AN EXPLORATION OF THE RELATIONSHIP BETWEEN PARENTING STYLES AND HEALTH RISK-TAKING BEHAVIORS AMONG EARLY PHASE ADOLESCENTS

by

Mollie W. Howerton

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APPROVED:

Charles R. Baffi, Chairman

Kerry J. Redican

Arthur L. Buikema, Jr.

Javaid Kaiser

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(ABSTRACT)

The purpose of this study was to examine whether a relationship exists between parenting styles, adolescent self-esteem, and health risk behaviors. The sample consisted of 343 middle school students from Harrisonburg, Virginia who completed a questionnaire consisting of three major components: parenting styles, self-esteem, and health risk behaviors. The health risk behaviors component contained questions concerning alcohol use, drug use, sexual activity, and eating behaviors. The parenting styles section of the questionnaire classified the participants into one of four types of parenting styles: authoritarian, authoritative, permissive, and neglectful. The Rosenberg Self-Esteem scale divided the participants into one of three levels of self-esteem: low, average, and high. The risky behaviors component of the questionnaire classified the participants as being low risk-takers, experimenters, or high risk-takers, with the exception of the eating behaviors component, which classified participants as being either high or low risk takers. In general, no relationship was found between parenting styles, self-esteem, and health risk behaviors.

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Chapter 1

INTRODUCTION

Adolescence is a period of growth, development, experimentation, and risk taking. During this time, adolescents tend to rely less on their families, and more on their peer groups to help them establish their independence and identity (Shedler & Block, 1990). A part of the adolescent's quest for independence often involves experimentation with a variety of roles and behaviors. Behaviors associated with sex, drugs and alcohol, dieting, tobacco, and violation of curfews become especially salient during this developmental period. Experimentation with these behaviors is considered, by some experts, to be normal and psychologically healthy for adolescents. Taking risks with sex, drugs, alcohol, tobacco use, and dieting, involve decisions that they personally make instead of their parents, thus, helping adolescents take an important step toward gaining independence. At times, however, experimentation can become problematic (Windle, 1991). Problems may arise, for example, when the adolescent models the wrong peers and, thus, develops problem or risky behaviors..

Behavioral psychologists believe that the environment can also contribute greatly to the development of problem behaviors such as excessive drinking and drug use, risky sexual practices, and eating disorders. As the environment can be shaped by parents, their behaviors in general, and the particular styles they use to parent, it appears that parents may play an important role in the development of risky behaviors on the part of adolescents.

Parents, for example, can have a strong influence over the personality, attitudes, and beliefs of their children. These, in turn, affect behaviors. In fact, the professional literature supports the belief that parenting styles affect a child's behavior and self-esteem (Lamborn et al, 1991; Dornbusch et al., 1985; Steinberg et al., 1991; Dornbusch et al., 1987; Baumrind, 1971; Baumrind, 1989; Baumrind, (1991); Patterson & Stouthamer-Loeber, 1984). Specifically, parenting styles have been correlated with school performance (Steinberg et al., 1989; Dornbusch et al., 1987), delinquency (Patterson & Stouthamer-Loeber, 1984), psychiatric disorders (Kashani et al., 1987), low self-esteem (Margolin et al., 1988; Hoffman et al., 1988; & Isberg et al., 1989), and many other problem behaviors, including alcohol abuse (Coombs & Landsverk, 1988; Barnes, 1984; & Neinstein & Scott, 1992), drug abuse (Neinstein & Scott, 1992), teenage pregnancy (Neinstein, 1991; Santrock, 1990), and eating disorders (Bensinger & Natenshon, 1990; Neinstein, 1991; Cobb, 1992) (See Figure 1).

Parenting Styles

Baumrind (1989) suggests that parenting styles can be categorized as authoritative, authoritarian, permissive, and neglectful. These classifications are commonly described in the following manner.

Authoritarian

In authoritarian households, parents attempt to mold their children through control. Authoritarian parents evaluate their child's behavior and attitudes according

- Types of Parenting Style

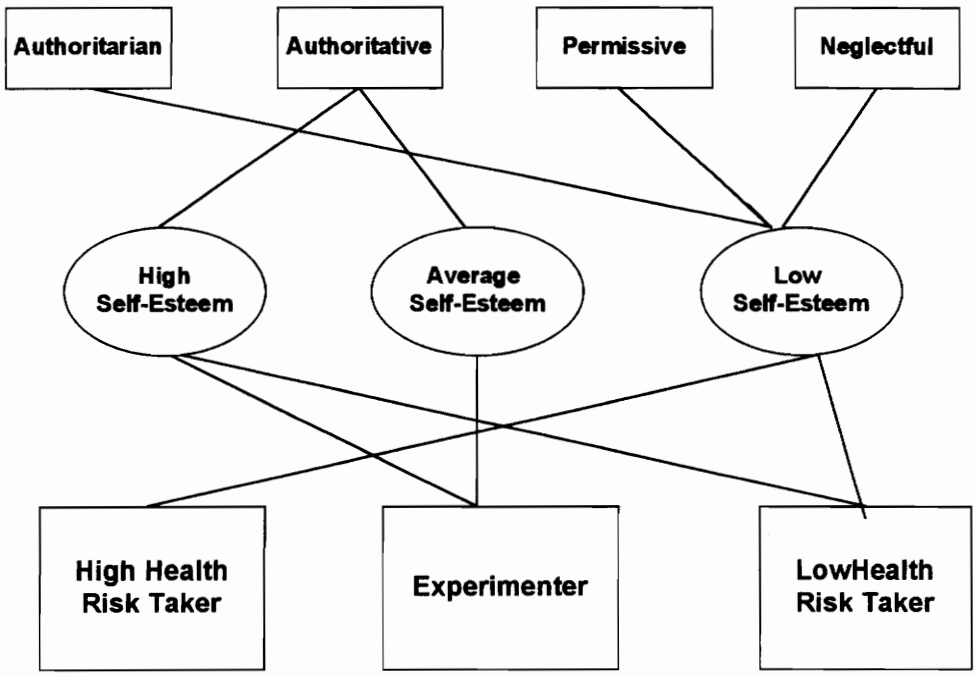

Figure 1. Effects of Parenting Styles on Health Risk Behaviors

to an absolute standard of conduct (Baumrind, 1989). These parents are controlling, and they use punitive measures to gain obedience; their word is law. Authoritarian parents do not respond well to their child's needs. Children from these households are discontent, withdrawn, distrustful, detached, and therefore, controlling. Their free expression of opinion is not encouraged.

Authoritative

The authoritative parenting style is characterized by high parental control and the encouragement of autonomy. When an adolescent, whose parents use this style, breaks known rules, he is likely to be disciplined, with the parents indicating the reasoning behind the disciplinary measures. Parents in authoritative households also encourage the adolescent to express his opinions. Although authoritative parents have firm control over their children, they do not impose many restrictions (Baumrind, 1989). This quasi freedom enables the adolescent to break away from the parental influence and become more independent. Children raised in authoritative households tend to be more self-reliant, self-controlled, exploratative, and content than do children raised in households employing one of the other types of parenting styles (Baumrind, 1991).

Permissive

On the other hand, parents in permissive households can be characterized as warm and autonomy granting. In addition, they try to be nonpunitive and accepting of their child's individuality. These parents are not very controlling, but instead act as resources for their children when needed. Permissive households are often

characterized as warm and trusting. Permissive parenting evolves from a philosophy of democracy, and indulgence (Lamborne et al., 1991). These parents try not to use power as a means of controlling their children. Instead, they allow their children to control and regulate their own activities. Children raised in permissive households receive no feedback from their environment, and so they may choose incorrect behaviors. Permissive parents are less self-reliant, explorative, and noncontrolling when compared to authoritarian and authoritative households (Baumrind, 1989).

Neglectful

Neglectful parents are characterized as nondirecting and rejectful parents. They place low demands on and provide low to medium responsiveness to their children. Neglectful parents provide little structure in their child's life as they do not want the responsibility of raising a child. There is no warmth in neglectful households. Neglectful parents do not monitor their child's activities (Lamborne, S., Mounts, N., Steinberg, L.,& Dornbush, 1991; & Baumrind, 1991).

Purpose

The purpose of this study was to determine whether a relationship exists between parenting style and adolescent health risk behaviors.

Research Questions

1. Do parenting styles influence adolescent health risk behaviors and adolescent self-esteem?
2. Is there a relationship between adolescent self-esteem and health risk behaviors?

Significance

Little research has been reported in the professional literature linking parenting syles with health risk-taking behaviors among adolescents. This study will enrich what work has already been conducted by focusing on specific health risk-taking behaviors: i.e. alcohol and drug abuse, sexual risk taking, and eating disorders. This study will also incorporate self-esteem as a mediating variable in adolescent health risk-taking, and will determine whether or not relationships exist between parenting styles, self-esteem, and health risk-taking. If parenting styles can be linked to risky behaviors, then prevention programs can be aimed at parents in addition to their children.

Limitations

A limitation of this study was its reliance on subjects to honestly report their risk-taking behaviors. Those who participated in the study may have either underreported or exaggerated their behaviors and beliefs, or reported what they believed the researcher wanted rather their actual behaviors and beliefs.

A second limitation is that tobacco use was not adequately measured.

A final limitation is that the subjects were able to identify and were willing to report on their parent's parenting styles. Some of the questions asked in the parenting style questionnaire were abstract and, thus, the answers depended on the participant's understanding of the question and the scale.

Definition of Terms

The following definitions are offered in order to clarify terms used in this study:

1. Parenting styles are the ways in which parents interact with their children, which, in turn, influences the child's attitudes, beliefs, values, and behaviors. Parenting styles may be classified in various ways. In this study parenting styles will be classified into four categories: authoritarian, authoritative, permissive, and neglectful.

2. Authoritarian is a type of parenting style that involves low interaction between parent and child. The parent tries to control the child through punitive measures which coincides with their absolute standard of conduct. They have high demands and utilize punitive measures to enforce their rules. These parents do not encourage autonomy, and the child's feelings are not taken into account.

3. Authoritative is a type of parenting style characterized by high interaction between parent and child. The parent has firm control over their child, but also encourages autonomy in the child.

4. Permissive is a type of parenting style that is characterized by nonpunitive and noncontrolling behaviors. The parents act more as resources for the children when needed. They try to avoid the use of power to meet their parental demands.

5. Neglectful parenting styles are characterized by parents who neglect and reject their children. The make few demands on their children, and do not monitor their child's activities.

6. Adolescence is a period of time, between the ages of 11 and 21, that involves breaking away from the familial or parental influence, and becoming more autonomous. Adolescence is also a time for exploration and experimentation. The peer group also becomes important during this time.

7. Alcohol abuse among adolescents occurs when alcohol consumption creates problems with school performance, family relationships, peer relationships, health, and the law.

8. Drug abuse among adolescents occurs when the use of the drug interferes with the adolescent's health, school performance, peer relationships, family relationships, and the law. Drug abuse may also be considered drug use when the drug in question is an illegal drug.

9. Anorexia is a disease characterized by the refusal to maintain normal weight for height and age. Anorexics have an enormous fear of gaining weight and being fat and subject themselves to self-starvation to the point where they may lose up to 25% of original body weight. Ninety-five percent of anorexics are female.

10. Bulimia nervosa is a disease characterized by repeated binging and purging behaviors. Bulimics eat a large amount of food in a short period of time, often within two hours. Purging is done through self-induced vomiting, the abuse of laxative, diuretics, stimulants, stringent dieting or fasting, or heavy exercise in order to prevent weight gain.

11. Risky sexual behaviors occurs when condoms or other methods of birth control is not used during sexual intercourse. When adolescents do not use

contraception of any form, they put themselves at risk for unwanted pregnancies, STDs, and AIDS.

12. Self-Esteem is a measure of how good a person feels about him/herself. It can also be a measure of how well a person likes him/herself.

13. Parental control can be defined as how much a parent monitors his/her child's whereabouts and actions.

14. Parental support is characterized by nurturance.

15. Sexually Transmitted Diseases are infections that are passed through genital-genital, oral-genital, oral-oral, or genital-anal contact. These diseases include chlamydia, syphilis, herpes, gonorrhea, human papilloma virus (HPV), and pubic lice. AIDS can be included in this category since it can be transmitted sexually.

16. AIDS is a fatal disease that suppresses the immune system to the point where it can no longer fight any infection. It is caused by HIV or the Human Immunodeficiency Virus, and can be transmitted sexually, perinatally, through blood transfusions, and IV drug use.

Chapter II

REVIEW OF LITERATURE

In this chapter some of what is known and has been reported in the professional literature regarding parenting styles, adolescent self-esteem, and health risk behaviors will be reviewed.

Adolescence

Adolescence is a transitional time between childhood and adulthood where an individual's physical, mental, social, and spiritual development occurs. It is characterized as a period of growth, development, experimentation, and risk taking. Physically, adolescents are getting taller, growing to their full adult height. They are experiencing many hormonal and bodily changes such as breast development, voice changes, menarche, and spermarche (Neinstein & Kaufman, 1991). It appears that adolescents must accomplish four tasks during this period:

1. Achieving independence from parents
2. Adopting peer codes and lifestyles
3. Assigning increased importance to body image and acceptance of one's body image
4. Establishing sexual, ego, vocational, and moral identities(Neinstein, 1991, p. 40):

The establishment of one's identity is an important task that all individuals endeavor to accomplish during adolescence (Shedler & Block, 1990; Pardeck & Pardeck, 1990). They no longer want to be known as somebody's child, but instead, as their own person. Thus, their peer groups become much more important than their families during this quest for independence and autonomy. A part of their quest for independence may involve experimentation with a variety of behaviors. Some commonly tried behaviors are sex, drugs and alcohol, dieting, tobacco, and curfews. Additionally, experimentation with these behaviors is considered, by some experts, to be psychologically healthy and necessary for adolescents as it allows them to make personal decisions about how they want to behave and act (Windle, 1991; Shedler & Block, 1990).

Phases

Early Adolescence. Two pertinent phases of adolescence are early adolescence (12 to 14 years of age) and middle adolescence (15 to 17 years of age) (Neinstein, 1991). Those who are in early adolescence are mostly middle school students. These adolescents are concerned with their social roles in society. They may begin experimenting with make-up, clothes, and hairstyles. Since they are most likely in the midst of puberty during this time, they may be anxious about their developing bodies and appearances (Cobb, 1992). For adolescents in the early phase of development, "adolescents' self-images are strongly tied to their body images; this is true for both sexes" (Cobb, 1992, p.121). If they do not like their body image, they may have lower self-esteem (Cobb, 1992). They want to know if what is happening to them is normal.

They also become more aware of themselves as sexual beings as a consequence of their developing bodies (Neinstein, 1991). Also, during the junior high school years, adolescents start to detach themselves from their families emotionally and rely more on their peer groups for friendship and support. Cognitively, early adolescents may think more abstractly than they did during childhood. They have formal operational thoughts. In other words, the early adolescent phase of development results in individuals thinking about their thoughts, or why they think in a particular way (Cobb, 1992; Santrock, 1990). Early adolescence can also be a period of inconsistency and confusion, leading to mood swings (Neinstein, 1991).

Middle Adolescence. During middle adolescence or high school, adolescents break further away from their families and rely more heavily on the peer group (Windle, 1991). The peer group defines how the adolescent should dress and behave. It also defines the values and codes the adolescent should adopt (Neinstein, 1991). This can lead to risky activities such as drinking alcoholic beverages and taking drugs if the peer group is involved with these activities. Also, since there is an "increased involvement in heterosexual relations, manifested by dating actiivy, sexual experimentation, and intercourse" (Neinstein, 1991, p.42), middle phase adolescents may take risks by not being responsible contraceptors, making them vulnerable to sexually transmitted diseases, AIDS,and pregnancy.

During middle adolescence, the individual also becomes more idealistic and pragmatic. It is also common for adolescents to think of themselves as immortal. They have the attitude that the consequences of risk-taking behaviors will not happen

to them (Neinstein, 1991). At this critical time in their development, adolescents may model the wrong peers, and thus, develop problem behaviors. In addition, parental behaviors and parenting styles may encourage or allow these problem behaviors to occur.

PARENTING STYLES

Diana Baumrind developed the typology for parenting styles. Her work has mainly been with preschool children. However, Dornbusch, Ritter, Leiderman, & Fraleigh (1987) demonstrated that parenting styles and the consequences these styles generate can be readily applied to adolescents.

Authoritarian Parents

Authoritarian households are characterized as ones with a high degree of control. Parents from these households "demand respect for authority, work, tradition, and the preservation of order" (Dornbusch et al., 1987, p.1245). These adolescents are not encouraged to think for themselves. Instead, they are governed by "an absolute standard of conduct" (Baumrind, 1989, p.353). Authoritarian parents have high, and probably unrealistic, standards and expectations for their children, and punish them whenever the standards and expectations are not met. Authoritarian parents are very dictatorial towards their children. They may be so overcontrolling that they constrain or constrict their child's activities, possibly preventing developmentally appropriate activities, for example, from occurring (Baumrind, 1989; Barber, 1992).

Psychological overcontrol is characterized by an "environment that intrudes on the psychological and emotional development of the child, either through the forced inclusion of others in the child's definition of the self, or through the manipulation of the child's emotions" (Barber, 1992, p.72). Parents who exhibit psychological overcontrol discourage their child's development of psychological autonomy. This type of parenting style does not encourage the child to become independent and autonomous. It leads to withdrawal and reduced self-esteem on the part of the child (Barber, 1992). High parental control is also associated with risky behaviors such as alcohol and drug abuse (in addition to deviance within the past year (Barnes & Windle, 1987)).

Authoritarian parents do not encourage autonomy, but instead, encourage their children to act robotically to their every command. Open discussions about discipline and rules are neither encouraged nor wanted by these parents. Their word is law, and they will use punitive measures to gain the obedience they demand (Baumrind, 1991; Pardeck & Pardeck, 1990).

Authoritarian parents do not respond well to their child's needs. In some cases, adolescents whose parents exhibit high levels of discipline and control tend to practice more risky behaviors (Barnes & Windle, 1987); in others, adolescents who come from authoritarian households have fewer problems with behaviors such as alcohol and drug use, school misconduct, and delinquency because they are too scared of the consequences of getting caught engaging in these behaviors (Lamborn, Mounts, Steinberg, & Dornbusch, 1991). Baumrind (1991) states that adolescent females from

authoritarian homes use more drugs and have more internal behavior problems. Also, adolescents from authoritarian homes are more dependent on others since they are never allowed to make decisions for themselves (Pardeck & Pardeck, 1990). Their input is not wanted in family decisions (Dornbusch, Carlsmith, Bushwall, Ritter, Leiderman, Hastorf, & Gross, 1985), and their free expression of opinion is not encouraged. Adolescents from authoritarian households partake in more anitisocial behaviors (Parteck & Parteck, 1990).

Authoritarian parents may have children with lower self-esteem (Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Loeb, Horst, & Horton, 1980, as cited in Dornbusch et al., 1987). This could be the case because these parents demonstrate that they view adolescents as incompetent, inadequate,and untrustworthy (Openshaw et al., 1984, as cited in Margolin, Blyth, & Carbone, 1988) (See Figure 2).

Authoritative Parents

In the authoritative parenting style parents have control over adolescents, but they also grant autonomy. These parents provide more structure, rules, and guidelines than permissive parents, and are more loving and nurturing than authoritarian parents. Authoritative parents try to guide instead of dictate their child through adolescence. Authoritative parents tend to have adolescents who are low risk takers. Authoritative parents encourage independent thinking and decision making, but they also monitor their childs' behaviors. These adolescents have freedoms with limitations. Parents set clear standards for adolescents to follow (Dornbusch, Ritter, Leiderman, & Fraleigh, 1987). Parents monitor their child's activities in order to ensure a safe and orderly

- **Types of Parenting Style**

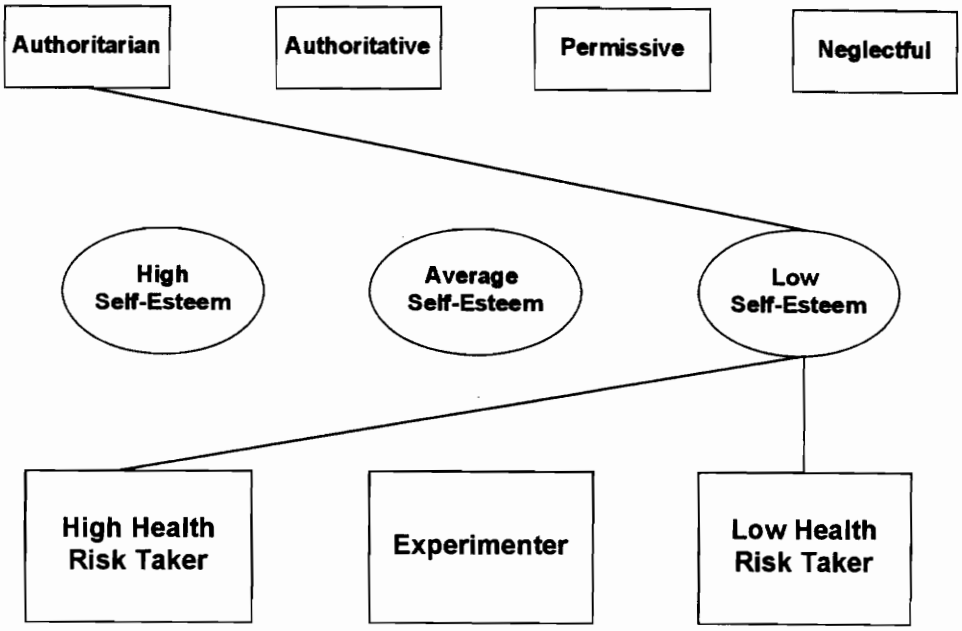

Figure 2

Effects of Authoritarian Parenting Styles on Adolescent Risk Taking

Authoritarian parents may cause their child to have low self-esteem because the child has no control over his/her life. The parents monitor everything the child does and the child is not encouraged to express his or her opinions. The child may become a high risk taker out of rebellion or loneliness. Rebellion becomes a way for the adolescent to gain some sort of control over life. On the other hand, the adolescent may become a low health risk taker because the parents have so much control over his life that the adolescent assesses the consequences of getting caught performing the risky behaviors not worth the effort.

environment (Baumrind, 1989; Barber, 1992). For example, they may allow adolescents to go to parties but they restrict them by giving them curfews, or they allow their adolescent to go out on the condition that the parents know where the adolescent is. Also, when adolescents make mistakes or choose improper behaviors, parents discipline them, and explain why they are disciplining them. Parents in authoritative households encourage the child to express his opinions. During adolescence, adolescents and parents have conflicts and disagreements. Part of the disagreement is often due to the adolescent's new ability to think in more abstract terms and to question everything. When disagreements do occur, authoritative parents encourage adolescents to think and express their opinions. This philosophy encourages autonomy, allowing for adequate cognitive growth in adolescents (Cobb, 1992). Although authoritative parents have firm control over their children, they are not overly restrictive (Baumrind, 1989).

Adolescents raised in authoritative households tend to be more psychologically healthy, socially responsible, and autonomous, than adolescents raised in authoritarian households (Steinberg, Mounts, Lamborn, & Dornbusch, 1991; Pardeck & Pardeck, 1990). In addition, adolescents from these households have higher grades in school, report psychological distress, and report fewer problem behaviors (Steinberg et al., 1991; Lamborn et al., 1991; Baumrind, 1991; Dornbusch et al, 1985) (See Figure 3).

- **Types of Parenting Style**

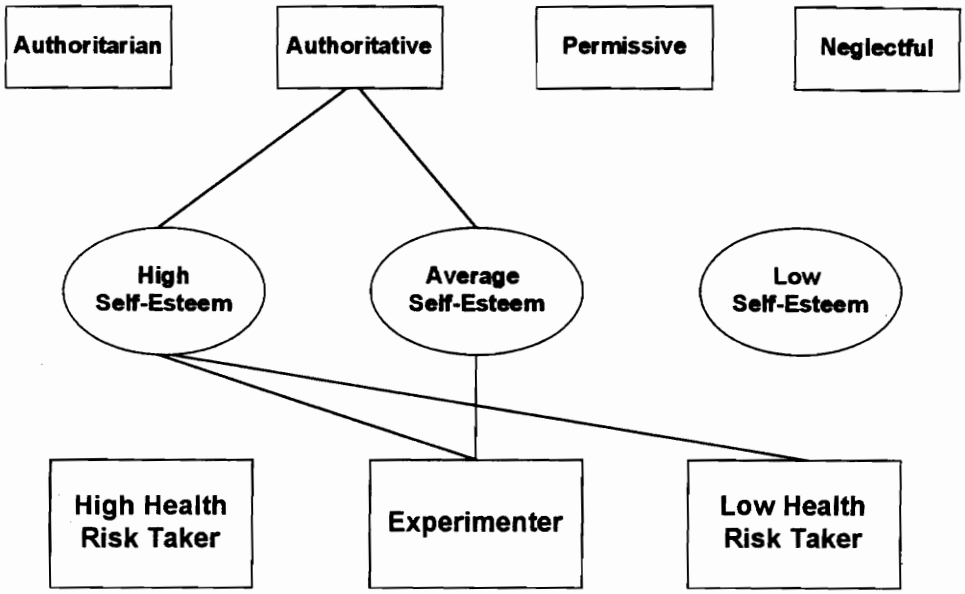

Figure 3. Effects of Authoritative Parenting Styles on Adolescent Risk Taking

Authoritative parents will have children with either high or average self-esteem. Adolescents who have high self-esteem are likely to be either average or low health risk takers. These parents will instill enough confidence in their children such that they will be less likely to experiment with drugs, alcohol, sex, or dieting. Adolescents with high self-esteem may still become experimenters or average health risk takers simply because experimentation is the nature of adolescence. Adolescents with average self-esteem are likely to become average health risk takers, or experimenters, because they have enough confidence in themselves not to take so many risks. However, they probably will experiment with drugs, alcohol, sex, and dieting simply because of the developmental nature of their age.

Permissive Parents

Parents in permissive households can be characterized as warm and autonomy granting (Baumrind, 1989). In addition, they try to be nonpunitive and accepting of their child's individuality (Lamborn et al., 1991). These parents are not very controlling, but instead act as resources for their children when needed (Baumrind,1989). Permissive parents are often characterized as warm and trusting, and their styles of parenting evolve from a philosophy of "trust, democracy, and indulgence" (Lamborne et al., 1991, p.1050). They try not to use power as a means of controlling their children. Instead, they allow their children to control and regulate their own activities. Children raised in permissive households receive no feedback from their environment, and so they may choose incorrect behaviors. Adolescents reared by permissive parents are less self-reliant and independent than adolescents reared by authoritarian or authoritative parents (Dornbusch et al., 1987; Baumrind, 1989). These adolescents also have little control over their impulses (Dornbusch et al., 1987), which could lead to risk-taking behaviors. Adolescents are more likely to use drugs and alcohol if they have permissive parents. They are psychologically well-adjusted, and are more peer-oriented than family-oriented, which is a factor in risk-taking behavior (Lamborn et al., 1991) (See Figure 4).

Neglectful Parents

Neglectful parents are characterized as nondirecting, rejecting, and neglecting parents. They place few if any demands on their children, and are not very responsive towards their children. Neglectful parents provide little structure in their child's life as

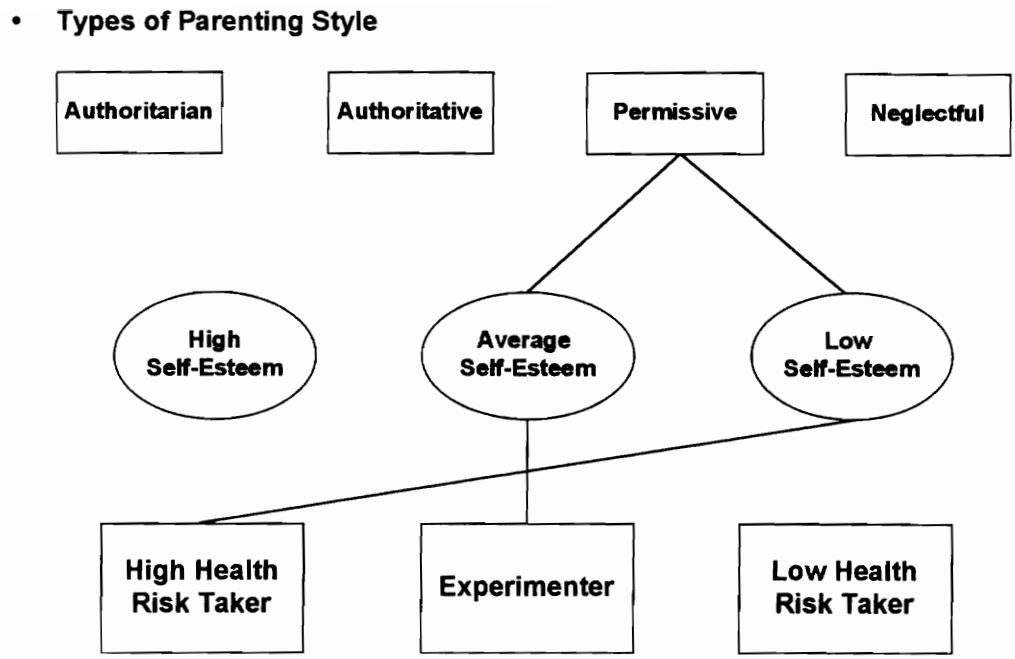

Figure 4. Effects of Permissive Parenting Styles on Adolescent Risk Taking

Adolescents whose parents are permissive are most likely to have average to low self-esteem. They are most likely to have average self-esteem because they come from a loving family. However, because they do not receive environmental cues from their parents telling them how to practice safe health behaviors, adolescents from this type of family may also have low self-esteem because their parents do not monitor their behavior, and they can do mostly what they want, potentially making them model the wrong people, and practicing the wrong behaviors. Therefore, adoelscents with low self-esteem coming from permissive households will probably be high health risk takers.

they do not want the responsibility of raising a child (Lamborn et al., 1991). There is no warmth in neglectful households. Neglectful parents do not monitor their child's activities (Lamborne, et al., 1991; & Baumrind, 1991).

Barber (1992) states that behavioral undercontrol relates to a lack of rules or restrictions, or a lack of knowledge or monitoring of the child's activities. It has been negatively linked to a child's behavior. Adolescents whose behaviors are insufficiently monitored do not develop the skills necessary to resist risks and temptations when exposed to them. These include sex, alcohol, and drugs. In addition, these youths spend more time with their peers, which can lead to an increased exposure to risks and temptations. Adolescents who are poorly monitored also tend to misbehave in order for them to determine their parents' limitations for their misconduct (Barber, 1992). Parents who exhibit behavioral undercontrol as a parenting style are permissive or neglectful parents.

Adolescents who have neglectful parents suffer most from internalized behaviors such as depression and eating disorders, and such externalized problem behavior as alcohol and drug problems, and risky sexual activity (Baumrind, 1991, p.753; Lamborne et al., 1991). These adolescents are at the greatest risk for being heavy drug users (See Figure 5).

SELF-ESTEEM

An adolescent's self-esteem is influenced by his environment, his interactions with family, friends, and peers, and his attributions to his behaviors with those stated above (Schweitzer, Seth-Smith, & Callan, 1992). Self-esteem is correlated with the

- **Types of Parenting Style**

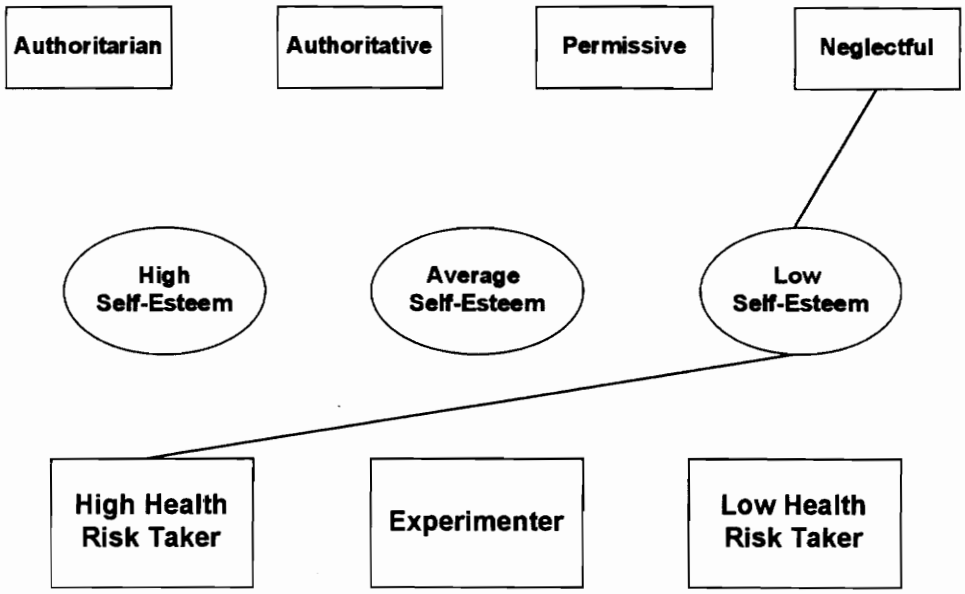

Figure 5. Effects of Neglectful Parenting Styles on Adolescent Risk Taking

Adolescents from neglectful parents are likely to have low self-esteem, causing them to be high health risk takers. They will have low self-esteem because their parents neglect and reject them, or they want nothing to do with them. These adolescents may feel that nobody loves them, and, thus, exhibit risky behaviors often to get attention. They, like adolescents from permissive households, may model the wrong people practicing risky behaviors, which can either become addicting, life-threatening, or both.

adolescent's relationship with his parents (Walker & Greene, 1986; Margolin, Blyth, & Carbone, 1988; Schweitzer, Seth-Smith, & Callan, 1992) and risk-taking behaviors (Vernon, 1990).

Parental support has been positively associated with adolescent self-esteem (Burke & Weir, 1979; Greenberg et al., 1983; O'Donnell, 1976; Siddique & D'Arcy, 1984; as cited in Hoffman, Ushpiz, and Levy-Shiff, 1988). When parents are not very supportive of the adolescent, then the adolescent tends to rely on peers for support and guidance (Hoffman, Ushpiz, & Levy-Shiff, 1988). Also, adolescents who rely mostly on their friends or peers are more likely to engage in risky behaviors. Barnes and Windle (1987) show a relationship between low parental support, deviance and drug use. On the other hand, adolescents whose parents are nurturing and supportive show fewer risky behaviors than those who have little support (Barnes, 1984).In a study reported by Hoffman, Ushpiz, and Levy-Shiff (1988), low adolescent self-esteem was found to be correlated with a low level of maternal support. In addition, self-esteem decreased as the number of stressful life events increased for the adolescent. They indicated that the level of maternal support and stressful life events were not interactive effects of self-esteem, but instead additive effects.

Adolescent perceptions of parenting styles are also related to the development of adolescent self-esteem. It, therefore, becomes useful when attempting to predict adolescent self-esteem, to understand an adolescent's perception of the styles their parents use to parent (Isberg et al., 1989; Margolin, Blyth, & Carbone, 1988; Schweitzer, Seth-Smith, & Callan, 1992). If adolescents perceive their families as

being rejecting and disapproving, then they are more likely to have lower self-esteem. Walker and Greene (1986) conclude from their study that "in spite of increasing autonomy from the family, the importance of parental relationships to self-esteem did not diminish from early to late adolescence" (p.320).

RISKY BEHAVIORS

Alcohol Abuse

Alcohol abuse among adolescents is a growing concern in the United States. Approximately 70% of adolescents have tried alcohol by the eighth grade (Horgan, Marsden, & Larson, 1993), 87-90% of adolescents have tried alcohol by the time they are eighteen years of age (Associated Press, 1994; Horgan, Marsden, & Larson, 1993; & Neinstein and Scott, 1991), and as many as 4.6 million adolescents aged 14-17 have problems with alcohol (Neinstein and Scott, 1992). The average age for adolescents first use of alcohol is 12.6 years, or those who are in seventh and eighth grades (Horgan, Marsden, & Larson, 1993). In addition, studies indicate that adolescents who use alcohol before the age of fifteen are at a greater risk for developing problems with drinking and drugs (Horgan, Marsden, & Larson, 1993). For example, many adolescents who commit suicide or attempt to commit suicide have alcohol in their bloodstream (Neinstein and Scott, 1992; Windle, Miller-Tutzauer, & Domenico, 1992; Horgan, Marsden, & Larson, 1993; Clark, 1992; & Barnes, 1984).

Alcohol-related traffic fatalities is the leading cause of death for people aged 17-24 (Horgan, Marsden, & Larson, 1993; Neinstein and Scott, 1991; Clark, 1992). The minimum legal drinking age has been raised in all fifty states to twenty-one years

of age in an attempt to reduce adolescent drinking and alcohol related traffic fatalities. However, adolescents are still drinking.

Use of alcohol and drugs by adolescents may be broken down into three categories: abstainers, experimenters, and frequent users (Shedler & Block, 1990; Beschner & Friedman, 1986). Abstainers are those adolescents who have never used or tried alcohol or any other drugs, or those who drink less than once per year. Experimenters, on the other hand:

1. tend to use drugs infrequently and in small amounts
2. generally limit experimentation to marijuana and alcohol
3. understand the difference between risk-taking and danger and between pleasure-seeking and reality avoidance (Beschner & Friedman, 1986, p.6; Shedler & Block, 1990).

Shedler and Block (1990) state that experimenters limit their drug use to *"no more than* one drug other than marijuana" (p.615). In regards to alcohol use, experimenters drink "once a week and consume 2-4 drinks per occasion *or* drink three to four times a month and consume 5-12 drinks per occasion" (Barnes, 1984, p.334).

Frequent users are those who "drink at least once a week and drink 5-12 drinks per typical drinking occasion" (Barnes, 1984, p.334). They use marijuana at least once a week in addition to one or more drugs other than marijuana (Shedler & Block, 1990). These adolescents' lives may be greatly affected by their alcohol and drug use, especially in regards to their physical health and their social and personal relationships.

Their lives may become centered around their next drunken experience or their next high (Beschner & Friedman, 1986).

Alcohol use among adolescents may be related to various factors, including family, peers, low self-esteem, and age (Neinstein and Scott, 1992). Family factors relating to alcohol abuse among adolescents include a family history of alcoholism, modeling, parenting styles, and perceived family support (Neinstein and Scott, 1992).

Alcoholism tends to run in families. This could be due to either genetic or biological factors, environmental factors, or a combination of the two. Evidence does suggest that a genetic predisposition for alcoholism does exist among children of alcoholics (Goodwin, 1984, as cited in Barnes & Windle, 1987). If alcoholism is due to environmental factors, then adolescents may model their parents' drinking habits. They may develop their parents' attitudes toward drinking. This occurs when adolescents see their parents' drinking as a way of coping with stress. Plus, if someone in their family has a problem with drinking, then they are continuously exposed to heavy drinking, which may make a large impression on adolescents' drinking attitudes (Windle, 1991; Chassin, Mann, & Sher, 1988). Forty-eight percent of adolescents report that parental drinking causes them to drink alcoholic beverages (Clark, 1992; Roper Reports, 1990), and sixty percent report parental influence on their decisions to drink (Roper Youth Reports, 1991). Clark (1992) also reports that "59% of all students, with at least one parent who they believed drank regularly, were themselves heavy drinkers" (p.227). Adolescents who do not communicate well with their parents are also at greater risk for alcohol abuse (Clark, 1992).

In addition to parents acting as role models, their style of parenting also affects adolescent drinking behaviors. Adolescents from authoritarian households, or who have parents who are very controlling, tend to have more problem behaviors (Neinstein & Scott, 1992; Barnes & Windle, 1987). A reason for this is simply that these adolescents may have a problem with parental authority (Clark, 1992). Adolescents are trying to become independent and autonomous, and when they have very controlling parents, they may try to rebel. Parents who are permissive and neglectful may also have an adolescent who practices risky behaviors (Neinstein and Scott, 1992). Both permissive and neglectful parents may impose too few rules and restrictions on their adolescents. This leads adolescents to turn to their peer groups as a means of information gathering and to serve as role models for such risky behaviors as alcohol.

The peer group is an important element in adolescent alcohol abuse since it provides the "social context for drinking" (Santrock, 1990, p.535; Windle, 1991). It has the most influence in early adolescence because this is the time when adolescents are trying to become less dependent upon their parents (Cobb, 1992). Approximately 70 percent of adolescents report that their friends and peers are the most important factors that cause them to drink (Roper Reports, 1990; Clark, 1992), and 17 percent say that their best friends influence them the most about their decsions to drink (Roper Youth Reports, 1991). Adolescents may also drink in order to gain social acceptance, or become one of the crowd.

Why do adolescents drink? Clark reported that 41% of adolescents drink because they are upset. They could be stressed out about school or something else, they may be having family problems, they may have relationship problems. Twenty-five percent of adolescents who consume alcoholic beverages drink simply because they are bored. Another twenty-five percent report they drink in order to get "high" (1988). Adolescents may also drink out of pure rebelliousness (Clark, 1992; Beschner, 1986).

Problem drinking among adolescents is a public health issue because it can lead to unprotected sexual intercourse by acting as a social and sexual lubricant (Clark, 1992). Problem drinking may lead to deviant behaviors such as running away from home, and the intentional destruction of property. Finally, alcohol is considered by many experts to be a gateway to other drugs (Horgan, Marsden, & Larson, 1993; Ellickson et al., 1992).

Drug Abuse

Drug use and abuse is a problem. Drugs, such as marijuana, cocaine, crack, LSD, and psychadelic mushrooms continue to infiltrate the schools. Approximately ten percent of adolescents have tried marijuana by the eighth grade, two percent have tried cocaine, and 44% have tried cigarettes. By the twelfth grade, about 37 percent of adolescents have tried marijuana, 8% cocaine, and 63% cigarettes (Horgan, Marsden, & Larson, 1993). The average age of first use of cigarettes among adolescents is 11.5 years (6th or 7th grade), 13.5 years for marijuana (8th or 9th grade), 14.2 years for cocaine (9th grade), and 14.4 years for hallucinogens (Horgan,

Marsden, & Larson, 1993). It seems that the eighth and ninth grades are especially risky years for the onset of drug use among adolescents. This could be due to the change in school environment, where drugs and alcohol are more readily available in high school. Kids are being approached about buying and taking drugs at younger ages. Drugs are presented as a way for children and adolescents to feel good. Later, for many adolescents, drugs become a great way to escape a bad or overbearing homelife. Peers are influential in adolescent use of illegal drugs (Dinges & Oetting, 1993). Adolescents who use marijuana have twice as many friends who use drugs other than marijuana than do adolescents who are not marijuana users. Also, there is a greater chance for adolescents to have friends who use drugs they do not yet use if the adolescent uses drugs other than marijuana (Dinges & Oetting, 1993).

Alcohol, cigarettes, and marijuana are considered to be gateway drugs to other, harder drugs (Ellickson et al., 1992). The longer adolescents delay the onset of use of these gateway drugs, then the less likely they are to have problems with these and other harder and illicit drugs.

Sexual Activity

Sexual activity among adolescents is also a major concern. Adolescents are not wearing condoms, and if they do, many are not using them properly. As a result, many are contracting AIDS and STDs. The increasing prevalence of AIDS among this age group has become problematic. A recent report from the Centers for Disease Control and Prevention (CDC) indicates that teenagers are a group that is at greatest

risk for becoming infected with HIV (Centers for Disease Control and Prevention, 1994).

Many adolescents are also becoming pregnant. Teenage pregnancy is both a national and a public health concern. Adolescent pregnancy was the biggest threat to adolescent females in the U.S. in 1990 (Strasburger, 1990). The U.S. has the highest incidence of teenage pregnancy and abortion of all the Westernized countries (Hardy, 1991; Strasburger, 1990). In addition, the pregnancy rate for U.S. adolescents less than fifteen years of age is four times greater than the other developed countries (Hardy, 1991). Strasburger (1990, p.4) states that "teenage sexual activity can be viewed from a variety of perspectives - as a normal developmental milestone, a transition-marking behavior, or as risk-taking behavior."

Approximately 50 percent of adolescents engage in sexual intercourse by 16 years of age, and 70 percent by the age of 19 (Shafer & Moscicki, 1991). Adolescents cite many reasons for engaging in sexual intercourse. Some include making them feel more grown up or adult, becoming more independent and autonomous, experimenting with their newly developed adult bodies, seeing how intimate they are capable of being, determining their level of physical attractiveness to both themselves and to others, and finally, rebelliousness (Strasburger, 1990; Cobb, 1992). Many of the stated reasons are due to the nature of adolescence, including the curiosity and experimentation associated with it.

Pregnancy rates are high among American adolescents for a variety of reasons. Approximately 67% of sexually active adolescent females aged 15-19 indicate that

they do not use contraceptives, or if they do, they use them sporadically (Shafer & Moscicki, 1991, Cobb, 1992). A common belief among adolescents, indicated in these statistics, is that one cannot get pregnant the first time one engages in coitus because they are special (Cobb, 1992), or they may not be cognitively developed enough to realize the full consequences of early intercourse (Neinstein, 1991) . This belief can probably be carried over to not being able to catch sexually transmitted diseases or AIDS the first time. A consequence of not using condoms or some other form of contraception is pregnancy. Approximately 50 percent of teenage pregnancies occur within six months of their becoming sexually active (Strasburger, 1991; Neinstein, 1991). Contraception such as birth control pills are not generally considered by teens until 6-12 months after first intercourse (Strasburger, 1990).

Some reasons why adolescents do not wear condoms are lack of information, immaturity, and an inability to accept one's sexuality (Cobb, 1992). Many adolescents are uncomfortable discussing sex and contraception, especially with their parents. They often get their information from peers, movies, TV, books, and magazines. Also, the information they are receiving is either not enough or incorrect. This leads to poor sexual choices and risky sexual behaviors (Cobb. 1992). If adolescents cannot talk about sex, then they are unlikely to use contraception.

The adolescent-parent relationship is important to adolescent sexuality. As stated before, adolescents and their parents generally are uncomfortable discussing sex and the issues associated with it (Cobb, 1992; Neinstein, 1991). However, adolescents who have close relationships with their parents are more likely to have open

discussions regarding sex. Self-esteem and level of autonomy are also associated with whether adolescents discuss sex with their parents (Papini, Belk, & Clark, & Micka, 1988, as cited in Cobb, 1992). Teenagers may engage in coitus as a means of feeling loved and cared for. If they are not getting the nurturance that they need at home, then they will seek it elsewhere through sexual intercourse (Strasburger, 1990). Low self-esteem is associated with teenage pregnancy (Neinstein, 1992; Santrock, 1990). Early sexual intercourse and pregnancy are also correlated with substance abuse, physical abuse, sexual abuse, neglect, and violence within the family (Neinstein, 1991; Shafer & Moscicki, 1991; Mott & Haurin, 1988, as cited in Strasburger, 1990).

An increasing health concern among adolescents is AIDS. AIDS is a disease that suppresses the immune system to the point of death. Simple infections become life-threatening. The incidence of AIDS is increasing among adolescents. A common belief among adolescents is that they cannot get STDs and AIDS if they are clean-cut and well-dressed. In actuality STDs and AIDS does not discriminate between age groups and socioeconomic status, and they do occur to well-dressed, clean-cut people (Cobb, 1992).

Approximately one percent of total AIDS cases are among adolescents (Neinstein, 1991). However, about 25 percent of adults who currently have AIDS became infected during adolescence, and 21 percent of total AIDS cases involve people aged 20-29 years (Neinstein, 1991). Also, about 50 percent of the total STD cases reported annually involve people who are 25 years and under (Shafer &

Moscicki, 1991). Among the adolescent population, AIDS is contracted primarily through heterosexual contacts.

Neinstein (1991, p. 441) lists some adolescent risk factors for the contraction of AIDS. They are:

1. greater experimentation and greater degree of influence by peer behaviors
2. naiveté and lack of good judgement
3. feelings of immortality and invulnerability
4. ignorance of the modes of AIDS transmission and prevention
5. denial of personal risk
6. identification with moral codes (i.e., those of peers) other than that of parents

Eating Disorders

Eating disorders, which include anorexia nervosa and bulimia nervosa, are also problematic among adolescents. Anorexia and bulimia are diseases that affect mostly adolescent females. Eating disorders may evolve from a social pressure to be thin (Neinstein, 1991; Bensinger & Natenshon, 1990; Cobb, 1992). Adolescent females are already uncertain about their changing bodies, and the mass media promotes an ideal body image that includes women who are very thin, beautiful, and happy. These actresses and models serve as role models for many adolescent females (Neinstein, 1991; Cobb, 1992). In addition, magazines and commercials are constantly promoting diets that allow the person to lose weight fast and easy. This sets the stage for anorexia and bulimia.

Eating disorders are associated with dysfunctional families and poor self-esteem (Bensinger & Natenshon, 1990; Neinstein, 1991; Cobb, 1992). Neinstein (1991, p. 486) states some family risk factors for adolescents who have eating disorders. They include families who are "achievement oriented, intrusive, enmeshed, overprotective, rigid, and unable to resolve conflicts. [They are] frugal with support, nurturance, and encouragement. [They have] overinvested in food, diet, weight, appearance, and physical fitness. [Also,there are] other family members with a history of an eating or affective disorder" (Cobb, 1992). Many of the characteristics that Neinstein states are characterisics of authoritarian households. These adolescents cannot become independent and autonomous because the boundaries in these families are not properly defined. They develop eating disorders as a means of gaining control over their lives. Adolescents with anorexia and/or bulimia can gain control over both their lives and their families by controlling their food intake. Parents cannot force the adolescent to eat or to stop eating (Cobb, 1992).

Anorexia and bulimia occur in mostly white middle and upper class families. These families look ideal and perfect to outsiders; however, if outsiders are able to get a true perspective of the families, they would see that the families have some serious problems with its dynamics. Adolescents with eating disorders tend to have grades and intelligence that are above average (Bensinger & Nantenshon, 1990; Neinstein, 1991). Bulimia has also been associated with substance abuse and sexual promiscuity (Neinstein, 1991).

Summary

According to research, adolescents from authoritative households will be the most well adjusted. They are likely to experiment with alcohol, drugs, and sex. How parents deal with this experimentation is important in determining later risk-taking.

Adolescents from authoritarian households will have low self-esteem. They are more likely to be risk takers due to rebellion or loneliness. They will rebel in an attempt to gain control over their lives. They may also become detached and lonely, resulting in their taking more health risks.

Adolescents from permissive households are also likely to be risk takers. They have no environmental constraints that will tell them how to control their behaviors. They may learn their risky behaviors through modeling the wrong people. They may also take risks because of a lack of discipline, or as a means of trying to obtain some sort of discipline.

Adolescents from neglectful households may take risks because of low self-esteem. They may be depressed, which makes them take more risks, making them even more depressed.

Adolescents who engage in risky behaviors may be doing so simply out of experimentation. Through experimentation they are able to gain a sense of independence and autonomy, which is developmentally appropriate behaviors during adolescence. However, adolescents may become high risk-takers through the abuse of alcohol and drugs, risky sexual activities, and eating destructively. These behaviors

could be due to low parental support, too much parental control, or as a means of escape.

Chapter III

METHODOLOGY

This chapter describes the selection of subjects, the pilot study, the instrumentation, the method for data collection, and the statistical analyses used in the study. Data collection occurred in December, 1993 at the Harrisonburg City middle school, located in Harrisonburg, Virginia.

Pilot Study

A pilot study was conducted to determine the readability of the questionnaire, the amount of time required to answer the questionniare, which questions were unnecessary and thus could be eliminated, and to determine any potential problems with the conduct of the study.

The pilot study was conducted during the summer of 1993 at the Shawnee Swim Club in Blacksburg, Virginia. The club's board of directors granted permission to conduct the pilot study. Each board member was given a copy of the questionniare, at the July 11, 1993 board meeting, and was given the opportunity, at this time, to ask the researcher questions about the questionniare and the study. No questions were asked. The board decided that parental consent was necessary for the students to fill out the questionniare. A letter explaining the nature of the study was written, on Virginia Tech letterhead, asking parents for their consent for their child to participate in the study (See appendix A). On July 12, potential participants were identified based on whether they were at the pool that day. They were asked to show their parents the letter and obtain permission to participate in the study. If the parents were at the

pool, they were shown a copy of the permission slip, and verbally explained the nature of the study. The letters were given to twenty-five potential middle and twenty-five potential high school participants to take home to their parents if their parents were not at the pool that day. Parents were told that a copy of the questionniare was available for their review in the guard office at the pool. A few of the parents wanted to see the questionniare. The parents were told that the questionniare had to be completed at the pool, in the presence of the head lifeguard, and without any adults around. The participants were asked to complete the survey at the picnic tables located in front of the pool. The parents, in most cases, were very encouraging and wanted their children to participate in the study.

Once parental permission was secured, forty-three of the fifty students who received letters were asked to participate in the study. Three students declined to participate in the study. This resulted in twenty middle school and twenty high school subjects. Participants were told that their responses would remain confidential and that the only individuals who would know that they participated in the pilot study were the participants themselves, and the researcher. Names of the participants were not collected and did not appear anywhere on the questionnaire. Participants were also informed that their parents, members of the swim club, lifeguards, teachers, and friends would never know the results of the pilot study.

Middle school students received a blue questionniare, high school students a yellow questionniare. They were asked to code their responses on the OPSCAN provided by the researcher. They were also told that their main job was to answer the

questions honestly, and to determine if there were any questions that were not easily understood. Should they find a question that they did not understand, or if they did not understand some of the directions, they were asked to write the question number on the directions sheet provided (see Appendix B) what they felt was wrong with the question, and suggestions for how it could be fixed. The students were also asked to write down the time they began answering the survey, and the time they finished. The questionniare, the OPSCAN, and the direction sheet were then returned to the researcher and placed in an envelope.

They took between 25-50 minutes to complete the survey. They seemed to be taking the survey seriously, which initially was a concern due to the location of the pilot study.

The middle school students who took the survey seemed more serious about it and more conscientious in writing down problems they had with the survey than did the high school students. However, the researcher noticed that there were sections of questions that were not answered by some middle school students. It is not known whether this was due to the sensitive nature of some of the questions (sex), and the fact that they were too embarrassed to answer the questions, or whether they did not understand the questions or whether the questions did not pertain to them.

The OPSCANS were read into a computer file by the Learning Resource Center. Frequency of responses were run. Neither correlations nor an item analysis could be performed on the data due to the sample size being smaller than the number

of questions on the questionniare. Therefore, item analysis could not be used to eliminate items in the questionnaire.

Items were eliminated from the questionniare by breaking the survey down to its skeleton. This meant reducing the questionnaire to items that were essential for what was being measured in the study. Because both the parenting styles and self-esteem sections of the survey were developed and previously tested by other researchers, they were left entirely intact. For the rest of the survey, if there were any items that were not directly related to parenting styles and health risk behaviors, they were eliminated. To avoid duplication of efforts, questions were eliminated because they were asked in other drug surveys admistered by the state of Virginia. Some questions were eliminated by the researcher because they were irrelevant to this study. Finally, some questions were eliminated because they were asking about the consequences of risky behaviors and not about the performance of the behaviors. Based on the students' comments about the survey, questions were reworded so that they could be more easily understood. The frequency of no responses to questions determined which questions would be eliminated. Items numbered 50, 51, 52, 53, and 54 were all eliminated because a significant number of students, 18, 26, 26, 18, and 19, respectively, did not respond to these items. One student failed to answer the sex, alcohol, and part of the parenting styles sections. The result was the questionnaire was reduced to 81 items.

Subjects

The target population identified by the researcher consisted of adolescents, who were in the stage of early adolescence, and resided in Harrisonburg, Virginia. The sample consisted of middle school students in grades six through eight in the Harrisonburg City Schools. There were 343 usuable questionnaires from the sample of 348 participants. Five questionnaires were not useable because major sections were left unanswered.

Approximately forty-six percent of the participants were male, 56 percent female; and 78 percent were white, 10 percent black, and 5.6 percent hispanic. The sample consisted of 33.3 percent sixth graders, 26.3 percent seventh graders, and 40.4 percent eighth graders. Sixty-seven percent of the sample reported living with both of their natural parents, while 24 percent reported living with their mothers; fifty-five percent reported that their mothers work full-time, 17 percent have mothers that work part-time, 18 percent have mothers who are homemakers or who do not work outside of the home, 4.2 percent have mothers who are unemployed, 2.4 percent have mothers who are full-time students, and 2.1 percent have mothers who are retired or disabled.

Since the parenting style scale used specified that parental involvement and behavioral control measures be used to determine parenting styles, there were 140 participants who were not classified into a particular parenting style because they did not meet at least one of the requirements specified by the scale for the classification of a particular type of parenting style. However, 202 participants had authoritative

parents and one had neglectful parents (see Table 1). Twenty participants did not answer all of the questions in this section of the questionnaire.

There were five participants who had low self-esteem, according to the Rosenberg Self-Esteem scale, 122 with average self-esteem, and 199 with high self-esteem. Seventeen participants did not answer all of the questions that were in the scale.

In terms of alcohol use, there were 290 participants who were abstainers or low risk takers, 38 who were experimenters, and 5 who were heavy users, and 10 missing observations. In addition, there were 328 participants who were low risk takers in terms of drug use, 4 who were experimenters, and four who were heavy users. In regards to sexual activity, 292 participants were low risk takers, 35 were experimenters, and seven were high sexual risk takers. Finally, there were 294 participants who were low risk takers in regards to eating behaviors, and 42 participants who were high risk takers.

Instrumentation

The 81 item questionnaire used in this study was a compilation of the Parenting Style scale developed by Lawrence Steinberg (1990), the Rosenberg Self-Esteem Scale (Rosenberg, 1965), health risk behaviors developed by the Centers for Disease Control (CDC), Kids Eating Disorder Survey (KEDS), an eating disorders survey, developed by Cheldress, Brewerton, Hodges, & Jarrell (1993), the results obtained in the pilot study (Appendix C),and suggestions made by three judges who reviewed the questionnaire.

Table 1. Involvement by Control

	(1) Low control	(2) Average control	(3) High control	Total
(1) Low involvement	1 neglectful	0	0 authoritarian	1
(2) Average involvement	0	31	27	58
(3) High involvement	0 permissive	62	202 authoritative	264
Total	1	93	229	323

The first ten items of the questionnaire covered demographics; items 11-36 consisted of the parenting style questions; items 37-46 consisted of the Rosenberg Self-Esteem scale; and items 47-81 consisted of the health risk behaviors, including the KEDS questions, items 73-81. The parenting style questions and the self-esteem questions asked the respondents to base their responses on one of four selections: agree a lot, agree, disagree, and disagree a lot. Items 47-81 were arranged according to behavior, including, in respective order, items on alcohol abuse, drug abuse, sexual activity, tobacco use, and eating behaviors.

The 26-item Parenting Style questionnaire was selected as it best represented the questions wanted for the survey. It defined the types of parenting styles according to three key characteristics: parental involvement, psychological autonomy granting, and behavioral control. Items 11, 13, 15, 17, 19, 21, 23, 25, and 27 describe parental involvement; items 12, 14, 16, 18, 20, 22, 24, 26, and 28 describe psychological autonomy granting by the parents; and items 29 through 36 describe behavioral control. The calculated reliability for the parenting styles scale was .73.

The Rosenberg Self-Esteem Scale was selected because it was brief, only 10 questions, it was easy to incorporate into the questionnaire, it had been used by other researchers to measure adolescent self-acceptance, and it had a reported reliability of .92 (Robinson & Shaver, 1974). In this study the reliability was .80.

The health risk behavior questions (items 47-72) were derived from the 1993 Youth Risk Behavior Survey conducted by Virginia Commonwealth University for the Virginia Department of Education. The questions in the Virginia survey came from

the Centers for Disease Control Youth Risk Survey. The items used in our study focused on alcohol and drug use, sexual activity, and tobacco use. The questions pertaining to eating disorders were derived from the KEDS (Childress, Brewerton, Hodges, & Jarrell, 1993), which was developed specifically for middle school students.

Data Collection

Permission was obtained from the principal of Harrisonburg Middle School to use the school in this study. A letter was sent home to the parents by the Principal of the middle school explaining the nature of the study and giving parents the option to opt their child out of participating in the study. Any student whose parent(s) refused permission, or who personally refused to participate in this study, was omitted from the survey. No one refused to participate. Data were collected in December, 1993. Questionnaires (see Appendix D) were distributed by three monitors from VPI and JMU, who were not employed by Harrisonburg City Schools, to students in grades 6 through 8 during their health classes.

The health classes were selected by the school principal as the most convenient. The monitors in each of the classrooms explained the directions and instructed the students regarding the proper completion of the survey. Any questions that the students had at that time, as well as during the administration of survey, were answered by the monitors. Students had approximately 40-45 minutes to answer the questionnaire. Only four students, each of whom were non-English speaking, were excluded from the survey. Respondents were asked to code their answers onto OPSCANS. They were also asked not to fill in their names or any other identifying

marks or numbers on either their questionnaires or OPSCANS. No talking was permitted between the students during the course of the survey. At the end of the class period, the OPSCANS and the questionnaires were collected by the researchers. The OPSCANS were taken to the Test Scoring Center at Virginia Tech to be read by their computers. Once the responses were read into a computer file, the questionnaires were discarded.

Data Analysis

Data were analyzed by analysis of variance. Negatively worded items in each of the scales were reversed before analysis. The level of significance used in this study was .05.

Recoding

Parenting Styles. The items describing parental involvement, numbers 11, 13, 15, 17, 19, 21, 23, 25, and 27, were recoded so that students who coded in one's were indicating that their parents were not very involved in their lives; and students who coded in four's were indicating that their parents were very involved in their lives. Therefore, items were recoded such that responses of 1's would become 4's, 2's would equal 3's, and so on. Items 22, 29, and 30 were also recoded in the same manner. However, items 29 and 30 were recoded again so that there would be the same number of responses for the behavioral control subscale, making all of the behavioral control questions having only 3 options for the computer to analyze instead of 7 and 3.

The responses for the parental involvement questions were totaled, and a variable named INVOLV was created in order to store that total; PSYAUTO was created in order to store the total scores for psychological autonomy granting questions; and CONTROL was created in order to store the total scores for the behavioral control questions. INVOLV and PSYAUTO were recoded in order to organize the total scores of each parenting style characteristic into ranges, and then each range was labeled as either "1," "2," or "3." These variables were divided into ranges of 1-12, 13-24, and 25-36. If INVOLV or PSYAUTO were in the range of 1 thru 12, then INVOLV or PSYAUTO were recoded to equal 1; if INVOLV or CONTROL was in the range of 13 thru 24, then 2; if INVOLV or CONTROL was in the range of 25 thru 36, then 3. The CONTROL variable was divided into the following ranges: 8-13, 14-18, and 19-24. If CONTROL was in the range of 8 thru 13, then CONTROL was recoded to equal 1; if CONTROL was in the range of 14 thru 18, then CONTROL equaled 2; if CONTROL was in the range of 19 thru 24, then CONTROL equaled 3.

Parenting styles were classifed according to the acceptance/involvement dimension and the behavioral control dimension. Another name for parental behavioral control is monitoring. Authoritative parents were labeled as 3's on both the aceptance/involvement (INVOLV) and the behavioral control (CONTROL) dimensions; authoritarian parents were labeled as a 3 on behavioral control and a 1 on acceptance/involvement; permissive parents were labeled as a 1 on behavioral control

and a 3 on acceptance/involvement; and neglectful parents were labeled as a 1 on both the behavioral control and the acceptance/involvement dimensions.

Rosenberg Self-Esteem Scale. Each item in the scale had four choices: agree a lot, agree, disagree, and disagree a lot. According to the scale, two answers for each item described high self-esteem, and the other two indicated low. Items 38, 39, 41, 43, and 44 were recoded such that choices "1 and 2," indicated low self-esteem, and choices "3 and 4," indicated high self-esteem. The numbers coded in by the student for all ten items, questions 38-47, were totaled and categorized into one of three dimensions. These dimensions were low self-esteem, average self-esteem, and high self-esteem. Adolescents who were characterized as having low self-esteem had scores in the range of 10-20; adolescents with average self-esteem had scores between 21 and 29; and adolescents with high self-esteem had scores between 30 and 40.

Health Risk Behaviors. The responses to all of the behavioral questions, exluding the KEDS questions, were divided into one of three categories: low risk-taking, experimenting, and high risk-taking. Responses were recoded to either a 1, 2, or 3 where 1 = low risk-taking and 2 = experimenting, and 3 = high risk-taking. Experimentation was included in the recoding procedure because there was a lot of grey area between low risk taking and high risk taking. As stated in chapter 2, experimentation is a developmentally appropriate behavior for adolescents, and there was a difference between experimentation with risky behaviors (where some risk is involved) and problem behaviors (where a lot of risk can occur to both the adolescent's mental and physical health). Item number 49, "If you drink alcohol,

where do you most often do it?," was not recoded into one of the risky behavior categories because it was not a measure of actual behavior. Instead it indicated where the behavior occurred. Some items, particularly #s 58, 59, 60, 61, 63, 66, and 70, were recoded into either high or low risk categories. There was no room for experimentation because participating in one of these behaviors was clearly high risk. The numbers coded in for each response were totaled for each health risk behavior: alcohol use, drug use, sexual activity, tobacco use, and eating behaviors.

The KEDS scale, items 73 through 81, had only two options for the majority of the questions since questions 73-79 were asked in a yes/no format. The participants' responses were recoded to either 1's, indicating low risk behaviors, or 2's, indicating high risk behaviors.

Chapter IV

RESULTS AND DISCUSSION

The findings of the study will be presented and discussed in this chapter. In the first section, the demographics of the participants will be presented in addition to the classifications of parenting styles, the levels of self-esteem, and the degrees of risky behaviors for alcohol, drugs, sexual activity, and eating. The second section will discuss the results of the study.

Results

Parenting Style Scale

When parenting styles were classified as authoritarian, authoritative, permissive, and neglectful, many of the participants were not included in the classification procedure because they did not fit into the mold of the parenting style. Specifically, 202 participants had parents who were classified as authoritative and one as neglectful.

There were 31 participants who indicated that their parents exhibited average control and were fairly involved in their lives. Sixty-two participants had parents who were between permissive and authoritative parents. This means that the participants indicated that their parents were highly involved in their lives and were fairly controlling. Also, twenty-seven participants indicated that their parents were between authoritarian and authoritative parents. This means that their parents were highly controlling in addition to being fairly involved in their lives.

Rosenberg Self-Esteem Scale

An analysis of variance was run to determine whether there were any differences between self-esteem and adolescent health risk behaviors. ANOVA was used only on those participants who indicated having authoritative parents. No differences were found between adolescent self-esteem and health risk behaviors (See Tables 2 through 5). Parenting styles were cross-tabulated with adolescent self-esteem. There was one participant with authoritative parents who had low self-esteem, 49 who had average self-esteem, and 146 who had high self-esteem. The one participant who had neglectful parents had average self-esteem. Also, when self-esteem was cross-tabulated with alcohol use, drug use, sexual activity, and eating behaviors, three participants were classified as having low self-esteem. However, there was no relationship between the level of self-esteem and risky behaviors.

Alcohol Use

There were no differences in the type of parenting styles and alcohol use. Approximately 90.1 percent of the 152 males and 84.9 percent of the 179 females were abstainers or low risk-takers, and 9.2 percent of the males and 13.4 percent of the females were experimenters. Of the 112 sixth graders, 92 percent were abstainers or low alcohol users, 7.1 percent were experimenters, and 2.7 percent were heavy users. Of the 86 seventh graders, 88.4 percent were abstainers, 7.0 percent were experimenters, and 4.6 percent were heavy users. Of the 134 eighth graders, 82.1 percent were abstainers, 17.9 were experimenters. Finally, 184 of the participants who had authoritative parents were abstainers and 16 were experimenters. The participant

Table 2. Analysis of Variance on Alcohol Usage by Self-Esteem Using Children who had Authoritative Parents

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	2.858	2	1.429	.539	.584
ESTEEM	2.858	2	1.429	.539	.584
Explained	2.858	2	1.429	.539	.584
Residual	498.179	188	2.650		
Total	501.037	190	2.637		

202 cases were processed.

Table 3. Analysis of Variance on Drug Usage

by Self-Esteem Using Children

who had Authoritative Parents

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	.282	2	.141	.080	.923
ESTEEM	.282	2	.141	.080	.923
Explained	.282	2	.141	.080	.923
Residual	330.870	188	1.760		
Total	331.152	190	1.743		

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202 cases were processed.

Table 4. Analysis of Variance on Sexual Practices by Self-Esteem Using Children who had Authoritative Parents

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	1.633	2	.816	.167	.846
ESTEEM	1.633	2	.816	.167	.846
Explained	1.633	2	.816	.167	.846
Residual	917.739	188	4.882		
Total	919.372	190	4.839		

202 cases were processed.

Table 5. Analysis of Variance on Eating Disorders by Self-Esteem Using Children who had Authoritative Parents

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	2.297	2	1.148	.869	.421
ESTEEM	2.297	2	1.148	.869	.421
Explained	2.297	2	1.148	.869	.421
Residual	248.478	188	1.322		
Total	250.775	190	1.320		

202 cases were processed.

who had neglectful parents was an abstainer.

Drug Use

One-hundred fifty-four of the male participants and 173 of the female participants were drug abstainers or low risk-takers, two males and two females were experimenters, and three females were classified as heavy drug users. The heavy drug users were in sixth and seventh grade, where there were one and three, respectively.

Sexual Activity

For sexual risk-taking, 92.9 percent of the 156 males and 83.0 percent of the 176 females were low risk-takers, 5.1 percent of the males and 15.3 percent of the females were experimenters or moderate risk-takers, and 1.9 percent of the males and 2.1 percent of the females were high sexual risk-takers. Approximately 4.5 percent of the 112 sixth graders, 13.5 percent of the 89 seventh graders, and 13.6 percent of the 132 eighth graders were moderate sexual risk takers; 4.5 percent of the seventh graders and 2.3 percent of the eighth graders were high sexual risk takers. In regards to parenting styles and sexual risk-taking, there were 13 participants who had authoritative parents who were considered moderate sexual risk-takers, and one who was considered high. The individual who had neglectful parents was a moderate sexual risk-taker.

Eating Behaviors

There were 20 males and 22 females who were at risk for developing an eating disorder. When calculated by grade level, there were 11 sixth graders who had high risk eating behaviors, 10 seventh graders, and 20 eighth graders. In terms of

parenting styles, sixteen participants who had authoritative parents had risky eating behaviors, while the participant who had neglectful parents was at low risk.

Discussion

Parenting Styles

Over one-third of the participants in this study did not fit into one of the four categories of parenting styles. This suggests that there may not be just four types of parenting styles. Instead, there may be as many as nine. Perhaps the four parenting styles used in this study can be considered the extremes, or the black and white areas of parenting styles, and the other five could be considered to be more abstract, or the grey area of parenting styles. Considering that a significant number of surveys, 120, did not fall into one of the four classifications of parenting styles, leads one to believe that a change in the definintion or the classification of parenting styles is warranted.

The parenting styles seen in this survey (see Table 1) were clustered towards authoritative parenting, or in the lower right-hand corner of the diagram. This suggests several things: parenting styles really cannot be classified; most parents in this study lean towards authoritativeness; the parenting styles questionnaire was poor; the sample could have been too small to see other parenting styles; another sample would have a wider variety of parenting styles; this is the normal response for a school-based sample; or the sample was too young, and a different and wider variety of responses would be elicited from a high school sample.

According to research, authoritative parents will have children who are more psychologically healthy. This study did not refute this concept. The majority of the

participants had authoritative parents, or parents who were clustered around that style of parenting. The sample was too uniform in its responses to determine if parenting styles had any effect on adolescent self-esteem. The literature supports the fact that the adolescent's environment and his relationship with his family and friends contribute to self-esteem (see chapter 2). It was suggested in this study that adolescents from authoritative households would have average or high self-esteem. This was not refuted in the study. However, nothing else could be said about parenting styles and its effects on adolescent self-esteem because there were no participants who were classified as having permissive or authoritarian parents, and there was only one participant who was classified as having neglectful parents.

The question regarding whether parenting styles are related to adolescent risk taking could not be adequately answered. The literature supported the fact that adolescents from authoritative households would be either experimenters or low health risk takers. The majority of participants who were classified as having authoritative parents were low risk takers. In addition, the one participant who had neglectful parents was a low risk taker. There was not enough information to support the other postulations about parenting styles and adolescent risk-taking because authoritarian, permissive, and neglectful parents were not represented in the study. If this study was administered to a larger, different, or older sample, then the results may have been different. Also, a clearer classification of parenting styles may appear if the survey was administered to a clinical population of troubled adolescents because many of these adolescents engage in at least one high risk behavior and are likely to be at the

extremes of their peer group in terms of risky behaviors. If troubled adolescents are classified as being high risk takers, then their parents' styles of parenting may be more true to the definitions of authoritative, authoritarian, permissive, or neglecful .

Rosenberg Self-Esteem Scale

Self-esteem did not seem to be a factor in this study. The majority of adolescents had high or average self-esteem. However, had there been more adolescents who reported having low self-esteem, then more could be said about self-esteem and how it relates to parenting styles. There also needs to be a wider range of parenting styles and more risk-taking behaviors in addition to more participants reporting low self-esteem for any generalizations or relationships to be reported. One of the research questions asked whether there was a relationship between adolescent self-esteem and health risk behaviors. The ANOVA test indicated that there was no such relationship. It was indicated in Figure 3 that adolescents who had high self-esteem would be low risk takers or experimenters. Were these participants an indication that self-esteem is not a factor in risk-taking behaviors, or did this happen by chance? Further study with the same age group and high school students is needed to anwer this question.

Health Risk Behaviors

The two research questions which ask whether a relationship exists between parenting styles, self-esteem, and health risk behaviors cannot really be answered. The reason for this is because the majority of the participants did not practice the risky behaviors specified in the questionnaire. Did they not practice these behaviors because

of the parenting styles, making one of the research questions true; or were they too young of a sample? Research states that the average age for adolescents to have their first drink is 12.6 years (see chapter 2). This could mean that they have their first drink of alcohol in seventh or eighth grade, and then increase the level of drinking and other risky behaviors as they get older. In the study, alcohol risk-taking increased with grade level: 8.0 percent of sixth graders were considered experimenters or heavy alcohol users, 11.6 percent of seventh graders, and 17.8 percent of eighth graders. However, with drugs and sexual activity, the seventh graders had a higher pecentage of partcipants practicing risky behaviors.

Chapter V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study was designed to examine relationships between types of parenting styles, self-esteem, and adolescent risk-taking behaviors, specifically alcohol and drug use, sexual activity, and eating disorders. Parenting styles, self-esteem,and risk-taking behaviors were assessed through a questionnaire consisting of three main components: a parenting style scale, the Rosenberg Self-Esteem scale, and questions developed by the CDC regarding alcohol, drug use, and sexual activity. An eating disorders scale, designed specifically for middle school aged participants, was used. The questionnaire was distributed to a sample of middle school students in Harrisonburg, Virginia. The responses were recoded, totaled, and classified into categories according to the scales' recommendations. Frequencies were calculated for each item and cross-tabulations were run to obtain a better idea of what the data were indicating. The statistical analysis run was ANOVA to deterimine if there were any differences between adolescent self-esteem and health risk behaviors for participants who had authoritative parents.

Conclusions

In regards to the research questions pondered in this study, the following conclusions were drawn.

1. Parenting styles does not influence and adolescent health risk behaviors and adolescent self-esteem.
2. No relationship existed between adolescent self-esteem and health risk behaviors.

Recommendations

Based on the results of this study the following are recommended. First, if this questionaire is administered to a middle school sample again, either the sixth grades should not be included in the study or the questionnaire should be revised to their reading level. More sixth graders had problems understanding the questions in this section of the questionnaire than the seventh and eighth graders, who had no problems with the questionnaire's readability. Second, the method used to classify the parenting styles resulted in a great deal of information being lost when responses did not quite fit into one of the four classifications. Therefore, there were five potential parenting styles that were not included in this study that should be included in future studies. These nine parenting styles need to be identified, defined, and tested on a large sample, and then possibly have a simular survey administered to a sample of high school and middle school students to determine if parenting styles affect adolescent risk-taking.

The entire survey needs to be administered to an older sample, consisting of high school students. The middle school students are still too young to be engaging in health risk behaviors, although some are doing so with a vengeance. A middle school sample is good for determining possible precursers to risky behaviors such as family factors, self-esteem, and other factors. However, a high school sample is good for examining the actual risky behaviors, and then determining if family factors, peer factors, or self-esteem is involved.

This study would also greatly benefit from having a clinical sample of troubled adolescents examined since many times they engage in more than one high risk behavior. Here, the four categories of parenting styles may be more pronounced than in a school sample. A clinical sample would also help determine the factors that contributed to the adolescent having the problems that he or she does.

There are many factors that are involved in adolescent risk-taking behaviors. The specific roles parenting styles and self-esteem play in high risk-taking are not clear. Therefore, further study is needed on larger, older, and clinical samples.

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Appendix A

Informed Consent for Pilot Study

July 12, 1993

Dear Parents,

Mollie Howerton from the Department of Health and Physical Education at Virginia Tech is conducting a pilot study for her Master's thesis at Shawnee Swim Club. She is looking for volunteers who are in grades 6-12 to answer a questionnaire concerning parenting styles, and health risk behaviors. The behaviors measured are alcohol and drug use, sexual activity, and nutrition.

The purpose of this pilot study is to determine the readability of the survey, reduce the number of questions, and establish some reliability and validity coefficients for the survey. All responses will remain confidential. I am not interested in determining individual behavior, but instead, the readability of the survey. I need to find out if the questionnaire works.

Participation in the survey is strictly voluntary. Parental consent is required due to the ages of the participants and the nature of the questions. Volunteers are greatly appreciated.

Thank you,

Mollie Howerton

Appendix B

Pilot Study Directions Sheet

Participation in this survey is voluntary. The survey asks you questions about parenting styles and your health behaviors. Please answer the questions honestly. NOBODY WILL KNOW WHAT YOU SAID. There will be no way that anything that you said can be traced back to you. Your parents, your teachers, the lifeguards, or your friends will not know what was said. Also, whatever you say on the survey will remain confidential.

Your health behaviors is not as important to me as the readability of the questionniare. If there is a question that is hard to understand, please write the question number down, and reword the question so that it is easier for you to understand.

Please mark your responses to the questionnaire on the OPSCAN provided. Make sure you are filling in the correct number on the OPSCAN. If you have any questions please ask Mollie. Thank you for your help.

Please write down the time you started taking the survey and the time you finished

Time started:
Time finished:

Are there any questions that you do not understand, or that you think can be reworded?
If so, please write down the question number and how you would reword the question so that it is more understandable.

Appendix C

Pilot Study Questionnaire

Information about Yourself

1. How old are you?
    1. under 10
    2. 10-12
    3. 13-15
    4. 16-18
    5. over 18

2. What is your sex?
    1. Female
    2. Male

3. What is your current grade in school?
    1. 6th grade
    2. 7th grade
    3. 8th grade
    4. 9th grade
    5. 10th grade
    6. 11th grade
    7. 12th grade

4. To what racial or ethnic group do you belong?
    1. White - not Hispanic
    2. Black - not Hispanic
    3. Hispanic
    4. Asian or Pacific Islander
    5. Native American or Alaskan Native
    6. Other

5. Whom do you live with **most** of the time?
    1. Natural parents - Mom and Dad
    2. Stepparent
    3. With mother only
    4. With father only
    5. Group home or foster home

6. Are your parents divorced or separated?
    1. Yes
    2. No

7. How many times have they been divorced/separated?
    1. 0 times
    2. 1-2 times
    3. 3-4 times
    4. 5 or more times

Answer these questions about **the adults you live with**.

8. Does your mother (or other adult female you live with) work?
    1. I don't live with my mother or an adult female
    2. Employed full time (32 hours or more per week)
    3. Employed part time (less than 32 hours per week)
    4. Homemaker/not working outside the home
    5. Unemployed, but looking for work
    6. Full-time student
    7. Retired/disabled

9. Does your father (or other adult male you live with) work?
    1. I don't live with my mother or an adult female
    2. Employed full time (32 hours or more per week)
    3. Employed part time (less than 32 hours per week)
    4. Homemaker/not working outside the home
    5. Unemployed, but looking for work
    6. Full-time student
    7. Retired/disabled

10. How much education did your father/stepfather complete? Give your best guess if not sure.
    1. Elementary or junior high school
    2. High school
    3. Some college or technical school
    4. Graduated from a 4-year college
    5. Some school beyond a 4-year college
    6. Professional or graduate degree (Ph.D., M.D., M.A., law degree, etc.)
    7. Don't know

11. How much education did your mother/stepmother complete? Give your best answer if not sure.
    1. Elementary or junior high school
    2. High school
    3. Some college or technical school
    4. Graduated from a 4-year college
    5. Some school beyond a 4-year college
    6. Professional or graduate degree (Ph.D., M.D., M.A., law degree, etc.)
    7. Don't know

Please answer the next set of questions about the parents (or guardians) you live with. If you spend time in more than one home, answer the questions about the parents (or guardians) who have the most say over your daily life.

Read each item carefully. Then write the number that shows how much you agree with each statement.

1 - if you AGREE STRONGLY with the item
2 - if you AGREE SOMEWHAT with the item
3 - if you DISAGREE SOMEWHAT with the item
4 - if you DISAGREE STRONGLY with the item

____12. I can count on my parents to help me out, if I have some kind of problem.
____13. My parents sy that you shouldn't argue with adults.
____14. My parents keep pushing me to do my best in whatever I do.
____15. My parents say that you should give in on arguments rather than make people angry.
____16. My parents keep pushing me to think independently.
____17. When I get a poor grade in school, my parents make my life miserable.
____18. My parents help me with my school work if there is something I do not understand.
____19. My parents tell me that their ideas are correct and that I should not question them.
____20. When my parents want me to do something they explain why.
____21. Whenever I argue with my parents, they say things like, "You'll know better when you grow up."
____22. When I get a poor grade in school, my parents encourage me to try harder.
____23. My parents let me make my own plans for things I want to do.
____24. My parents know who my friends are.
____25. My parents act cold and unfriendly if I do something they don't like.
____26. My parents spend time just talking to me.
____27. When I get a poor grade in school, my parents make me feel guilty.
____28. My family does fun things together.
____29. My parents won't let me do things with them when I do something they don't like.

30. In a typical week, what is the latest you can stay out on SCHOOL NIGHTS (Monday through Thursday)?

1 - I am not allowed out
2 - Before 8:00
3 - 8:00 - 8:59
4 - 9:00 - 9:59
5 - 10:00 - 10:59
6 - 11:00 or later
7 - As late as I want

31. In a typical week, what is the latest you can stay out on a FRIDAY or SATURDAY NIGHT?
    1 - I am not allowed out
    2- Before 8:00
    3 - 8:00 - 8:59
    4 - 9:00 - 9:59
    5 - 10:00 - 10:59
    6 - 11:00 or later
    7 - As late as I want

How much do your parents TRY to know....

	Don't try	Try a little	Try a lot
32. Where you go at night?	1	2	3
33. What you do with your free time?	1	2	3
34. Where you are most afternoons after school?	1	2	3

How much do your parents REALLY know.....

	Don't know	Know a little	Know a lot
35. Where you go at night?	1	2	3
36. What you do with your free time?	1	2	3
37. Where you are most afternoons after school?	1	2	3

Read each item carefully. Then write the number that shows how much you agree with each statement.

1 - if you AGREE STRONGLY with the item
2 - if you AGREE SOMEWHAT with the item
3 - if you DISAGREE SOMEWHAT with the item
4 - if you DISAGREE STRONGLY with the item

38. I feel that I'm a person of worth, at least on an equal basis with others.
39. I feel that I have a number of good qualities.
40. All in all, I am inclined to feel that I am a failure.
41. I am able to do things as well as most other people.
42. I feel I do not have much to be proud of.
43. I take a positive attitude toward myself.

44. On the whole, I am satisfied with myself.
45. I wish I could have more respect for myself.
46. I certainly feel useless at times.
47. At times I think I am no good at all.

In the next questions, a "drink" is a glass of wine or beer, a bottle or can of beer, a shot of liquor or a mixed drink. A "drink" does not include wine at a church service.

48. How often do you drink?
    1 - never
    2 - once or twice a week
    3 - once or twice a month
    4 - every weekend
    5 - several times a week
    6 - every day

49. When did you have your last drink?
    1 - never drank
    2 - not for over a year
    3 - between 6 months and 1 year ago
    4 - several weeks ago
    5 - last week
    6 - yesterday
    7 - today

50. How much do you usually drink, when you do drink?
    1 - 1 drink
    2 - 2 drinks
    3 - 3-6 drinks
    4 - 6 or more drinks
    5 - until "high" or drunk

51. Whom do you drink with? (CIRCLE ALL THAT ARE TRUE FOR YOU)
    1. parents or relatives
    2. with brothers or sisters
    3. with friends own age
    4. with older friends
    5. alone

52. What effects have you had from alcohol? (CIRCLE ALL THAT APPLY FOR YOU)
    1 - loose, easy feelings
    2 - moderately "high"
    3 - drunk
    4 - became ill
    5 - passed out
    6 - was drinking heavily and the next day didn't remember what happened

53. What effects has drinking had on your life? (CIRCLE ALL THAT APPLY FOR YOU)
    1 - no problem at all
    2 - I can control myself, but my friends easily influence me
    3 - I often feel bad about my drinking
    4 - I often fee bad about my drinking
    5 - I need help to control myself
    6 - I have had professional help to control my drinking

54. How do others see you? (CIRCLE ALL THAT APPLY TO YOU)
    1. can't say or as a normal drinker
    2. when I drink, I tend to neglect my family or friends
    3. my family or friends advise me to control or cut down on my drinking
    4. my family or friends tell me to get help for my drinking
    5. my family or friends have already gone for help for my drinking

55. During the past **month**, have you had 5 or more alcoholic drinks at one time?
    1. Never
    2. Yes, once
    3. Yes, twice
    4. Yes, 3-5 times
    5. Yes, 6-9 times
    6. Yes, 10 or more times

56. If you drink, where do you **usually** get the alcohol that you drink?
    1. I don't drink
    2. I take it from my parents or from my friend's parents **without them knowing**
    3. I get it from my friends my own age
    4. I buy it myself at a store, tavern, or bar
    5. I ask someone of legal age to buy it for me
    6. Older friends give it to me
    7. My parents give it to me
    8. A sibling (sister or brother) gives it to me
    9. Other

57. If you drink alcohol, where do you most often do it?
    0 - I don't drink
    1 - At my home **without** parents' permission
    2 - At my home **with** parents' permission
    3 - At a friend's home **without** their parents' permission
    4 - At a friend's home **with** their parents' permission
    5 - At a party
    6 - In a car, truck, or van
    7 - Outside in a park or hangout
    8 - At a school event
    9 - In a bar, tavern, or restaurant

58. During the **past month** have you ridden in a motorized vehicle (i.e., car, truck, motorcycle, snowmobile, boat) with a driver who was drinking alcohol?
    1 - No
    2 - Yes, once
    3 - Yes, twice
    4 - 3-5 times
    5 - 6 times or more

59. During the **past 30 days**, , on how many times did **you** drinve a car or other vehicle when you had been drinking alcohol?
    1 - 0 times
    2 - 1 times
    3 - 2 or 3 times
    4 - 4 or 5 times
    5 - 6 or more times

60. How old were you when you had your first drink of alcohol other than a few sips?
    1 - I have never had a drink of alcohol other than a few sips
    2 - Less than 9 years old
    3 - 9 or 10 years old
    4 - 11 or 12 years old
    5 - 13 or 14 years old
    6 - 15 or 16 years old
    7 - 17 or more years old

61. During the past 30 days, on how many days did you have at least one drink of alcohol?
    1 - 0 days
    2 - 1 or 2 days
    3 - 3 to 5 days
    4 - 6 to 9 days
    5 - 10 to 19 days
    6 - 20 to 20 days
    7 - all 30 days

62. During the past 30 days, on how many days did you have at least one drink of alcohol **on school property**?
    1 - 0 days
    2 - 1 or 2 days
    3 - 3 to 5 days
    4 - 6 to 9 days
    5 - 10 to 19 days
    6 - 20 to 20 days
    7 - all 30 days

63. How old were you when you tried marijuana (also called "grass" or "pot") for the first time?
    1 - I have never tried marijuana
    2 - Less than 9 years old
    3 - 9 or 10 years old
    4 - 11 or 12 years old
    5 - 13 or 14 years old
    6 - 15 or 16 years old
    7 - 17 or more years old

64. During your life, how many times have you used marijuana?
    1. 0 times
    2. 1 or 2 times
    3. 3 to 9 times
    4. 10 to 19 times
    5. 20 to 39 times
    6. 40 to 99 times
    7. 100 or more times

65. During the past 30 days, how many times did you use marijuana?
    1 - 0 times
    2 - 1 or 2 times
    3 - 3 to 9 times
    4 - 10 to 19 times
    5 - 20 to 39 times
    6 - 40 or more times

66. During the past 30 days, how many times did you use marijuana **on school property**?
    1. 0 times
    2. 1 or 2 times
    3. 3 to 9 times
    4. 10 to 19 times
    5. 20 to 39 times
    6. 40 or more times

67. During your life, how many times have you used the **crack or freebase** forms of cocaine?
    1. 0 times
    2. 1 or 2 times
    3. 3 to 9 times
    4. 10 to 19 times
    5. 20 to 39 times
    6. 40 or more times

68. During your life, how many times have you used any other type of illegal drug, such as LSD, PCP, ecstasy, mushrooms, speed, ice, heroin, or pills without a doctor's prescription?
    1. 0 times
    2. 1 or 2 times
    3. 3 to 9 times
    4. 10 to 19 times
    5. 20 to 39 times
    6. 40 or more times

69. During your life, how many times have you taken **steroid** pills or shots **without** a doctor's prescription?
    1. 0 times
    2. 1 or 2 times
    3. 3 to 9 times
    4. 10 to 19 times
    5. 20 to 39 times
    6. 40 or more times

70. During your life, have you ever injected (shot up) any illegal drug?
    1. Yes
    2. No

In the next questions "sexual intercourse" refers to "going all the way."

71. Have you ever had sexual intercourse?
    1. Yes
    2. No

72. How old were you when you had sexual intercourse for the first time?
    1. I have never had sexual intercourse
    2. Less than 12 years old
    3. 12 years old
    4. 13 years old
    5. 14 years old
    6. 15 years old
    7. 16 years old
    8. 17 or more years old

73. During your life, with how many people have you had sexual intercourse?
    1. I have never had sexual intercourse
    2. 1 person
    3. 2 people
    4. 3 people
    5. 4 people
    6. 5 people
    7. 6 or more people

74. During the **past 3 months**, with how many people did you have sexual intercourse.
    1. I have never had sexual intercourse
    2. I have had sexual intercourse, but not during the past 3 months
    3. 1 person
    4. 2 people
    5. 3 people
    6. 4 people
    7. 5 people
    8. 6 or more people

75. Did you drink alcohol or use drugs before you had sexual intercourse the **last time**?
    1. I have never had sexual intercourse.
    2. Yes
    3. No

76. The **last time** you had sexual intercourse, did you or your partner use a condom?
    1. I have never had sexual intercourse
    2. Yes
    3. No

77. How many times have you been pregnant or gotten someone pregnant?
    1. 0 times
    2. 1 time
    3. 2 or more times
    4. Not sure

78. If you have had sexual intercourse, how often do you and/or your partner use some form of birth control?
    1. I have never had sexual intercourse
    2. Never
    3. Rarely
    4. Sometimes
    5. About half the time
    6. Most of the time
    7. Always

79. If you have had sexual intercourse, what kind of birth control do you **usually** use?
    1. Not sexually active, abstinent
    2. Never use birth control
    3. Condoms
    4. Foam
    5. The Pill
    6. Withdrawal
    7. Other

80. Do you have a steady boyfriend or girlfriend?
    1. No
    2. Yes, we've been going together for a month or less
    3. Yes, we've been going together for about 2-6 months
    4. Yes, we've been going together for 7-12 months
    5. Yes, we've been going together for 1 year or more

81. Have you ever been physically abused by an adult (e.g. beat up, hit with an object, kicked, or some other form of physical force)?
    1. No
    2. I am currently being physically abused
    3. I was physically abused, but the abuse has stopped

82. Have you ever shared a surgical needle with anyone (e.g, for using drugs, taking steroids, or diabetic medication)?
    1. No, never
    2. Yes, once
    3. Yes, twice
    4. Yes, three or four times
    5. Yes, five or more times

83. During the **past year**, have you seriously thought about running away from home?
    1. No
    2. Yes, once or twice
    3. Yes, occasionally
    4. Yes, very often

84. How many times have you used smoking tobacco (cigarettes, cigar, pipe)?
    1. 0 times
    2. 1-2 times
    3. 3 times per month
    4. 3-6 days per week
    5. Every day

85. How often do you use chewing tobacco or snuff?
    1. I never use smokeless tobacco
    2. 1-4 times in my life
    3. once per month
    4. 3 times per month
    5. 3-6 times per week
    6. Every day

86. How far would you like to go in school?
    1. Quit school as soon as possible
    2. Finish high school
    3. Get some college, vocational or military training after high school
    4. Get a two-year community college degree
    5. Finish college with a four-year college degree
    6. Finish college and take further training (medical, law school, etc)

87. How far do you expect to go in school?
    1. Quit school as soon as possible
    2. Finish high school
    3. Get some college, vocational or military training after high school
    4. Get a two-year community college degree
    5. Finish college with a four-year college degree
    6. Finish college and take further training (medical, law school, etc)

88. How much is your mother (stepmother or female guardian) involved in your high school education?
    1. Not in family
    2. Extremely involved
    3. Very involved
    4. Moderately involved
    5. Slightly involved
    6. Not at all

89. Do you want to lose weight now?
    1. yes
    2. no

90. Have you *ever* thought that you looked fat to other people?
    1. yes
    2. no

91. Have you *ever* been afraid to eat because you thought you would gain weight?
    1. yes
    2. no

92. Have you *ever* tried to lose wight by *dieting* (Dieting means eating at least some food, but less than you usually eat.)
    1. yes
    2. no

93. Have you *ever* tried to lose weight by *fasting*? (Fasting means eating no solid food for at least 24 hours).
    1. yes
    2. no

94. Have you *ever* made yourself throw up (*vomit*) to lose weight?
    1. yes
    2. no

95. Have you *ever exercised a lot to lose weight*? (A lot means more than one hour a day everyday.)
    1. yes
    2. no

96. Have you *ever* taken *diuretics or water pills* to lose weight?
    1. yes
    2. no

97. Have you *ever* taken *laxatives* to lose weight?
    1. yes
    2. no

98. Circle the number below that is *similar* to the *largest* amount of food you have *ever* eaten in *less than two hours* (even if you did not eat exactly the same foods).
    1. Less food than in answer 2.
    2. Two doughnut and a cup of ice cream and two cookies.
    3. Four doughnuts and a pint of ice cream or five cookies.
    4. Six doughnuts and a quart of ice cream and ten cookies.
    5. Eight doughnuts and a half gallon of ice cream and fifteen cookies.
    6. More food than in answer 5.

99. How many times have you *ever* eaten *the amount of food you circled above*?
    1. 1 or 2 times only
    2. 3 to 12 times
    3. 13 to 24 times
    4. 25 to 50 times
    5. more than 50 times

Appendix D

Questionnaire

DIRECTIONS

Your participation in this survey is voluntary. This survey asks you questions about parenting styles and your health behaviors. Please answer all of the questions to the best of your ability. ALL ANSWERS WILL BE CONFIDENTIAL. NO ONE WILL KNOW HOW YOU HAVE RESPONDED TO ANY QUESTION.

Please mark your responses to the questionnaire on the OPSCAN that we have provided. Be sure that you fill in the correct question number on the OPSCAN. Be sure to use the #2 pencil that we have provided. Again, answer all questions to the best of your ability. Do not skip any questions. **Thank you for your help.**

1. What is your sex?
    1. Female
    2. Male

2. What is your current grade in school?
    1. 6th grade
    2. 7th grade
    3. 8th grade
    4. 9th grade
    5. 10th grade
    6. 11th grade
    7. 12th grade

3. To what racial or ethnic group do you belong?
    1. White - not Hispanic
    2. Black - not Hispanic
    3. Hispanic
    4. Asian or Pacific Islander
    5. Native American or Alaskan Native
    6. Other

4. Whom do you live with **most** of the time?
    1. Natural parents - Mom and Dad
    2. Stepparent
    3. With mother only
    4. With father only
    5. Group home or foster home

5. Have your parents ever been divorced or separated?
    1. Yes
    2. No

6. How many times have your parents been divorced/separated?
    1. My parents have never been divorced or separated
    2. 1-2 times
    3. 3 or more times

7. Does your mother (or other adult female you live with) work?
    1. I don't live with my mother or an adult female
    2. Employed full time (32 hours or more per week)
    3. Employed part time (less than 32 hours per week)
    4. Homemaker/not working outside the home
    5. Unemployed, but looking for work
    6. Full-time student
    7. Retired/disabled

8. Does your father (or other adult male you live with) work?
    1. I don't live with my father or an adult male
    2. Employed full time (32 hours or more per week)
    3. Employed part time (less than 32 hours per week)
    4. Homemaker/not working outside the home
    5. Unemployed, but looking for work
    6. Full-time student
    7. Retired/disabled

9. How much education did your father/stepfather complete? Give your best guess if not sure.
    1. Elementary or junior high school
    2. High school
    3. Some college or technical school
    4. Graduated from a 4-year college
    5. Some school beyond a 4-year college
    6. Professional or graduate degree (Ph.D., M.D., M.A., law degree, etc.)
    7. Don't know

10. How much education did your mother/stepmother complete? Give your best answer if not sure.
    1. Elementary or junior high school
    2. High school
    3. Some college or technical school
    4. Graduated from a 4-year college
    5. Some school beyond a 4-year college
    6. Professional or graduate degree (Ph.D., M.D., M.A., law degree, etc.)
    7. Don't know

Please answer the next set of questions about the parents (or adults) you live with. If you spend time in more than one home, answer the questions about the parents (or adults) who have the most say over your daily life.

Read each item carefully. Then write the number that shows how much you agree with each statement.

1 - if you AGREE A LOT with the item
2 - if you AGREE with the item
3 - if you DISAGREE with the item
4 - if you DISAGREE A LOT with the item

____11. I can count on my parents to help me out, if I have some kind of problem.
____12. My parents say that you shouldn't argue with adults.
____13. My parents keep pushing me to do my best in whatever I do.
____14. My parents say that you should give in on arguments rather than make people angry.

____15. My parents keep pushing me to think independently.
____16. When I get a poor grade in school, my parents make my life miserable.
____17. My parents help me with my school work if there is something I do not understand.
____18. My parents tell me that their ideas are correct and that I should not question them.
____19. When my parents want me to do something they explain why.
____20. Whenever I argue with my parents, they say things like, "You'll know better when you grow up."
____21. When I get a poor grade in school, my parents encourage me to try harder.
____22. My parents let me make my own plans for things I want to do.
____23. My parents know who my friends are.
____24. My parents act cold and unfriendly if I do something they don't like.
____25. My parents spend time just talking to me.
____26. When I get a poor grade in school, my parents make me feel guilty.
____27. My family does fun things together.
____28. My parents won't let me do things with them when I do something they don't like.

29. In a typical week, what is the latest you can stay out on SCHOOL NIGHTS (Monday through Thursday)?
    1 - I am not allowed out
    2 - Before 8:00
    3 - 8:00 - 8:59
    4 - 9:00 - 9:59
    5 - 10:00 - 10:59
    6 - 11:00 or later
    7 - As late as I want

30. In a typical week, what is the latest you can stay out on a FRIDAY or SATURDAY NIGHT?
    1 - I am not allowed out
    2- Before 8:00
    3 - 8:00 - 8:59
    4 - 9:00 - 9:59
    5 - 10:00 - 10:59
    6 - 11:00 or later
    7 - As late as I want

How much do your parents TRY to know....

	Don't try	Try a little	Try a lot
31. Where you go at night?	1	2	3
32. What you do with your free time?	1	2	3
33. Where you are most afternoons after school?	1	2	3

How much do your parents REALLY know.....

	Don't know	Know a little	Know a lot
34. Where you go at night?	1	2	3
35. What you do with your free time?	1	2	3
36. Where you are most afternoons after school?	1	2	3

Read each item carefully. Then write the number that shows how much you agree with each statement.

1 - if you A LOT with the item
2 - if you AGREE with the item
3 - if you DISAGREE with the item
4 - if you DISAGREE A LOT with the item

____37. I feel that I'm a person of worth, at least on an equal basis with others.
____38. I feel that I have a number of good qualities.
____39. All in all, I am inclined to feel that I am a failure.
____40. I am able to do things as well as most other people.
____41. I feel I do not have much to be proud of.
____42. I take a positive attitude toward myself.
____43. On the whole, I am satisfied with myself.
____44. I wish I could have more respect for myself.
____45. I certainly feel useless at times.
____46. At times I think I am no good at all.

In the next questions, a "drink" is a glass of wine or beer, a bottle or can of beer, a shot of liquor or a mixed drink. A "drink" does not include wine at a church service or a "sip".

47. How often do you drink?
    1 - never
    2 - once or twice a year
    3 - once or twice a month
    4 - every weekend
    5 - several times a week
    6 - every day

48. During the **past month**, have you had 5 or more alcoholic drinks at one time?
    1 - Never
    2 - Yes, once
    3 - Yes, twice
    4 - Yes, 3-5 times
    5 - Yes, 6-9 times
    6 - Yes, 10 or more times

49. If you drink alcohol, where do you most often do it?
    0 - I don't drink
    1 - At my home **without** parents' permission
    2 - At my home **with** parents' permission
    3 - At a friend's home **without** their parents' permission
    4 - At a friend's home **with** their parents' permission
    5 - At a party
    6 - In a car, truck, or van
    7 - Outside in a park or hangout
    8 - At a school event
    9 - In a bar, tavern, or restaurant

50. During the **past 30 days** have you ridden in a motorized vehicle (i.e., car, truck, motorcycle, snowmobile, boat) with a driver who was drinking alcohol?
    1 - No
    2 - Yes, once
    3 - Yes, twice
    4 - 3-5 times
    5 - 6 times or more

51. During the **past 30 days**, on how many times did **you** drive a car or other vehicle when you had been drinking alcohol?
    1 - I don't have a driver's license
    2 - 0 times
    3 - 1 times
    4 - 2 or 3 times
    5 - 4 or 5 times
    6 - 6 or more times

52. How old were you when you had your first drink of alcohol other than a few sips?
    1 - I have never had a drink of alcohol other than a few sips
    2 - Less than 9 years old
    3 - 9 or 10 years old
    4 - 11 or 12 years old
    5 - 13 or 14 years old
    6 - 15 or 16 years old
    7 - 17 or more years old

53. During the past 30 days, on how many days did you have at least one drink of alcohol **on school property**?
    1 - 0 days
    2 - 1 or 2 days
    3 - 3 to 5 days
    4 - 6 to 9 days
    5 - 10 to 19 days
    6 - 20 to 20 days
    7 - all 30 days

54. How old were you when you tried marijuana (also called "grass" or "pot") for the first time?
    1 - I have never tried marijuana
    2 - Less than 9 years old
    3 - 9 or 10 years old
    4 - 11 or 12 years old
    5 - 13 or 14 years old
    6 - 15 or 16 years old
    7 - 17 or more years old

55. During your life, how many times have you used marijuana?
    1 - 0 times
    2 - 1 or 2 times
    3 - 3 to 9 times
    4 - 10 to 19 times
    5 - 20 to 39 times
    6 - 40 to 99 times
    7 - 100 or more times

56. During the past 30 days, how many times did you use marijuana?
    1 - 0 times
    2 - 1 or 2 times
    3 - 3 to 9 times
    4 - 10 to 19 times
    5 - 20 to 39 times
    6 - 40 to 99 times
    7. 100 or more times

57. During the past 30 days, how many times did you use marijuana on school property?
    1. 0 times
    2. 1 or 2 times
    3. 3 to 9 times
    4. 10 to 19 times
    5. 20 to 39 times
    6. 40 or more times

58. During your life, how many times have you used any form of cocaine (powdered, crack, freebase)?
    1. 0 times
    2. 1 or 2 times
    3. 3 to 9 times
    4. 10 to 19 times
    5. 20 to 39 times
    6. 40 or more times

59. During your life, how many times have you used any other type of illegal drug, such as LSD, PCP, ecstasy, mushrooms, speed, ice, heroin, or pills without a doctor's prescription?
    1. 0 times
    2. 1 or 2 times
    3. 3 to 9 times
    4. 10 to 19 times
    5. 20 to 39 times
    6. 40 or more times

60. During your life, how many times have you taken **steroid** pills or shots **without** a doctor's prescription?
    1. 0 times
    2. 1 or 2 times
    3. 3 to 9 times
    4. 10 to 19 times
    5. 20 to 39 times
    6. 40 or more times

61. During your life, have you ever injected (shot up) any illegal drug?
    1. Yes
    2. No

In the next questions "sexual intercourse" refers to "going all the way" or "doing it."

62. How old were you when you had sexual intercourse for the first time?
    1. I have never had sexual intercourse
    2. Less than 12 years old
    3. 12 years old
    4. 13 years old
    5. 14 years old
    6. 15 years old
    7. 16 years old
    8. 17 or more years old

63. During your life, with how many people have you had sexual intercourse?
    1. I have never had sexual intercourse
    2. 1 person
    3. 2 people
    4. 3 people
    5. 4 people
    6. 5 people
    7. 6 or more people

64. During the **past 3 months**, with how many people did you have sexual intercourse.
    1. I have never had sexual intercourse
    2. I have had sexual intercourse, but not during the past 3 months
    3. 1 person
    4. 2 people
    5. 3 people
    6. 4 people
    7. 5 people
    8. 6 or more people

65. Did you drink alcohol or use drugs before you had sexual intercourse the **last time**?
    1. I have never had sexual intercourse.
    2. Yes
    3. No

66. The **last time** you had sexual intercourse, did you or your partner use a condom?
    1. I have never had sexual intercourse
    2. Yes
    3. No

67. How many times have you been pregnant or gotten someone pregnant?
    1. 0 times
    2. 1 time
    3. 2 or more times
    4. Not sure

68. If you have had sexual intercourse, how often do you and/or your partner use some form of birth control?
    1. I have never had sexual intercourse
    2. Never
    3. Rarely
    4. Sometimes
    5. About half the time
    6. Most of the time
    7. Always

69. If you have had sexual intercourse, what kind of birth control do you **usually** use?
    1. Not sexually active, abstinent
    2. Never use birth control
    3. Condoms
    4. Foam
    5. The Pill
    6. Withdrawal
    7. Other

70. Have you ever shared a surgical needle with anyone (e.g., for using drugs, taking steroids, or diabetic medication)?
    1. No, never
    2. Yes, once
    3. Yes, twice
    4. Yes, three or four times
    5. Yes, five or more times

71. During your life, how often, or how many times have you used smoking tobacco (cigarettes, cigar, pipe)?
    1. I have never used smoking tobacco
    2. 1-4 times in my life
    3. once per month
    4. 3 times per month
    5. 3-6 days per week
    6. Every day

72. During your life, how many times have you used smokeless tobacco or snuff?
    1. I have never used smokeless tobacco
    2. 1-4 times in my life
    3. once per month
    4. 3 times per month
    5. 3-6 days per week
    6. Every day

	Yes	No
73. Do you want to lose weight now?	1	2
74. Have you *ever* tried to lose weight by *dieting* (Dieting meanseating at least some food, but less than you usually eat.)	1	2
75. Have you *ever* tried to lose weight by *fasting*? (Fasting means eating no solid food for at least 24 hours).	1	2
76. Have you *ever* made yourself throw up (*vomit*) to lose weight?	1	2
77. Have you *ever exercised a lot to lose weight*? A lot means more than one hour a day everyday.)	1	2
78. Have you *ever* taken *diuretics or water pills* to lose weight?	1	2
79. Have you *ever* taken *laxatives* to lose weight?	1	2

80. Circle the number below that is *similar* to the *largest* amount of food you have *ever* eaten in *less than two hours* (even if you did not eat exactly the same foods).
    1. Less food than in choice 2.
    2. Two doughnut and a cup of ice cream and two cookies.
    3. Four doughnuts and a pint of ice cream or five cookies.
    4. Six doughnuts and a quart of ice cream and ten cookies.
    5. Eight doughnuts and a half gallon of ice cream and fifteen cookies.
    6. More food than in choice 5.

81. How many times have you *ever* eaten *the amount of food you circled above*?
    1. 1 or 2 times only
    2. 3 to 12 times
    3. 13 to 24 times
    4. 25 to 50 times
    5. more than 50 times

VITA

Name:	Mollie Winfree Howerton
Date of Birth:	January 26, 1970
Address:	2213 Surrey Place Lynchburg, Virginia 24503
Education:	Virginia Polytechnic Institute and State University Blacksburg, Virginia B.S. in Community Health Education Virginia Polytechnic Institute and State University Blacksburg, Virginia M.S. in Community Health Education
Honors and Awards:	1991, 1992 1st place U.S. Department of Energy and Argonne National Laboratory sponsored American Tour de Sol Video Contest videographer, writer, and editor
Employment:	Virginia Polytechnic Institute and State University Blacksburg, Virginia Graduate Assistant
Services:	Virginia's 1993 Youth Risk Behavior Survey Survey Administrator 1986-1993 American Red Cross Swim Instructor 1992-1994 American Red Cross Community First Aid and Safety Instructor 1991-1994 American Red Cross Lifeguard
Presentations:	Virginia Association for Health, Physical Education, Recreation, and Dance "Cognitive Dissonance: Implications for Health Education and Mass Media Advertising" Roanoke, Virginia December 4, 1992

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