to stress and are regarded as an indicator of broader mental health difficulties. Parenting practices, and parental support in particular, are recognised as protective for adolescent mental health, but the association of parental support with psychosomatic complaints is less consistently described. This online cross-sectional survey, conducted as part of a doctoral study of parenting and adolescent psychosomatic health, examined the association between perceived parental support and the frequency of self-reported psychosomatic complaints among 75 adolescents aged 12 to 18 years attending 10 schools, and tested whether the association persists after adjustment for sociodemographic factors, peer support and psychological distress. Parental support was measured with the family subscale of the Multidimensional Scale of Perceived Social Support (MSPSS) and psychosomatic complaints with the somatic items of the Health Behaviour in School-aged Children (HBSC) Symptom Checklist. Data were analysed with multivariable linear regression (with school-clustered standard errors) and logistic regression, and moderation by sex and age and mediation by psychological distress were also examined. The mean parental support score was 4.81 (SD = 1.19) on the 1–7 scale and the mean somatic complaint score was 8.21 (SD = 3.34) on the 0–16 scale; 81.3% of adolescents reported at least two symptoms weekly or more often. Higher parental support was associated with fewer complaints ($r = -.34$, 95% CI [−.52, −.12], $p = .003$), and the association persisted after adjustment for age, sex, family structure, family affluence, peer support and psychological distress ($B = -0.93$ per scale point, 95% CI [−1.57, −0.28], $p = .006$). It did not differ by sex ($p = .996$) or age ($p = .654$), and psychological distress did not mediate it (indirect effect 0.00, 95% bootstrap CI [−0.15, 0.14]). The association with the binary indicator of frequent complaints was in the same direction but not significant (adjusted OR = 0.71, 95% CI [0.40, 1.25]). Higher perceived parental support was therefore associated with fewer psychosomatic complaints, independently of peer support, distress and sociodemographic factors. Because the sample is small and the design is cross-sectional, the findings describe association only and need confirmation in larger samples.

Keywords: Parental Support, Parenting Practices, Psychosomatic Complaints, Adolescents, Mental Health, Cross-Sectional Study.

I. Introduction

Psychosomatic complaints, such as headache, stomachache, backache and dizziness, are among the most common health concerns reported by young people. They are subjective physical symptoms that often have no identifiable organic cause, are commonly associated with stress, and are generally regarded as an indicator of broader mental health difficulties. Large international surveys, notably the Health Behaviour in School-aged Children (HBSC) study, show that a substantial share of adolescents report at least one such symptom more than once a week, with prevalence generally higher among girls and rising through the teenage years, and psychosomatic complaints are recognised as a public health concern in many countries [1]. Although many of these complaints are benign, frequent complaints are linked to school absence, reduced quality of life and greater use of health services, and they often co-occur with anxiety and low mood.

A biopsychosocial view treats these complaints as the product of biological, psychological and social influences rather than of physical pathology alone. Within the social domain, the family is the most proximal context of adolescent development. Attachment theory proposes that a secure relationship with caregivers supports emotion regulation and stress coping [2]. The stress-buffering hypothesis adds that perceived availability of support reduces the physiological and psychological impact of stressors [3]. If adolescents who feel supported by their parents appraise stressors as less threatening and regulate distress more effectively, they should report fewer stress-related somatic symptoms.

The family is also the setting in which parenting practices operate. Parenting practices are the specific behaviours through which parents carry out their role, and they are distinguished from parenting style, the broader emotional climate in which those behaviours are expressed [4]. Three practices are frequently examined in relation to adolescent psychosomatic complaints: parental support, parental knowledge of the adolescent's activities and friends, and parental rule-setting [1]. Parental support has the most consistent protective profile. Lower parental support has been linked to more psychosomatic and psychological complaints in adolescents [5], [6], and in a Swedish national cohort parental support showed the strongest and most consistent inverse cross-sectional association with psychosomatic complaints in both middle and late adolescence [1]. Parenting is not static, since practices fluctuate over time within families [7], and the benefits of parental warmth and autonomy support appear to hold in most families [8]. Parent and peer support may also compensate for one another [9], which makes it important to take peer support into account when examining the role of parents.

Empirical studies broadly agree with this reasoning, linking lower parental support, poorer family communication and family conflict to more frequent headaches, abdominal pain and other somatic symptoms in youth. However, several gaps remain. Many studies treat parental support as one component of a general family or social support score, so the specific contribution of parental support is unclear. Findings on whether the association differs by sex and age are mixed. Few studies adjust simultaneously for peer support and psychological distress, even though both are plausible confounders or mediators. Most studies are cross-sectional, so the direction of association is uncertain, and results from different cultural settings and family structures are not always comparable. Contemporary parenting challenges such as digital technology and social media use, and the perspectives of adolescents themselves, have also received limited attention.

The present study is part of a doctoral research programme on parenting and psychosomatic health among adolescents. The wider programme is designed to examine parenting styles, cultural context, family structure, digital technology and intervention strategies; the data reported here address one component, the association between perceived parental support and psychosomatic complaints. The objectives were (i) to examine the association between perceived parental support and the frequency of self-reported psychosomatic complaints among adolescents, (ii) to test whether this association is independent of age, sex, family structure, family affluence, peer support and psychological distress, and (iii) to examine whether it differs by sex and age and whether it is mediated by psychological distress. The following hypotheses were tested:

H1. Higher perceived parental support is associated with a lower frequency of psychosomatic complaints.
H2. This association remains after adjustment for age, sex, family affluence, peer support and psychological distress.
H3. The association is stronger among girls and older adolescents.

II. Methodology

2.1. Study Design and Reporting

This is a cross-sectional survey conducted with an online, self-administered questionnaire. The study is part of the first author's doctoral research, and the design follows the cross-sectional survey approach set out in the doctoral synopsis, in which parenting practices and psychosomatic complaints are measured at a single point in time. Reporting follows the STROBE statement for cross-sectional studies [10]. Data were collected over a period of 10 months, with the questionnaire circulated online so that responses would come from multiple locations rather than from a single area.

2.2. Setting and Participants

The sample comprised 75 students aged 12 to 18 years (grades 7 to 12) from 10 schools, with between 2 and 13 students per school. Forty-one students attended government schools and 34 attended private schools; 45 attended urban and 30 rural schools. The study protocol specified stratified random sampling of secondary-school students, with stratification by region, cultural background, family structure and school type (government versus private). Eligible participants were adolescents aged 12 to 18 years enrolled in secondary school; adolescents with a diagnosed severe psychological disorder that could confound the results were to be excluded. Participants completed the questionnaire online.

2.3. Sample Size

A sample of about 780 participants would be needed to detect a small correlation ($r \approx 0.10$) with 80% power at a two-sided alpha of 0.05. Allowing for a design effect of about 1.5 due to clustering and for an expected 10% of

incomplete questionnaires gives a target of about 1,300 students. The achieved sample of 75 is far smaller; it has 80% power only for correlations of about $|r| \geq 0.32$, so small associations, interactions and subgroup differences could not be detected reliably and confidence intervals are wide. The doctoral protocol planned a sample of about 500 adolescents, which, ignoring clustering, would give 80% power for correlations of about 0.125 or larger and allow subgroup analyses by cultural context and family structure; the present analysis is based on the 75 adolescents who completed the questionnaire, and this shortfall is a limitation.

2.4. Measures

Perceived parental support (exposure). Perceived parental support was measured with the family subscale of the MSPSS, which has four items rated on a seven-point scale from "very strongly disagree" (1) to "very strongly agree" (7) [11]. Scores are averaged, with higher scores indicating greater perceived support. Wording was adapted to refer to parents or primary caregivers. Cronbach's alpha in this sample was .81.

Psychosomatic complaints (outcome). Psychosomatic complaints were measured with the somatic items of the HBSC Symptom Checklist: headache, stomachache, backache and dizziness [12]. Each symptom is scored from 0 to 4 for its frequency over the past six months (0 = rarely or never, 1 = about every month, 2 = about every week, 3 = more than once a week, 4 = about every day). Responses are summed to a somatic complaint score (0–16; $\alpha = .70$). A binary indicator of frequent complaints (two or more symptoms at least weekly, i.e., item scores of 2 or more) was derived from the item scores for secondary analyses.

Covariates. Covariates were age (years), sex, family structure (nuclear, joint/extended, single-parent or other), family affluence, perceived peer support and psychological distress. Family affluence was recorded as a single self-reported item (low, medium or high) rather than with the Family Affluence Scale [13]. Peer support was measured with the MSPSS friends subscale (four items, 1–7, mean score; $\alpha = .82$). Psychological distress was measured with a seven-item scale scored 0–3 per item and summed to a total of 0–21 ($\alpha = .90$). Because age and grade were perfectly aligned, only age was modelled. Because only four students reported "other" family structures, they were combined with single-parent families (n = 15) in the regression models. Parental education, school type, school location and number of siblings were examined descriptively.

2.5. Procedure

The questionnaire was self-administered online and anonymous. No identifying information was collected, and respondents were identified only by codes (A001–A075) assigned for analysis.

2.6. Statistical Analysis

Data were analysed in Python (pandas, SciPy and statsmodels). Descriptive statistics summarise participant characteristics and scale scores by sex and age group (12–14 vs. 15–18 years). Normality was checked with the Shapiro-Wilk test. Bivariate associations were examined with Pearson correlations, with Spearman correlations as a sensitivity check, and group comparisons with Welch t-tests and one-way ANOVA. The main analysis used multivariable linear regression of the somatic complaint score on parental support, entered in blocks: Model 1 unadjusted, Model 2 adding age, sex, family structure and affluence, Model 3 adding peer support, and Model 4 adding psychological distress. The binary frequent-complaints outcome was analysed with logistic regression and reported as odds ratios with 95% confidence intervals; because the outcome had only 14 non-events, only a parsimonious model (age, sex, peer support, distress) was fitted. Clustering of students within the 10 schools was assessed with the intraclass correlation and handled with cluster-robust standard errors as a sensitivity analysis; a random-intercept model did not converge, consistent with a near-zero intraclass correlation. Interaction terms (support × sex, support × centred age) tested moderation. Because psychological distress may lie on the pathway between support and complaints, Model 4 is interpreted as an estimate of the association net of distress rather than the total association, and a mediation analysis (support → distress → complaints, adjusted for age, sex, family structure and affluence) with a percentile bootstrap (5,000 resamples) was conducted as a secondary analysis. There were no missing data, so no imputation was needed. Significance was set at $p < .05$, and effect sizes are reported alongside p values.

III. Results

3.1. Participant Characteristics

All 75 students provided complete data. The mean age was 14.8 ± 2.1 years (range 12–18); 57.3% were male and 42.7% female; 48.0% lived in nuclear families, 32.0% in joint or extended families, 14.7% in single-parent families and 5.3% in other arrangements; and self-reported family affluence was low for 26.7%, medium for

50.7% and high for 22.7% (Table 1). Mean parental support was 4.81 ± 1.19 (range 1.5–7.0), mean peer support 4.72 ± 1.16 (range 2.0–7.0), mean psychological distress 10.97 ± 5.13 (range 1–21) and mean somatic complaint score 8.21 ± 3.34 (range 2–16). Parental support was higher among younger (12–14 years: 5.12 ± 1.04) than older adolescents (15–18 years: 4.53 ± 1.26; t(72.1) = 2.23, p = .029) but did not differ by sex (p = .370). Distress was higher among male (12.12 ± 5.05) than female students (9.44 ± 4.91; t(68.0) = 2.31, p = .024), while peer support and complaint scores did not differ by sex or age group. Complaint scores differed by family affluence (F(2, 72) = 3.62, p = .032): students reporting low affluence had lower scores (6.55 ± 3.15) than those reporting medium (8.79 ± 3.28) or high affluence (8.88 ± 3.20). Scores did not differ by family structure, parental education, school type or school location (all p > .50). The intraclass correlation for school was approximately zero.

Table 1. Sample characteristics (N = 75)

Variable	Category	n	%
Sex	Male	43	57.3
	Female	32	42.7
Age group	12–14 years	36	48.0
	15–18 years	39	52.0
Family structure	Nuclear	36	48.0
	Joint/extended	24	32.0
	Single-parent	11	14.7
	Other	4	5.3
Family affluence (self-report)	Low	20	26.7
	Medium	38	50.7
	High	17	22.7
Highest parental education	No formal/primary	7	9.3
	Secondary	25	33.3
	Higher secondary	15	20.0
	Graduate or above	28	37.3
School type	Government	41	54.7
	Private	34	45.3
School location	Urban	45	60.0
	Rural	30	40.0

Note. Age: mean 14.8, SD 2.1, range 12–18 years. Number of siblings: mean 1.9, SD 1.1.

3.2. Prevalence of Psychosomatic Complaints

Weekly or more frequent complaints were common: headache was reported by 69.3% of students, stomachache by 68.0%, dizziness by 68.0% and backache by 66.7%. Almost all students (72 of 75; 96.0%) reported at least one symptom weekly or more often, 61 (81.3%) reported two or more, and 26 (34.7%) reported all four. Prevalence did not differ significantly by sex (frequent multiple complaints: 78.1% of girls vs. 83.7% of boys; Fisher's exact p = .563) or by age group (83.3% of 12–14-year-olds vs. 79.5% of 15–18-year-olds; p = .771) (Table 2).

Table 2. Students reporting each complaint at least weekly, by sex and age group, n (%)

Group (n)	Headache	Stomachache	Backache	Dizziness	≥ 2 symptoms
All (75)	52 (69.3)	51 (68.0)	50 (66.7)	51 (68.0)	61 (81.3)
Female (32)	24 (75.0)	20 (62.5)	21 (65.6)	22 (68.8)	25 (78.1)
Male (43)	28 (65.1)	31 (72.1)	29 (67.4)	29 (67.4)	36 (83.7)
12–14 years (36)	26 (72.2)	26 (72.2)	25 (69.4)	25 (69.4)	30 (83.3)

Group (n)	Headache	Stomachache	Backache	Dizziness	≥ 2 symptoms
15–18 years (39)	26 (66.7)	25 (64.1)	25 (64.1)	26 (66.7)	31 (79.5)

Note. "At least weekly" = item score of 2 or more. The last column is the derived indicator of two or more symptoms at least weekly.

3.3. Association Between Parental Support and Psychosomatic Complaints

Parental support was negatively correlated with the somatic complaint score (r = −.34, 95% CI [−.52, −.12], p = .003; Spearman's ρ = −.32, p = .006). Peer support (r = −.01) and distress (r = .18) were not significantly correlated with complaints, and parental support was only weakly related to peer support (r = −.22) and not to distress (r = −.04). In unadjusted regression (Model 1), each one-point increase in parental support was associated with 0.94 fewer complaint points (95% CI [−1.56, −0.32], p = .003; standardised β = −.34), explaining 11.2% of the variance. The coefficient changed little after adding age, sex, family structure and affluence (Model 2: B = −0.87, 95% CI [−1.51, −0.23], p = .009), peer support (Model 3: B = −0.92, p = .006) and psychological distress (Model 4: B = −0.93, 95% CI [−1.57, −0.28], p = .006; β = −.33) (Table 3). Model 4 was significant ($F(9, 65) = 2.30$, p = .026), with R^2 = .24 and adjusted R^2 = .14. Variance inflation factors were at or below 1.7 and residuals were approximately normal (W = .987, p = .661). With school-clustered standard errors (10 clusters) the Model 4 estimate was similar (95% CI [−1.56, −0.30], p = .004). Across the four symptoms, higher parental support was associated with fewer headaches (B = −0.25, p = .047), stomachaches (B = −0.24, p = .038) and dizziness (B = −0.28, p = .024) but not significantly with backache (B = −0.17, p = .157), in models adjusted as in Model 4.

Table 3. Linear regression of somatic complaint score on parental support, Models 1 to 4 (N = 75)

Model	B (95% CI)	β	p	R^2	Adjusted R^2
1. Unadjusted	−0.94 (−1.56, −0.32)	−.34	.003	.112	.100
2. + age, sex, family structure, affluence	−0.87 (−1.51, −0.23)	−.31	.009	.204	.121
3. + peer support	−0.92 (−1.57, −0.27)	−.33	.006	.216	.121
4. + psychological distress	−0.93 (−1.57, −0.28)	−.33	.006	.241	.136

Note. B = change in complaint score (0–16) per one-point increase in parental support (1–7). Reported statistics are for the parental support coefficient.

Among the covariates in the full model (Table 4), only family affluence was a significant predictor: students reporting medium affluence had 2.18 more complaint points than those reporting low affluence (95% CI [0.34, 4.02], p = .021), and those reporting high affluence had 2.07 more (95% CI [−0.05, 4.19], p = .056). Age, sex, family structure, peer support and distress were not significant.

Table 4. Model 4 coefficients for somatic complaint score (N = 75)

Predictor	B (95% CI)	p	Reference
Parental support (per point)	−0.93 (−1.57, −0.28)	.006	—
Age (per year)	−0.27 (−0.62, 0.09)	.138	—
Sex: female	0.33 (−1.25, 1.92)	.675	Male
Family: joint/extended	0.17 (−1.53, 1.87)	.841	Nuclear
Family: single-parent/other	−0.57 (−2.57, 1.42)	.567	Nuclear
Affluence: medium	2.18 (0.34, 4.02)	.021	Low
Affluence: high	2.07 (−0.05, 4.19)	.056	Low
Peer support (per point)	−0.37 (−1.02, 0.29)	.265	—
Psychological distress (per point)	0.11 (−0.04, 0.26)	.147	—

For the binary outcome (two or more symptoms at least weekly; 61 students), higher parental support was associated with lower odds of frequent complaints, but the association was not statistically significant either unadjusted (OR = 0.70 per point, 95% CI [0.41, 1.21], p = .200) or after adjustment for age, sex, peer support and

distress (AOR = 0.71, 95% CI [0.40, 1.25], p = .234; per SD: AOR = 0.66, 95% CI [0.34, 1.25]). With only 14 students without frequent complaints, this analysis had very low power.

3.4. Moderation and Mediation

There was no evidence of moderation (Table 5). The support × sex interaction was null (B = −0.003, 95% CI [−1.30, 1.30], p = .996) and so was the support × age interaction (B = −0.07 per year, 95% CI [−0.38, 0.24], p = .654). In stratified descriptive analyses the correlation between support and complaints was similar for girls (r = −.31, p = .089) and boys (r = −.37, p = .015), and for adolescents aged 12–14 (r = −.29, p = .084) and 15–18 years (r = −.39, p = .014); the differences in significance reflect subgroup size rather than a different association. Psychological distress did not mediate the association: parental support was unrelated to distress (a path: B = 0.002, p = .998), and the indirect effect was essentially zero (0.0002, 95% bootstrap CI [−0.15, 0.14]), with the direct effect (B = −0.87) equal to the total effect (B = −0.87).

Table 5. Moderation by sex and age, and mediation by psychological distress

Effect	Estimate	95% CI	p
Support × sex (female) interaction	−0.003	−1.303, 1.298	.996
Support × age (per year, centred) interaction	−0.070	−0.382, 0.241	.654
a path: support → distress	0.002	−1.042, 1.046	.998
b path: distress → complaints (adjusted for support)	0.103	−0.046, 0.252	.171
Indirect effect (a × b)	0.0002	−0.153, 0.143 (bootstrap)	—
Direct effect of support	−0.868	−1.506, −0.230	.008
Total effect of support	−0.868	−1.510, −0.226	.009

Note. Interactions were added to Model 4. Mediation models were adjusted for age, sex, family structure and affluence. Estimates are unstandardised.

IV. Discussion

4.1. Principal Findings

Higher perceived parental support was associated with fewer psychosomatic complaints. The association was moderate in size (r = −.34), corresponded to about one complaint point fewer per scale point of support (roughly 0.3 SD of the complaint score per SD of support), and survived adjustment for age, sex, family structure, affluence, peer support and psychological distress, supporting the first two hypotheses. This is consistent with attachment and stress-buffering accounts [2], [3]. The association was present for headache, stomachache and dizziness, and in the same direction for backache. The third hypothesis was not supported: the association did not differ meaningfully by sex or age. The association with the binary indicator of frequent complaints pointed in the same direction (AOR = 0.71) but was imprecise because few students fell below the threshold, so it should be read neither as confirming nor as contradicting the continuous result.

The direction and approximate size of the association are consistent with earlier work. In a Swedish national cohort, parental support showed the strongest inverse cross-sectional association with psychosomatic complaints of the three parenting practices examined [1], and a negative association between parental support and psychological complaints has also been reported among 15–16-year-olds in Stockholm [6]. The absence of an age interaction here is in line with the view that parental support remains relevant across middle and late adolescence [1]. The association remained after adjustment for peer support, so it is not simply explained by support from friends, although whether parent and peer support compensate for one another [9] was not tested. Because the present data were not analysed by cultural group, they cannot show whether the association is similar across cultural contexts; evidence that parental warmth and autonomy support benefit adolescents in most families [8] suggests that similar associations may be found elsewhere, but this needs direct testing.

Psychological distress did not account for the association. In this sample parental support was unrelated to distress, and distress was only weakly related to complaints, so the mediation analysis found no indirect effect. This differs from the expectation in the Introduction that support operates through emotion regulation and lower distress. It may reflect a distinct pathway, but it may equally reflect the small sample or the limits of the

distress measure, and it should not be taken as evidence against mediation in other populations. Two other findings differ from the patterns described in the Introduction: complaints were not more frequent among girls or older adolescents, and distress was higher among boys. The lower complaint scores among students in low-affluence households were unexpected; they rest on a single self-reported item and a small group (n = 20) and should be treated as exploratory. Stress-related complaints have also been documented among privileged youth [14], so higher affluence should not be assumed to be protective.

4.2. Interpretation

Several explanations can be offered for the association. Supportive parents may help adolescents regulate stress, reducing the somatisation of distress. Adolescents who feel supported may be more willing to seek help early, so symptoms are less likely to persist. Conversely, adolescents with chronic or recurrent symptoms may perceive less support, for example if parents respond with frustration or disbelief, or may place greater strain on family relationships. Shared third factors such as family conflict, socioeconomic strain or parental mental health could also influence both. The cross-sectional design cannot distinguish between these possibilities.

4.3. Strengths

Strengths include the use of established instruments (the MSPSS subscales and the HBSC somatic items) with acceptable to good internal consistency (α = .70–.90), complete data, the focus on parental support separately from peer support, adjustment for psychological distress, and the examination of moderation and mediation alongside the main association.

4.4. Limitations

The cross-sectional design precludes causal and temporal inference. All variables are self-reported, which introduces common-method variance and possible reporting bias, and perceived support may be shaped by current mood. Psychosomatic complaints are not medically verified, and the checklist does not capture severity or functional impact. The sample (N = 75) is small, giving wide confidence intervals and low power for interactions, subgroup analyses and the binary outcome, and it was recruited online from 10 schools, so it may not represent adolescents in other settings and self-selection cannot be excluded; with only 10 schools, cluster-robust standard errors are themselves imprecise, although the intraclass correlation was near zero. Family affluence was a single self-reported item, and psychological distress was measured with a brief seven-item scale. Because responses were collected online, the identity and eligibility of respondents could not be independently verified. Residual confounding is likely, and an online survey excludes adolescents without internet access and those who are out of school, who may have higher symptom burden. Multiple tests increase the risk of chance findings, and no correction for multiplicity was applied. The achieved sample (N = 75) is far below the roughly 500 adolescents planned in the doctoral protocol, and the reported prevalence of weekly complaints was high (96.0% reported at least one symptom weekly or more often, using a threshold of “about every week” or more), which may reflect self-selection of students with symptoms into an online survey about health, so prevalence estimates should not be generalised. Parental support was the only parenting practice measured: parental knowledge, rule-setting and parenting style, digital technology and social media use, cultural comparison and intervention effects, which are objectives of the wider doctoral research, were not examined in these data.

4.5. Implications and Future Research

If replicated in larger samples, the findings point to the value of family-oriented components in school and primary care approaches to recurrent adolescent complaints, such as parent communication programmes and routine enquiry about family relationships when young people present with unexplained symptoms. Longitudinal and cross-lagged designs are needed to establish direction, and future work should use larger, properly sampled cohorts, include parent-reported measures and use mixed methods to understand how support is experienced. Future work should also reach the planned sample of about 500 adolescents drawn by stratified sampling, measure parental knowledge, rule-setting and parenting style alongside support, examine digital technology, social media use and family structure as moderators, compare cultural contexts, and test intervention strategies that aim to strengthen parental support.

V. Conclusion

In this sample of 75 adolescents, higher perceived parental support was moderately associated with fewer psychosomatic complaints (r = −.34), and the association was robust to adjustment for age, sex, family structure, affluence, peer support and psychological distress. It did not vary by sex or age and was not mediated by distress.

Because the sample is small and the design is cross-sectional, these findings describe association only and should be confirmed in larger samples.

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