

Early Transitions: Risk and Protective Factors

Robert Blum

This paper focuses on younger teenagers, those 12–14 years of age who are in the 7th and 8th grades. It is based on the National Longitudinal Study of Adolescent Health, which is the largest study of adolescent health and development ever undertaken in the United States. While it is a longitudinal study, the data presented here is based on information collected in 1995.

Study Design: The study initially identified 80 high schools across the United States. A high school was defined as having an 11th grade and at least 30 students. In fact, there were between 42 and 4,200 students in the schools that participated; and schools were not limited to public schools, but included alternative, parochial, and private schools as well.

After identifying the high schools that would participate, we identified the “feeder schools” (generally middle or junior high schools); however, not all high schools have feeder schools (e.g., some are combined junior high and high schools while others go from kindergarten through 12th grade). As a result, the final sample consisted of 134 schools.

Of those, 129 invited us in to survey the students; the first phase of data collection involved information obtained from over 90,000 students, grades 7–12. In each of the participating schools we combined the survey data with school rosters to identify our “core” in-home sample. Using school rosters became important since we know that young people at risk for

most any negative outcome are more likely to be out of school than their peers on any given day.

From the rosters and school survey, we invited approximately 15,000 students to participate in the in-home survey and more than 12,000 agreed.

The surveys lasted approximately 90 minutes and used an innovative technology called CASI (Computer Assisted Survey Instrument), which allows for confidentiality in responses to the most sensitive questions since young people can directly answer the questions into the computer without sharing their response with the interviewer. Likewise, the computerized format allows questions to “branch,” making it unnecessary to ask questions of respondents where prior “screening questions” suggested they were not involved with the topic under discussion.

In addition to interviewing young people themselves, over 85% of their parents agreed to participate in the survey; and thus we have parent data (one parent for each teenager) on more than 10,000 young people and are able to match parent and teen responses. Original data collection was obtained in 1995; and a year later we went back into the home and reinterviewed the teenagers. This coming fall (2001) a group of researchers will collect a third wave of data.

How common are risk behaviors and risk-related situations?

Approximately 3.5% of 7th and 8th graders tell us they have attempted suicide at least once and

a fair proportion on multiple occasions. About 1 in 11 junior high school students (or 9%) report having either witnessed violence or used a weapon to threaten or hurt someone in the previous year. In the study a weapon was defined primarily as a gun or a knife.

We also see that approximately 3% of 7th and 8th graders tell us that they smoke six or more cigarettes a day, more than 7% say that they drink alcohol more than two times monthly, and an equal percent use marijuana once a month or more. In fact, what we are seeing is that marijuana use is double that of cigarette smoking at the junior high school level. Remember, for cigarette smoking we are talking about six or more cigarettes a day, which clearly represents a smoking addiction.

When we look at sexual behaviors of teenagers in the 7th and 8th grade, one in six indicate that they have had intercourse. Beyond that, from other studies such as the National Survey of Adolescent Males, and a recent report in *Family Planning Perspectives*, non-intercourse related sexual behaviors among young adolescents occur among approximately 30% of the population. Of those who have had intercourse in junior high school, approximately 12% reported that they have caused a pregnancy or have been pregnant.

What factors are associated with increased risk?

There is a fairly common belief that many adolescent health risk behaviors are substantially influenced by being a teen of color, or from low-income families, or from single parent households. In truth, we do see some variation by these demographic factors. For example, teens from upper-income families are less likely than their lower-income peers to initiate inter-



course. Likewise, those from poorer households are more likely to be involved with violence. For smoking, there is an inverse relationship with income; however, for drinking there is a direct relationship. That is to say, as income rises so does alcohol use—especially for white teens. We see a modest difference in terms of suicide risk by income, with upper income youth having a somewhat lower risk, but the difference is more pronounced among white teenagers than among African-American or Latino youth.

While there are these demographic differences, these factors themselves are extremely poor predictors of risk behavior at the individual level. For example, among 7th and 8th graders, race/ethnicity, income, and family structure taken together explained no more than 4% of cigarette smoking, 1% of alcohol use, 2.5% in weapon-related violence. It explained approximately 9% of early onset of sexual intercourse; but it should be noted that such explanatory power diminished rapidly after the 9th grade.

Youth who have problems at school are at a much higher risk for every health risk in the study.



What Is Associated With Youth Risk?

If these factors are relatively weak predictors, what then are the family, school, and individual factors that predispose a young person to risk, and what may be protective, independent of whether one is black or white or Latino; poor or rich; or from a single or two-parent household?

Within families where there is a history of suicide attempts or completions, young people are at much higher risk than their peers. Youth with access to guns (e.g., rifles or handguns) in the home for whatever purpose are more likely

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to report having attempted suicide as well as more likely to be involved with interpersonal violence. Likewise, parental smoking and drug use are associated with higher involvement

of their young teenage children in many of the health risks we have been exploring.

The school environment is a critical influence in the lives of young people. Youth who have problems with school, who are doing poorly in school, who are failing school, and who are skipping school are at much higher risk for every health risk behavior we studied. It is clear that school failure is a major public health problem of young people in America today. Additionally, prejudice—experiencing prejudice in school for whatever reason, whether it is skin color, learning problems, disability, etc.—puts young people at risk for many negative health outcomes.

At the individual level, we find that those who did not think that they would live past the age of 21 were at much higher risk for a range of health-related problems than their peers. Those who were developmentally out of sync (early or delayed in their maturation) were at greater risk for many of the same problems.

What Protects Young People from Harm?

When we explored the factors that protect young people, family connectedness was a consistent element. This is not a function of whether a young person is growing up in a single or two-parent family, but rather it is a question of emotional connectedness to at least one parent or adult family member. Additionally, parent's expectations for school completion is extremely important since young people who believe their parents have high expectations of them to graduate high school not only are more likely to do so and to do better academically, but they are also less likely to be involved with a whole range of health risk behaviors than their peers.

We explored the role of parental monitoring, especially a parent being home at “key” times during the day. We found there is no one magical time, but rather the more a parent is

home for their teenager, the better off she or he seems to be. The one, perhaps most important time is dinner; and young people who have dinner with their parents appear also to have higher level of connectedness than do others where dinnertime is rarely a family event. Parental monitoring seems to have greatest impact on substance use behavior and much less impact on sexual behavior and violence.

Young people who feel connected to school also are less likely to be involved with a range of health risk behaviors. School connectedness does not seem to be a direct function of school performance, but reflects whether a young person feels connected with an adult in the school and whether or not they experience prejudice from peers or others in the school setting.

Conclusions

What we see for young teenagers, and it is true for older teenagers as well, is that many of the factors that predispose them to risk and those that protect them from harm cut across various risk behaviors. Many of the same teenagers at risk for pregnancy are at risk for school failure, violence involvement, and other negative health problems.

For those who plan programs for teenagers, the evidence is as clear as it is for parents. First, without a sense of connectedness between the young person and the individuals delivering the program, there is very little reason to believe that the program will have a significant impact. Human connection is central, and fostering those human bonds is highly protective. Conversely, addressing attitudes, beliefs, and building skills alone will not address the main antecedents that put teens at risk for negative health outcomes. Simply advocating abstinence, or violence-free schools, or saying no to drugs will not address the antecedents that put young people at risk.

[T]he most promising approaches to the reduction of problem behaviors are to strengthen families, provide educational enrichment for young people who are failing school, and provide economic opportunities that create options for young people.

Second, there are no discrete risk factors for discrete problems. Many of the issues are generic and many of the solutions cross-cut a range of negative health outcomes.

Third, the most promising approaches to the reduction of problem behaviors are to strengthen families, provide educational enrichment for young people who are failing school, and provide economic opportunities that create options for young people.

Fourth, programs need to remember that to be successful they have to involve young people as part of the solution in thinking through the interventions and not just the focus of the intervention and the problem. And finally, the data tells us programs focusing on problems or risk reduction are less successful than those integrating our understanding of protective factors in the lives of young adolescents.

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To be effective, there must be a connection between young people and the individuals delivering programs.

