Protecting Adolescents from Risk

Transcript of a Capitol Hill Briefing on New Findings from the National Longitudinal Survey of Adolescent Health (Add Health)

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the Institute for Youth Development

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Table of Contents

Introduction 1
Shepherd Smith

New Research on Violence: What Predicts? What Protects? 5
Michael D. Resnick, Ph.D.

Reducing the Risk: Recent Lessons From Add Health on Adolescent Sexuality 15
Robert Wm. Blum, M.D., M.P.H., Ph.D.

The Influence of the Mother 25
Clea Sucoff, Dr.P.H.

The Effects of Family Structure and Family Processes on Adolescent Risk Behavior 29
Kathleen Mullan Harris, Ph.D.

Briefing Summary 43
Robert Wm. Blum, M.D., M.P.H., Ph.D.

Questions and Answers 47

New Research on Violence: What Predicts? What Protects?

Michael D. Resnick, Ph.D.

Good afternoon, everybody. I'm really glad to see you all here today, as we look into the National Longitudinal Study of Adolescent Health a little more deeply. This is the largest, most comprehensive study of adolescent health ever undertaken in the United States and I do want to give my particular appreciation and admiration to Christine Bachrach, the project officer from the National Institute of Child Health and Human Development (NICHD) who has done so much to make this possible.

Our focus on violence is two-fold. It's looking at both interpersonal violence, which, of course, has gotten a great deal of media attention of late, and also at self-directed violence, specifically suicide attempts. But the question we are framing here is one that really does represent this change in perspective that Shepherd Smith alluded to in his introductory comments: that is, not just focusing on risk or what we might call the "problemness" of kids, but also focusing on this wonderful notion of resiliency, the idea that there are in the lives of young people protective factors, circumstances, and events that can buffer them from harm.

So this issue of protective factors is really an attempt to delve more deeply into an understanding of what it is that young people need in order to keep them from going over the edge, to keep them from engaging in behaviors that are hazardous both to themselves and to others.

New Research on Violence:
What Predicts? What Protects?

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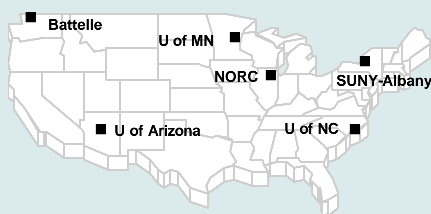
Key question:

What are the factors, the events, the life experiences that promote or diminish adolescents' involvement in self-directed or interpersonal violence?

National Longitudinal Study of Adolescent Health (Add Health)

- School based sample (N~90,000, grades 7-12)
- In-home interview (N~20,000, repeated one year later)
- Parent interview
- School administrator survey

The Add-Health Study



The National Longitudinal Study of Adolescent Health is a very complex, multi-layered study. So I'm going to do a great injustice to it by spending no more than two minutes talking about the sampling design and measurement issues. We started with a nationally representative sample of high schools and we identified the feeder schools, typically a junior high school that is linked to that high school. From that we were able to identify a nationally representative sample of 7th through 12th grade students, about 90,000 of which completed an in-school questionnaire. From this questionnaire we identified what will be called the in-home sample, meaning that using computer assisted technology about 20,000 of these young people participated in an in-depth interview which included the over-sampling of different populations of youth to make sure that they, too, were adequately represented in this design. In addition to conducting both the initial interview with the adolescent and another interview one year later, we also conducted interviews with parents (typically the mom though not always), and also gave a questionnaire to school administrators.

So what we're really looking at here is a multi-layered cake. We know something about the individual adolescent; we know something about the family; we know something about their school; and we also, in fact, know a lot about the community and neighborhood in which they live. It's that kind of richness and depth that allows us to look with much greater understanding than in the past as to what it is that determines the health and the well-being or the risky behaviors of young people.

The principal investigator, Dr. Richard Udry at the University of North Carolina Chapel Hill, was assisted by teams of co-investigators around the country: our interdisciplinary team at the University of Minnesota; colleagues at Batelle; at the University of Arizona; at the State University of New York Albany; and then finally the National Opinion Research Center (NORC) at the University of Chicago which did the field work, the data collection.

Let's turn attention now to the issue of suicide. What do we know about suicide rates generally among young people in the United States? In terms of trends,

Reducing the Risk: Recent Lessons From Add Health on Adolescent Sexuality

Robert Wm. Blum, M.D., M.P.H., Ph.D.

It, too, is a pleasure for me to have the opportunity to be back here and share with you some of the findings that have been coming from the Add Health Study over the past year or so.

When we look at some of the trends in adolescent pregnancy nationally we have, I think, a lot of good news. We've seen a significant reduction — a 15 percent reduction — in teen pregnancy between 1991 and 1997, another seven percent over the past year. The trends are coming down, for Hispanic kids, seven percent; for white kids, 16 percent; and for African American kids, 23 percent. And no matter what your political perspective is in this room, you can take credit for it. You can take credit because you can say it's an abstinence-only intervention, it's a family-strengthening intervention, it's a contraception-distribution intervention, you can name the intervention and can all take credit for it. But we, in our humility, shouldn't take too much credit for it because, in fact, any one of those factors has only marginally contributed. It is probably an entire set of converging factors that have made a difference.

And that's consistent with what Michael was just saying. Because I think we way too frequently and at way too great a peril tend to come up with reductionist interpretations of very important but very complex data. These are very important trends, but they cannot simply be reduced to fit into any of our pet interventions.

Reducing the Risk: Recent Lessons from Add Health on Adolescent Sexuality

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Prepared for:
A Congressional Briefing
U.S. Capitol
Washington, D.C.
June 3, 1999

Between 1991 and 1997 Teen Birth Rates Declined 15%

- Hispanic ↓7%
- White ↓16%
- African American ↓23%

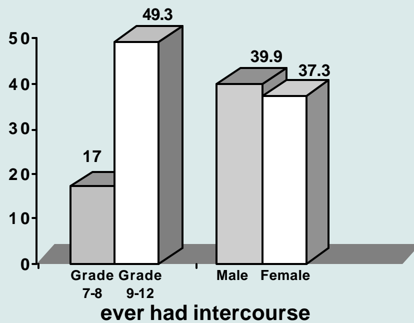
Birthrates by Race: 1997
15-19 Year Olds

	Per 1000
■ White	36.4
■ Native American	71.8
■ African American	89.5
■ Hispanic	99.1

When we look overall at birth rates, we still see stunningly high birth rates for 15 to 19 year olds: 36.4 percent for white kids; nearly 72 per thousand for Native Americans; 89.5 for African Americans; 99.1 per thousand for Hispanic kids. The Hispanic pregnancy rate has now surpassed every other ethnic group.

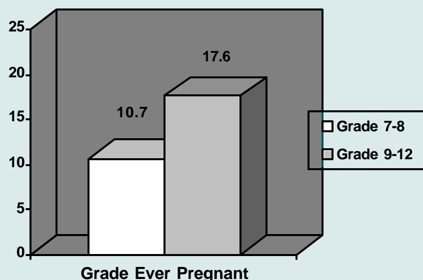
When we look at the Add Health data for sexual experience by grade, we see that for the younger grades, 7th and 8th grade, 17 percent of kids report ever having had intercourse, rising to one out of two in the 9^{h} through 12th grade. And as you can see (on your right), there's very little difference between adolescent males and females overall. This gender gap doesn't much exist; it does at the very young grades but it washes out later on.

Sexual Experience



When we look at Add Health data for pregnancy history, we see that one in nine 7^{h} and 8^{h} grade girls who have had intercourse have been pregnant. I don't know about you, but we were sufficiently stunned by that statistic that we reran the data thinking, "there must be a mistake here, this is way too high." It is way too high, but it's not a mistake. For 9^{h} through 12th graders – remember again, these are successful kids, these are the ones in school – one in six kids who have had intercourse report ever having been pregnant.

Pregnancy History



Well, all of this we talked about last year. We then wanted to try to tease out and understand a little bit better what is going on. You know, it's interesting that we often talk about research trying to influence policy, but I had the opportunity of a policy experience influencing research. About a year and a half ago I was sitting in the waiting room of the office for a meeting with Ron Haskins. There was this poster. You may recall it. . .it may still be there. It had a red light and a green light. Against the red light it said, "Stop juvenile violence." Against the green light it said, "Start two-parent families." It seemed reasonable, the methodology I wasn't sure about, but it triggered a whole set of questions that we've either asked or heard on the street. You know, "This isn't really an issue — teen pregnancy — for everyone, it's for poor kids." "It's really black kids." "It's really Hispanic kids." "It's a problem of single-parent families." So we said, "Okay, let's see if we can sort it out." Add Health is a data set that is large enough and has

The Influence of the Mother

Clea Sucoff, Dr.P.H.

Again, thank you for coming. It's much, much warmer here than in Minnesota, so we were very happy when we got off the plane last night.

I want to pick up where Bob Blum left off. We had this surprising finding that girls who were virgins were about 50 percent more likely to initiate sex during the subsequent year if their mothers said they talked to them frequently about sex.

What did this mean? This finding could have meant that when moms frequently talked to their daughters about sex, the girls somehow perceived that conversation as permission to have sex. We tested this hypothesis and we found that it wasn't the case.

What the data showed is that some mothers correctly figure out when their daughters are on the cusp of becoming sexually active. Bob presented a figure showing that when a mother thinks her daughter is sexually active, she is right 90 percent of the time. When she thinks her daughter is about to become sexually active, we suspect she's usually right about that too. We found evidence that when mothers suspect their daughters are about to become sexually active they increase the frequency of discussions about sex. A high proportion of the daughters still go on to become sexually active. That is the explanation for why mother-daughter discussions are associated with earlier age at first sex.

This finding could have meant:

Daughters perceive Mom is giving permission to have sex

The data show this finding really means:

Moms correctly figure their daughters are about to become sexually active, so they talk more frequently about sex in hopes of delaying the inevitable.

Most Moms strongly disapprove of their adolescent son or daughter having sex.

The degree of Mom's disapproval does not seem to delay first sex

When Moms have frequent discussions emphasizing negative:

1. **10th and 11th grade girls perceive greater disapproval**
2. **Younger boys and girls do not perceive greater disapproval**

Most mothers strongly disapprove of their adolescent son or daughter having sex. Yet the degree of maternal disapproval does not seem to delay first sex. On average, adolescents whose mothers strongly disapprove of them having sex initiate sex at the same ages as adolescents whose mothers say, "I disapprove but I don't strongly disapprove," or that tiny percentage of mothers who say," I don't really disapprove."

Fortunately Add Health gave us an opportunity to dig deeper. We were getting really depressed, thinking, "Do moms really *not* matter?" But Add Health interviewed both the mothers and the adolescents. So we have mom's report of disapproval and kid's report of how much they think their mom disapproves of them having sex. We found that moms and kids do not always report the same thing. Specifically, adolescents underestimate how much their mothers disapprove of them having sex: about 70 percent of mothers say, "I strongly disapprove of my son or daughter having sex," and about 55 percent of adolescents say, "My mother strongly disapproves of me having sex." That 15-percentage point gap is pretty constant among younger adolescents, among older adolescents, among boys, and among girls.

It is this discrepancy in perceptions that explains our finding that when mothers report, "I don't want my child to have sex," it doesn't seem to have an impact. As Bob reported, when kids perceive that their mother disapproves of them having sex, they act on that perception and delay first sex.

So we asked the question: "What can mothers do to effectively convey to their kids that they disapprove of their adolescents having sex?"

If I were the mother of an adolescent, I would think frequent communication about sex, particularly communication about the negative consequences of sex and the reasons not to have sex, might convey my disapproval. We found that for older girls — 10th and 11th grade girls — frequent communication seems to work. However, for younger girls — 8th and 9th grade girls — and for boys there was no association between frequency of conversation and what the kids perceived. So how can mothers get the message through?

The Effects of Family Structure and Family Processes on Adolescent Risk Behavior

Kathleen Mullan Harris, Ph.D.

Thank you, I'm very pleased to be here, and share my findings as the sole representative of the UNC team of researchers working on Add Health at the Carolina Population Center where the Add Health study is housed.

I'm going to present findings from research I've been conducting on the effects of family structure and family processes on adolescent health risk behavior in Add Health. I'm particularly interested in the role of parents, especially fathers, in promoting the healthy development of their children and protecting children from engaging in risk behavior.

To examine parenting effects, I focus on two dimensions of family processes: parent-child relations and parenting behaviors. But in order to understand how family relations and parents influence adolescent health risk behavior, we first must understand how family processes and parenting behaviors vary according to the family structure in which adolescents live. So any analysis of parenting effects must begin with family structure.

One of the unique design features of Add Health was a special genetic sample that Mike referenced in his talk. This design feature produced an over representation of a diverse set of family structures, including various forms of blended and stepfamilies and surrogate parent families that are typically too few in most data sets to study in any detail. So, Add Health provides one

of the richest data sets with which to study the growing diversity of family forms in which adolescents live.

Let me show you the distribution of family structure for adolescents in the United States in 1995. Here I'm showing you data from Wave One of the Add Health Study; the total sample size is 20,745 adolescents. These are the weighted percentages of adolescents in each of seven family structure categories. These represent the actual percentages in the U.S. population based on Add Health data. You can see that more than half of adolescents live with both biological parents. Although only a small percentage of adolescents live with two adoptive parents, because we over sampled adopted children in Add Health, this percentage is based on a fairly large number of adopted children, about 400.

We have two groups of stepfamilies and I define stepfamilies as families in which one parent is biological and the other is a step. When I refer to a parent as a "step", this is quite a broad category. It includes step, foster, adoptive, or the mother's or father's partner. So, in essence, a stepparent is any non-biological parent. Stepfamilies include biological mothers and step dads (the most common), about 14 percent of adolescents live in this type of stepfamily; and biological fathers and step moms, this is less common but, again, we have nice numbers to analyze, over 600 adolescents in our sample. About one-fifth of all adolescents live with a single mother; a small percentage live with a single father, but this number is over 600 adolescents in our sample. The last family structure category includes adolescents who do not live with a biological or an adoptive parent, but who live with a surrogate parent. A surrogate parent can include a relative. Lots of our kids live with grandparents, aunts, uncles, or other relatives. Surrogate parents can also include other adults, foster parents, and some of our kids live in group homes.

A well-known social science finding is that adolescent well-being varies according to the family structure in which children live. The dimensions of well being that I have examined are actually indicators of ill-being as I focus on four domains of health risk behavior in Add Health; they include delinquency, violence, sexual

Briefing Summary

Robert Wm. Blum, M.D., M.P.H., Ph.D.

I'd like to take just a moment to pull together some of the things we've been hearing that cross cut the presentations today. I think there are certain themes that have come up from what have been, in fact, fairly independent sets of analyses.

"Family characteristics matter."

One is that family characteristics matter. When we look at adolescent risk behaviors, whether it's violence, sexual debut, pregnancy risk and other risks as well, we see how family structure (single-parent, dual-parent, blended family, etc.) has some influence, but it is not terribly influential on adolescent risk behaviors. In fact, other characteristics are clearly much more important; connectedness with parents, highest among them, a sense of caring and concern.

"She or he is available when I need them."

We actually went out and asked groups of kids, "What is this sense of connectedness?" There was this clear understanding on their part of what it is. It isn't that, "My mother or father is always there, is always available, is sitting at home." But it's that "she or he is available when I need them." It's that "my mother remembers that I had a test last Thursday and asks, 'How did it go?'" "It's that my father remembers that I had a date, not only that I had a date, but it was with Johnny and not Sam or Harry or Larry, and asks how my date with Johnny was." "It's that my mother has a message on the refrigerator door, 'I'll be home at 6:00, but there's a snack in the refrigerator for you." "It's concrete things that say: 'You matter. I care, even when I'm not home.'" It's the neighbor who stops by who

Questions and Answers

The following section includes the question and answer session at the conclusion of the Add Health briefing. The names of both the person who asked the question and the presenters who responded are included.

Q: **Question — Peter Brandt, Focus on the Family:**

I want to congratulate you for having really uncapped this data since your first presentation here just about a year ago. I'd like to ask what insight you have come to as you've really looked at these numbers on the pledge of virginity issue? What dynamics have you come to understand on that issue?

A: **Answer — Robert Blum:**

Yes. As I have understood those findings on the pledge of virginity, I think it ties in fairly closely with some of the other findings of peer influence. That, in fact, perhaps that pledge serves as a values statement of a community within a community and it helps define a group, if it defines *us* and gives *us* identity then it's protective because it's a positive, a pro-social value. But if everyone does it, it no longer defines *us* and then as a group we seek other things for self or group definition. Perhaps that's where the power then begins to diminish.

Q: **Question — Shepherd Smith, IYD:**

To clarify, does the benefit of the pledge disappear or does the value of it not increase?

A: **Answer — Robert Blum:**

It disappears.

Answer — Christine Bachrach:

Let me just add that Peter Bearman's findings on this are extremely complex and it's hard to convey those very simply. One bottom line is that on average kids who take the pledge are very strongly protected against the initiation of first sexual intercourse, independent of other factors. The findings are extremely complex and they have a lot to do with the peer influence, but it does appear to be something that has pretty much held up.