

| Zisn behanas |

I could not get this to send, so here you go. file: risk behaviors



Ian Quinn

03/31/2000 03:46:17 PM



Record Type: Record

To: Ann O'Leary/OPD/EOP

cc:

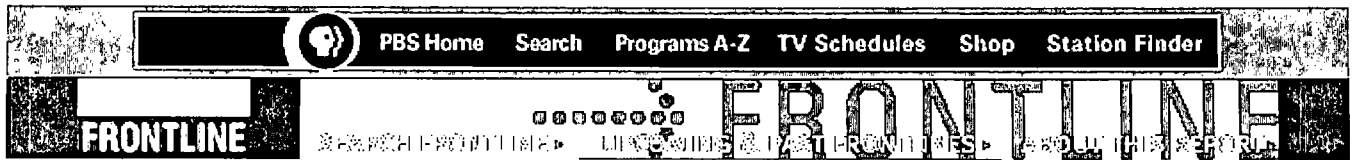
Subject: Frontline's Show on GA teen STD outbreak

In looking for parenting tips for teens on the web, one of my searches turned up this site from Frontline on the Georgia STD outbreak that was mentioned on your draft themes document that you passed out at the meeting earlier this week. In case you are interested, the url is

<http://www.pbs.org/wgbh/pages/frontline/shows/georgia/>

I would be more than happy to look at it in more depth as well...

Ian



THE LOST CHILDREN OF ROCKDALE COUNTY

Lost Children or Lost Parents of Rockdale County?

by Robert Wm. Blum, M.D., Ph.D. and colleagues

Blum is Professor and Director of the Division of General Pediatrics & Adolescent Health, University of Minnesota, Minneapolis

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For many reasons, "The Lost Children of Rockdale County" is a very disturbing portrayal of youth in a middle to upper middle class community. While on the surface this is a program about sex and sexual promiscuity, what is far more disturbing than that is the tremendous disconnect that exists between the children of Rockdale County and their families. Over and over again, throughout the program, we see parents who are either clueless or blatantly unconcerned about their children. We see parents who have replaced caring and personal involvement with the purchase of material goods and we see parents who are afraid to discipline their children--

"I thought that if I disciplined you, you would run away."

Or, who are afraid to hug their children--"We don't do that in our family." And who are afraid to set boundaries--"I felt that he should sow his wild oats when he was young so he wouldn't do it when he was older".

"What is so disturbing about the program is not that we are witnessing a rare event in the United States, but rather an event that is quite common."

We see young people who even three years after the event don't fully understand the magnitude of the behaviors in which they were participants. And, we see a community that has changed little or not at all as a consequence of the events in 1996. Fundamentally, Rockdale County is a setting where there are no resources for young people; there are no options except the strip mall, the movies and the bowling lane, and there is nothing for them to do. It is a community that is built for adults.

What is so disturbing about the program is not that we are witnessing a rare event in the United States, but rather an event that is quite common. First of all, the use of sex to attract friendships and maintain social connections (or to disrupt others' social connections) is age old and the fact that this is a white upper income community does not make it particularly surprising despite the editorial comments of the commentator. Rather, there may be a perception (there appears to be this bias in the program) that these events are rare in suburban America. The events are not rare; it may be that as adults we tend to be less willing to acknowledge them in this kind of community than in lower

income communities.

Another issue that was touched on in the program was access to pornography, with young people as young as 12 and 13 imitating what they saw on the Playboy Channel. In truth, we know that juveniles have easy access to pornography through the Internet, cable television and the corner magazine rack. The solution is not more laws or greater restrictions, for rarely have such interventions worked. Rather, we need to have adults continuously, visibly and actively present in the lives of young people. We need to have parents who are authoritative in their parenting, not authoritarian or laissez-faire as we saw in the program. Authoritative parents set clear boundaries, discuss and negotiate the rules but then follow through with pre-established consequences. Authoritative parents are both firm and fair. Rarely did we see such parents in the program. Rather, we saw parents who were unable to connect with their children and even when they did, they thought that caring was all that was needed. It isn't. Rather, adolescents need guidance as well as encouragement and they need to know that their parents, their relatives and the adult network in the neighborhood are all watching them, are all concerned, and see their upbringing as a priority. While the program is entitled "The Lost Children of Rockdale County" the reality is that these are the lost parents of Rockdale County and even after the syphilis epidemic and even after the town hall meeting, it is clear that the adults in the community are as clueless as they ever were.

In community after community across America we look at adolescent problem behaviors and we define them to be the result of problem adolescents. While we are happy and comfortable to scapegoat young people, we often don't look to the environment that we as adults have created that allow a situation to develop. Such is clearly the case here. For young people to flourish they need four things and until every town and village and major urban area in America are prepared to provide them, Rockdale County will not be a distant place, but in fact our backyard. The things critical for successful development include:

1. Safe places for young people to congregate with adult supervision;
2. Opportunities for young people to actively contribute to their family, their neighborhood and their community;
3. Opportunities for active recreation and for young people to have fun and enjoy themselves;
4. An adult in the life of every young person who is "crazy about them".

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THE LOST CHILDREN OF ROCKDALE COUNTY

Teenagers in Trouble: Understanding & Preventing Tragic Outcomes
by Richard Gallagher, Ph.D.

Richard Gallagher, Ph.D., is Director of the Parenting Institute
NYU Child Study Center, New York University Medical School

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Events that have been reported in the world of children and adolescents in the last years can make one feel numb and discouraged. We hear of students killing or attempting to kill one another, there are reports of frequent suicidal responses and suicide pacts among teens, and rampant sexual activity is found in younger and younger children. It appears that the world of children and adolescents is out of control. In fact, studies find that the incidence of unhealthy actions has increased dramatically in the last 30 years. We know: over half of adolescents have tried alcohol and drugs at least once, that 1 in 6 students feel threatened by physical harm from peers, that suicide is the 3rd leading cause of death in adolescence--following close behind homicide--and that over 75% of 19 year-old adolescents have had sexual intercourse at least once. Such worrisome numbers have led the Centers for Disease Control and the Department of Health and Human Services to label child and adolescent violence, substance abuse, suicide, and early sexual activity as public health disorders that require special study and intervention.

Research on adolescent behavior has provided great insight into the factors that contribute to poor adolescent conduct. We know that the relationships between parents and children and the childrearing practices of parents play a significant role in results. Children that do the best have parents that use both a great deal of warmth with their children and also

exercise a high level of control over their children's actions. High levels of both warmth and control characterize the form of parenting referred to as authoritative. In adolescence, parents who use this successful style encourage their children to participate in discussions about decisions over curfew and teenage freedoms, but the final decision rests with the parents. Additionally, parents enforce rules when violations occur.

A contrasting style, called the authoritarian style, is present when parents are high on control, but low on warmth. Children from these homes learn to follow rules when under supervision, but often engage in reckless actions when they know they are not being observed. Some parents use a high level of warmth, but exercise very little control in a

"At the end of discussions about adolescents who have made the wrong turns, we're often presented with people who imply there's nothing that can be done to stop such episodes. In fact, there are actions that can play an important role in decreasing high-risk adolescent conduct."

style that reflects democratic values. Adolescents from these homes often perceive themselves as equals who do not need to listen to adults. This is the pattern represented in many families with troubled kids. Although relationships between parents and children may be pleasant, the children are often out of control with few reasonable constraints on their actions. Finally, if parents show both little warmth and little control--called a laissez-faire approach--children are usually forgotten and behave accordingly. These children often search for connections in a forlorn or sometimes angry way that is reflected in many self-destructive or destructive actions.

These patterns of childrearing and their associated outcomes are important when considering the several paths of the adolescent examples in Rockdale County. First, many of the children reported a pattern of lax parental supervision that had been present from their early lives. Despite the fact that the children were often supported and often in close contact with their parents, they reported that their wishes were persistently fulfilled with no clear indication of the consequences that they had to face when they broke rules.

A second path seemed to emerge once children hit their teen years. This group of children had parents who were authoritative until the children reached their teen years. Similar to reactions of parents in several studies on the life course of delinquent adolescents conducted by the Oregon Social Research Center, parents' actions changed near puberty. Many parents of children with late conduct problems stop supervising their children upon their entrance to middle school or junior high school. Perhaps parents find that their children can care for their basic needs and note that their children can talk in mature ways which leads them to conclude that their children can supervise themselves. This conclusion fails to recognize that adolescents do not have adult judgment. Compared with adults, adolescents have a much shorter view into the future and they rarely anticipate all the possible consequences.

The third path described was laissez-faire; several students described disregard and disconnection in which parents and kids rarely crossed paths.

All of the paths described made the adolescents vulnerable to other important effects. Once out of adult supervision or influence, they used substances, primarily alcohol, which only makes poorly controlled behaviors even more likely. Second, they often acted in groups. All people are more susceptible to take more risks in the presence of a group and adolescents are especially vulnerable to group pressures. There does not need to be overt statements of pressure, simply observing others succumb to temptation is enough to set new standards for action. Then, status was achieved through some of the acts which only reinforced kids for participating. Thus, it is easy to propose that factors from the adolescents' backgrounds and factors unique to their party experiences made important contributions to unhealthy conduct.

Questions arise about the possibility of such negative situations occurring in other communities. It is not clear if episodes are increasing in frequency in the last decade, but it can be stated that nearly every community has the potential for such problems to occur. Why? There are several situations that create the potential.

First, adolescents are involved in unsupervised activities and less contact with adults with greater and greater frequency. Children and adolescents are spending increasingly less time with adults. In our society, we have shifted from a situation in which the majority of teens had a parent at home during the day to one in which the majority has parents in the work force. Over 75% of families have parents working out of the home. This is important because most episodes of high-risk behaviors in adolescence including sexual activity, substance use, and criminal actions occur between the hours of 3 p.m. and 7 p.m. on weekdays. During these hours, many adolescents have left the supervision of the school setting to situations where they do not report to anyone as their parents finish their workday.

Next, children and adolescents are exposed to significantly more information that either endorses or creates interest in high-risk behaviors. There are an increasing number of media outlets in the form of television programs, radio programs, newspapers, magazines, and internet sources that expose youth to glorified depictions of high-risk behaviors. Some of those resources strongly endorse high-risk sex practices, substance use, and violence.

Third, for sexually activity, the potential for high-risk actions is heightened because the biological press to become involved in sexual activity occurs at an earlier age. In each of the last several decades, the age at which children reach puberty has been decreasing. This has occurred at the same time that children's needs for education has increased. Thus, adolescents face a longer period of time in which they are biologically pressed to engage in sexual activity while they are equally pressed to delay getting involved in creating families.

Finally, most communities do not offer enough constructive recreational activities for teens. There are many teens that are on the outskirts of social groups that are connected to the schools or others organizations. These have the same amount of energy and social interest as others, but they do not have readily available settings in which to exercise those qualities. They are likely to congregate with one another and find things to do. Given the internal sexual pressures present in adolescence and an increased interest in trying new experiences that is also present during adolescence, varied sexual experiences are likely to be tried. Without adult supervision, teens are likely to believe that these actions are appropriate and desired. They may not view them as dangerous or harmful to their bodies or social interactions. Important information supports this impression.

The age of initiating sexual intercourse has been decreasing rapidly in the last two decades to the point that surveys of adolescents find that the average age for initiating sexual intercourse is 14 years old. Even for those teens that describe themselves as virgins because they have not engaged in sexual intercourse, nearly 30% report that they have engaged in other forms of genital sexual contact to the point of orgasm. Many of the teens report that sexual activity is "just another thing to do." They report similar perceptions about alcohol and drug use too. For many, these high-risk behaviors have become a part of the leisure time menu.

At the end of discussions about adolescents who have made the wrong turns, we're often presented with people who imply that there's nothing

that can be done to stop such episodes. In fact, there are actions that can play an important role in decreasing high-risk adolescent conduct:

- First, values are significant in resisting high-risk behaviors and in a teen's return to a course of healthy actions after experimentation. Families and school systems that stress sexual restraint, abstinence from substance use, and high academic effort have fewer teens involved in risky actions.
- Second, frequent and warm connections between teens and adults facilitate good adjustment and avoidance of high-risk behaviors. Children that are forgotten or who have little contact with parents or other supportive adults often become lost to a string of destructive behaviors and ineffective achievement.
- Third, supervision and firm adult control are crucial. Most teens cannot be left to their own devices because they do not possess the necessary judgement or understanding of consequences despite their "adult-like" talk and appearance. Mistakes need to be accepted and understood, but teens need to know that there are limits that will be imposed by adults and that appropriate restrictions will be placed upon them when they violate rules. This third step seems to have been missing from the lives of many of the "lost" children we have learned about in recent events.
- Finally, we need to be aware that mental and emotional illnesses are biological facts that emerge at very high rates during adolescence. A good number of teens are likely to encounter depression, social anxiety, and intense aggressive impulses. Without supportive connections to adults and a willingness to disclose their stresses, many teens turn to substances to alleviate distress or overcome social reluctance. In turn, substance use decreases their inhibitions to engage in risky sexual activity, violent actions, and diversions from a constructive path of development. A substantial minority of adolescents will succumb to substance dependence. Therefore, we need to be more alert to the expressions of mental disorders and we need to make more help available to teens, especially those at greatest risk because of family histories of mental disorder and substance use.

Given the seriousness of recent events and actions taken by adolescents and children, it is easy to become discouraged and conclude that we cannot take collective or individual steps to decrease or prevent the occurrence of destructive behaviors. However, the facts do not support that conclusion. We need to remember that despite increases in problematic actions by adolescents over the last two decades, the majority of teens are not engaged in regular substance use, regular risky sexual activity or sexual intercourse, and violent responses. A recent national survey based on the National Longitudinal Study on Adolescent Health found that only 23% of older adolescents are involved in regular alcohol use, that 16% of older adolescents use marijuana on a regular basis, and just half of older adolescents had been involved in sexual intercourse. The numbers for younger adolescents were lower.

This information makes it clear that many adolescents are choosing to

remain healthy. The survey and other data indicate that several steps by adults are useful. Taking steps to remain closely connected to adolescents, establishing scheduled family interactions that include adolescents, stressing values and reinforcing rules for teens while providing them with appropriate supervision and interesting recreational activities all help decrease the frequency of problematic behaviors. Building and maintaining communities that recognize that all adolescents, not just those that make the teams or shine in academics, need recreational outlets and encouragement in educational pursuits will create communities where fewer problems exist. Thus, adults working collectively have the capacity to change the course of adolescent development. It remains to be seen if we will expend the time, energy and resources necessary to do so.

RESOURCES FOR FURTHER READING

Books

Adolescence and Puberty. Bancroft, J, Reinisch, J M. (Eds.) (1990) New York: Oxford University.

Your Adolescent. Pruitt, D. (Ed.) (1999) New York: Harper Collins.

Handbooks

Gallagher, R. & Liz Claiborne, Women's Work Foundation (1998) "A Parents' Handbook: Teaching Your Kids about Developing Healthy Relationships." Requested by calling 1-800-449-STOP

Web Sites

www.AboutOurKids.org - Home site of the NYU Child Study Center

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THE LOST CHILDREN OF ROCKDALE COUNTY

Adrift in America

by Michael D. Resnick, Ph.D.

Michael D. Resnick, Ph.D. is a sociologist and professor of Pediatrics at the University of Minnesota, and director of the National Teen Pregnancy Prevention Research Center.

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It's hard to view a story that is so starkly told. It certainly wasn't clear who was the more lost, the children, or the parents of Rockdale county. It should be said from the outset that this story does not tell us about all of our children. It does not tell us about all parents. Yet...this depiction of adolescents, their parents, their community resonates beyond the limited portrait of a single setting. There are messages in here for all of us who work with and on behalf of young people, and who love and care about kids.

We heard a lot about emptiness. Houses that were empty and devoid of supervision, adult presence, oversight. There was for far too many of the adolescents a fundamental emptiness of purpose; a sense that they were not needed, not connected to adults, to tasks, to anything meaningful other than the raw and relentless pursuit of

"That this portrait of going to extremes is not an isolated incident is shown in the repetitions of the next generation - the young girls and boys who themselves are already enacting the empty dramas of adolescents but a few years older than themselves."

pleasure. And what empty pleasure-seeking it was. On reflection, so many of the girls indicated that they were feeling that emptiness, and one suspects that had one dug just a bit deeper, many of the boys would have reflected similar sentiment. Back in 1970 in his now classic book The Pursuit of Loneliness, sociologist Phillip Slater spoke of American culture at the breaking point, and one that willingly, senselessly embraced alienation and disconnection. That drama was played out with such pathos in the lives of these adolescents who were driven to extremes of self-destructive behavior by a very normal and healthy need, the need to belong. Bereft of meaningful expectations, responsibilities, healthy options for recreation and entertainment, and with a notable absence of adults who were capable of being adults and active, involved parents, these young people turned to the basest of impulses within and among themselves, with startling and pathetic results. What our research is showing--indeed what the research of many colleagues who focus on risky behaviors and protective factors in the lives of young people has shown--is that parents, families and adults outside of the family are fundamentally important to the healthy development of youth. It would seem that some parents in America embrace the myth that once their sons and daughters make it past childhood into adolescence, what they, the parents, say or do or hope or believe is no

longer relevant. Granted, many adolescents are very skillful at telling us, as adults, that we have become irrelevant in their lives. And WE make the mistake of believing that! What is clear from the national studies of adolescent health and resilience is that caring and competent adults who recognize, value and reward pro-social behavior in young people can have a profound effect on what adolescents value and believe, about themselves and the world around them.

But the impact of connections in the lives of adolescents does not stop at the borders of family. Indeed, we understand that adolescents who feel closely connected to their schools, are adolescents who are emotionally healthier, and far less likely to engage in risky behavior than their counterparts who feel no sense of community in their school - where school is not functioning, in the words of sociologist Roberta Simmons, as "an arena of comfort". Without question it is the formation of friendship networks within the school that help to provide that sense of community, along with the perception that teachers care, that teachers are fair, and that school is a place where one 'belongs.'

That this portrait of going to extremes is not an isolated incident is shown in the repetitions of the next generation - the young girls and boys who themselves are already enacting the empty dramas of adolescents but a few years older than themselves.

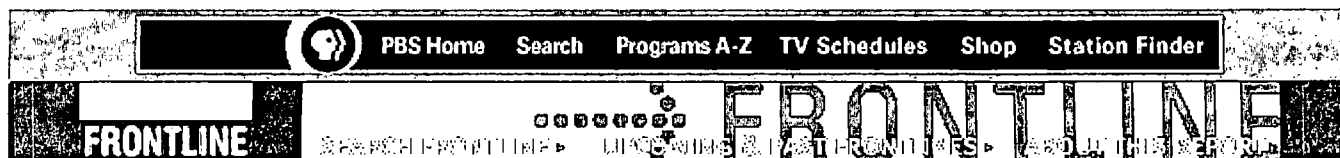
But none of this is inevitable. Adolescents' quest for independence and the desire to immerse themselves in the blended identity of a peer group does not automatically consign anyone to a whirlwind of self-destruction. Most appealing about this piece of journalism is its call to self-examination by parents, by adolescents, by a wide range of players involved with kids. Rather than resignation or despair, the underlying take-away message must be one that assures that there is always something that can be done. It requires our attention, our energy, and our care - and these very human elements are what truly make a difference in the healthy development of our children, in Rockdale and throughout the world.

Michael D. Resnick, Ph.D. is a sociologist and professor of Pediatrics at the University of Minnesota, and director of the National Teen Pregnancy Prevention Research Center. The Center is devoted to conducting and disseminating research and information on best practices, programs, and policies that prevent pregnancy among adolescents, and promote the healthy development of youth. Resnick has particular interest in the study of risk, resiliency and protective factors in the lives of youth, and how that research can be used in programs, policies and practices with and on behalf of youth.

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THE LOST CHILDREN OF ROCKDALE COUNTY

Links & Resources for Teens & Parents

► Talking With Kids About Tough Issues

The Kaiser Family Foundation and Children Now have launched a national campaign to encourage and give parents tools to talk to their kids early and often about tough issues like sex, drugs, alcohol, AIDS and violence. Their site offers a checklist of "10 Tips for Talking With Your Kids About Tough Issues." In addition, each of the five Tough Issues offers a substantive list of advice for parents. (The Kaiser Family Foundation is a national independent health care philanthropy and Children Now is a non-partisan voice for America's children.)

► The National Parenting Center

This site collects many short articles written by child-rearing experts designed to help parents. Type in 'teenager' or 'adolescent' in the search area to find articles listed under individual categories such as: "Talking About Sex," "Keeping the Lines of Communication Open," "Tips on Communicating with Teens and Adolescents," "Privacy, Stress and Setting Limits," "Dealing with Divorce," and "High School and Beyond."

► The National Campaign Against Teen Pregnancy

This organization's goal is to prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence. The "Tips For" section offers: "Tips for Parents," "Tips for Parents From Teens," "Tips for Teens From Teens," and "Tips to Help Faith Leaders and their Communities Deal with Teen Pregnancy."

► Parents' Resource Guide

Here's a list of books and booklets including, "How to Help Your Kids Say 'No' to Sex," "How to Talk to Your Child About Sex," "How To Talk So Kids Will Listen and Listen So Kids Will Talk." This material is also part of the Campaign Against Teen Pregnancy site.

► A New Survey of Parents and Kids Ages 10-15

This survey found that kids in families who talk openly about sex and relationships are more likely to say they would turn to a parent first if faced with a crisis. Read more details about this interesting survey and examine

related charts and graphs which go with it. (The survey was conducted by the Kaiser Family Foundation and Children Now.)

• [AboutOurKids.org](#)

This is the site of New York University's Child Study Center. Its staff offers mental health services for children and families, focusing on early diagnosis and intervention. The "Parenting" and "Is My Kid OK?" sections contain advice for parents--for example, how to handle violence, and concerns about a child's friends and friendships. The site also gives a rundown of different parenting styles, and a section on "Matching Parenting Styles/Children's Temperaments."

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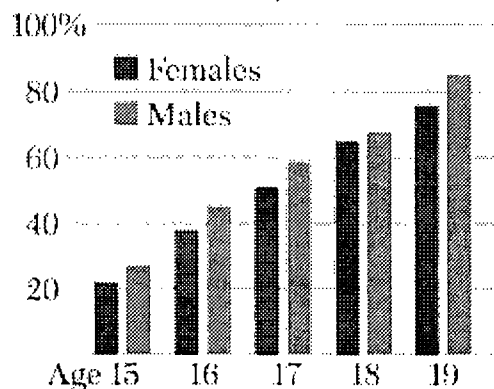
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- [Perspectives](#)
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- [The Last Word](#) by George F. Will

LIFESTYLE

SEXUAL ACTIVITY

Almost one out of five teenagers is still a virgin by the age of 20.

Percentage of teens who have had sexual intercourse, 1995



FAVORITE TV SHOWS

Boys

'The Simpsons'
'South Park'
'MTV'
'Home Improv.'
'Friends'

Girls

'Dawson's Creek'
'Friends'
'7th Heaven'
'The Simpsons'
'Buffy the V.S.'

COOLEST BRANDS

Boys

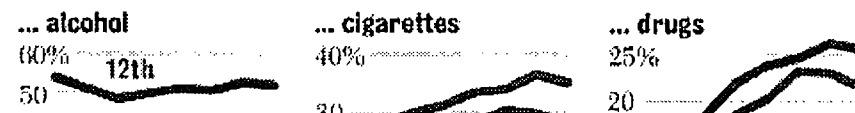
Nike
Sony
Tommy Hilfiger
Nintendo
adidas

Girls

Nike
adidas
Tommy Hilfiger
The Gap
Old Navy

LESS OF THE BAD STUFF: SMOKING, DRINKING AND DOING DRUGS

Today, teens say, they misbehave less than kids in the recent past. The percentage who, in the last 30 days, admit to having used...



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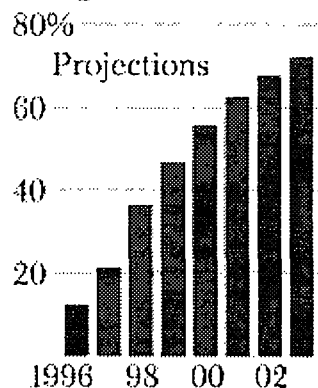
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by George F. Will

ONLINE

HOOKED UP

47% of teens are using the computer to go online this year.

Percentage of teens who go online



WHAT DO THEY DO?

They keep up with each other—and what's out there.

Top 10 Activities

E-mail	83%
Search Engine	78
Music sites	59
General Research	58
Games	51
TV/Movie Sites	43
Chat room	42
Own Web page	38
Sports sites	35

EVERY MOVE THEY MAKE

With age comes online freedom. Here's how parents say they monitor their kids while they're on the Net.

	Age 11-15	16-18
Sit with them while online	38%	9%
Kids can only log on with an adult	34	5
Mainly use for online games	28	15
Limit hours for kids' use	47	21
Know which Web sites kids can visit	68	43
Kids are online whenever they want	54	75
Use the Net more than watching TV	19	22

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Home life

PASSING THE HOURS

Kids spend more time partying than studying each week. They also like tube time.

Activity	percentage of teens/hours	
Watching TV	98%	11.0 hrs.
Listening to CDs, tapes, etc.	96	9.9
Doing chores	84	4.1
Studying	59	3.7
Going to parties	58	4.0
Going to religious functions	51	2.5
Working at a regular paid job	32	4.7

WHAT WERE WE TALKING ABOUT?

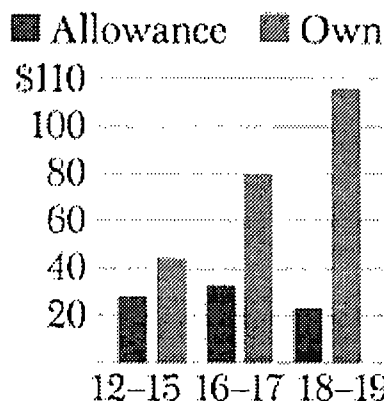
Parents and kids both say they're discussing important life issues.

Issue discussed	parents	kids
Alcohol/drugs	98%	90%
How to handle violent situations	83	80
Basic facts of reproduction	76	80
AIDS	78	75

85% of teens said Mom cares 'very much' about them. 58% said the same about Dad.

25% of teens said that their mom is 'always' home when they return from school. 10% said their dad was.

Weekly spending



Do parents let teenagers make their own decisions about the weekend curfew? 66% said no.

How much are teens 'understood' by their family members? 35% said 'quite a bit.'

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- by George F. Will

Peril and Promise: Teens by the Numbers

They watch too much television, and their parents may not be around enough, but today's teenagers are committing fewer crimes, having fewer babies and generally staying out of serious trouble. Here's a look at who they are—and what they're up to.

DEMOGRAPHICS

THE BREAKDOWN

Teenagers account for roughly 10 percent of the U.S. population.

Teens (13-19)

White 18,199,000 66%

Black 3,992,000 15

Hispanic 3,723,000 14

Asian, Pac. Islander 1,030,000 4

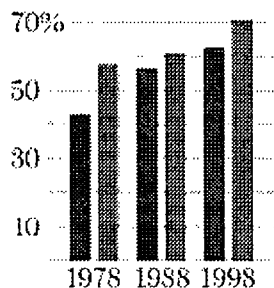
American Indian, Eskimo and Aleut 275,000 1

PARENTS AT WORK

Parents work more, so their teenagers are often left unsupervised.

Families with employed parents

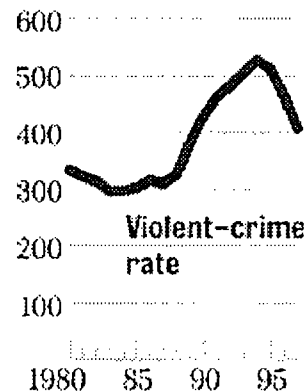
■ Both parents
■ Single mother



DROP IN CRIME

in 1997, kids were responsible for 17 percent of violent-crime arrests.

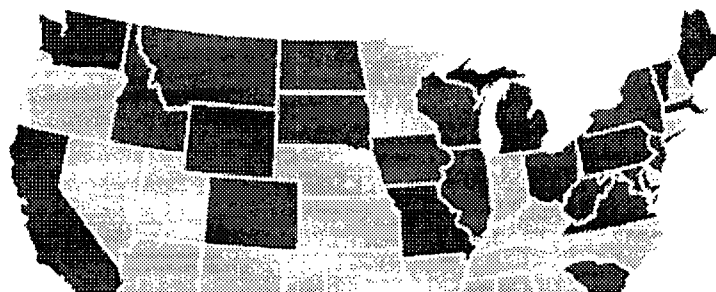
Arrests per 100,000 juveniles 10-17

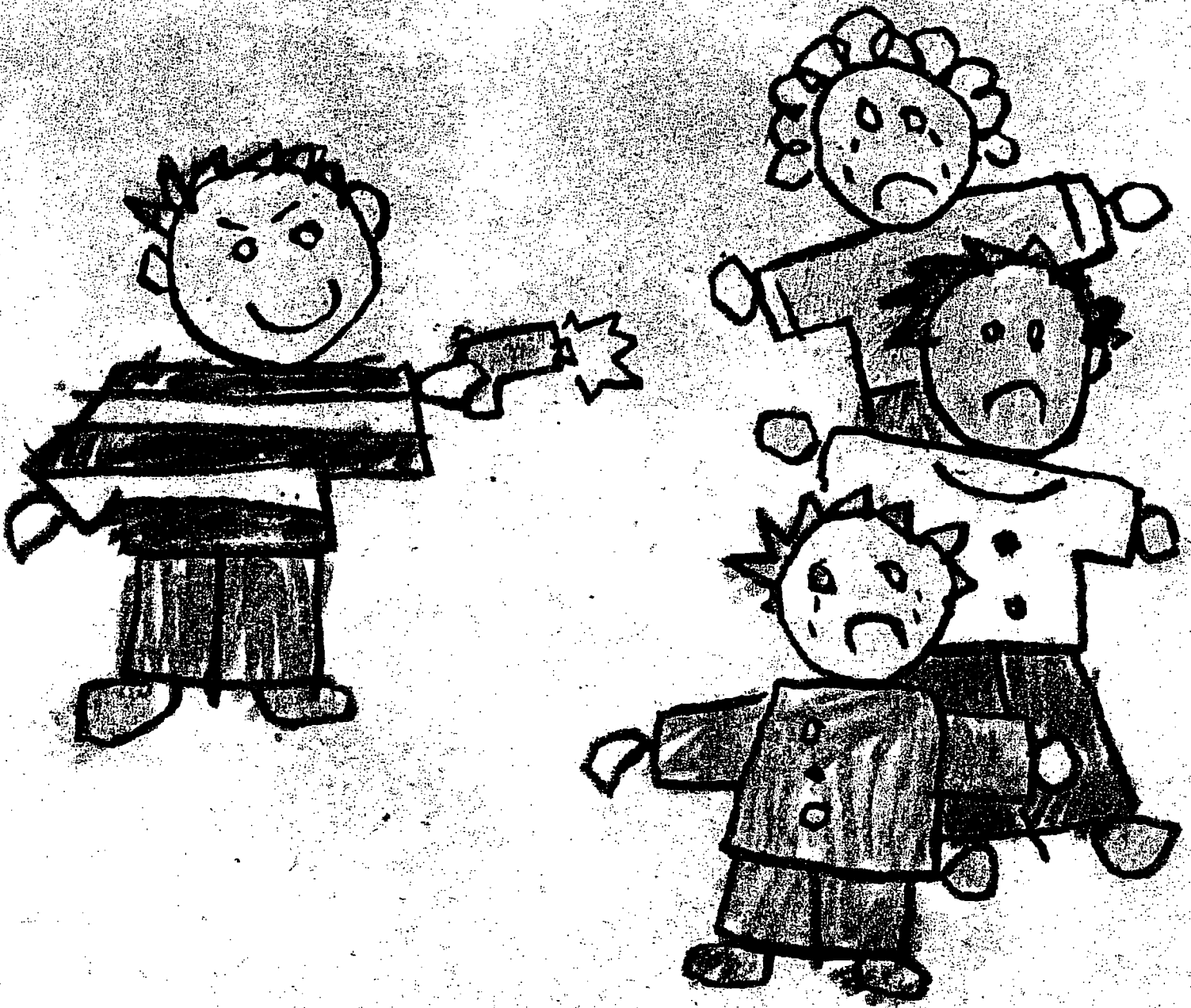


KIDS HAVING KIDS: A TREND ON THE DECLINE

The birthrate among teens has fallen dramatically, down 16 percent overall.

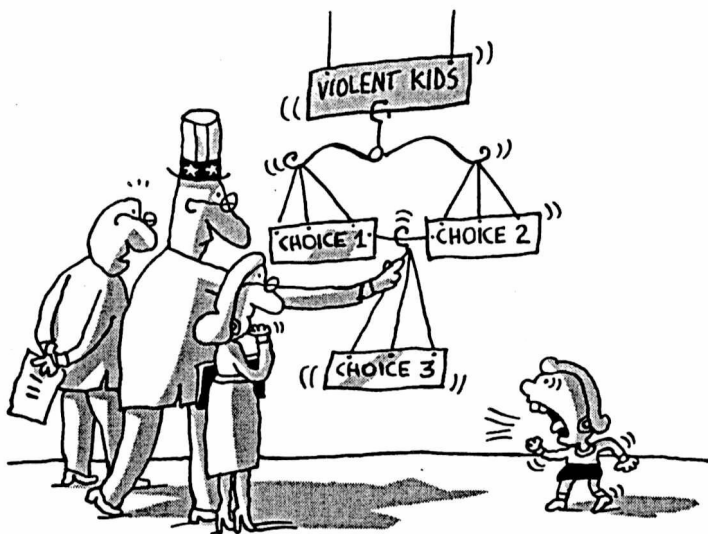
Birthrates for females 15-19





Comparing the Choices

Why are some children and teenagers turning to violence? What can we do? To help citizens consider these tough questions, this discussion guide breaks the issue down to some fundamental public policy perspectives, or choices. Each choice offers a different diagnosis of what's wrong, based on views and priorities voiced by many Americans in studies and surveys. Each choice also provides a direction for public action, or a way to approach the problem. These approaches include ideas and proposals that are drawn from across the political spectrum. Some elements of the choices are readily mixed, but not others, as each choice has its own priorities and agenda. An outline of the three choices appears on these pages.



Choice 1

Kids Need a Nonviolent Popular Culture

Kids are immersed in a violent, popular culture, making it difficult for parents to raise moral children. We need to clean up the culture and give kids healthy alternatives.

What Can Be Done?

- Ban the marketing of violent entertainment to children under 17.
- Boycott advertisers that support violent entertainment programs and products directed at children.
- Provide kids with healthy alternatives to violent entertainment. Increase investment in public television and expand after-school programs.



In This View

- It's wrong to use violence in the media as a way to capture children's attention and sell them products.
- Although media violence is not the only cause of violence in American society, "it is the single most easily remediable contributing factor," the American Academy of Pediatrics reported in 1995.
- Violent entertainment nourishes violence in America. About 3,000 studies have linked media violence to violent behavior.

In Other Views

- Research studies can't say whether an action movie caused a boy to act violently – or whether the boy already had a propensity for violence.
- A good reason for the popularity of violent entertainment is that it serves as a cathartic, allowing people to release aggressive feelings in a healthy, nonviolent way.
- Removing violence from the entertainment media would not remove it from children's lives. Young people develop emotional and behavioral problems that often lead to violence if they don't get help.

A Likely Tradeoff?

- In demanding less violence in the popular culture, this choice would restrict freedom of speech, setting a precedent for more restrictions.

Choice 2

Kids at Risk of Violence Need More Help

Relatively few children are at risk of developing behavior problems and falling into the cycle of violence. We know how to rescue troubled kids but lack a system to do the job.

What Can Be Done?

- Develop a national system for identifying and helping troubled kids and families at greater risk of violence.
- Teach parents, teachers, and kids how to recognize early warning signs of violent behavior and how to get help to the troubled kids.
- Rescue more children from chronically abusive homes, and provide them with care and treatment in foster or adoptive homes.

In This View

- Many children suffer from violence, and many of them will become violent themselves without help.
- Kids rarely become violent without prior warning. We need to do a better job recognizing early signs and helping troubled kids.
- We know where some children go wrong and how to help them; it's negligent not to act on this knowledge.



In Other Views

- This choice makes a powerful argument for helping children but overstates the impact this would have in reducing violence in society. Predicting which children are at greater risk of violence is not a science.
- Although this choice says children can be harmed by experiencing violence, its supporters voice no concern about children exposed to violent entertainment.
- The primary problem isn't the criminal abuse of children, but rather the more widespread problem of permissive parents who don't teach kids right from wrong.

A Likely Tradeoff?

- In trying to identify troubled kids and those at risk of violence, this choice would inevitably mislabel some children, disrupting their lives and families.

Choice 3

Kids Need More Moral Discipline

Many children grow up in permissive homes, schools, and communities. They aren't taught right from wrong, and many lack a moral compass to steer them clear of violence.

What Can Be Done?

- Urge parents, through public education campaigns, to teach kids right from wrong with strict discipline.
- Enact more laws to hold permissive parents accountable for supervising their children.
- Tighten school discipline and expand character education programs that instill core civic principles like respect and self-reliance.



In This View

- Failing to teach children right from wrong is the fundamental reason for the spread of juvenile violence.
- Kids need chores to learn responsibility, and they need consistent praise and punishment to learn right from wrong.
- An original mission of the public schools was to mold good citizens. Character education programs are reviving that mission.

In Other Views

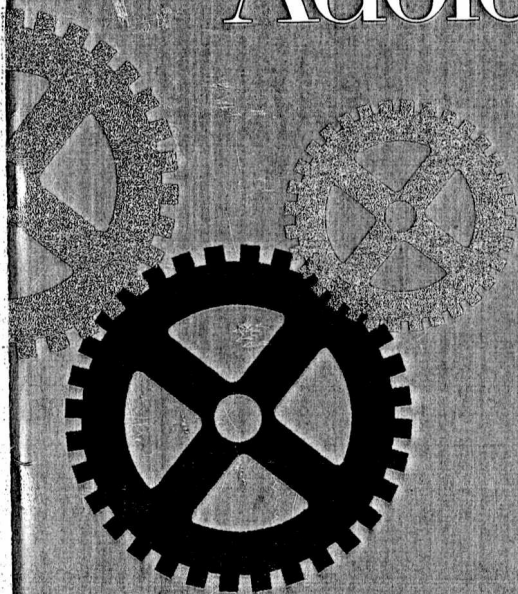
- If parents in the 1940s and 1950s did such a good job, how does this choice explain the rebellious youth of the 1960s?
- The parental problem isn't permissiveness, but absence. About one in three parents gives teenagers no guidance or emotional support at all, according to major studies.
- This choice ignores the need to provide adequate help to children who are troubled or at a higher risk of becoming violent.

A Likely Tradeoff?

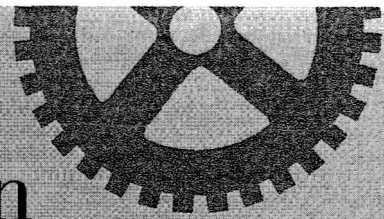
- With its concern about permissive parenting, this choice would make parents criminally liable for the misbehavior of their minor children.

Preventing Drug Use Among Children and Adolescents

A RESEARCH-BASED GUIDE



National Institute on Drug Abuse
National Institutes of Health



Prevention Principles

**FOR CHILDREN
AND ADOLESCENTS**

Prevention programs should be designed to enhance “protective factors” and move toward reversing or reducing known “risk factors.”

Prevention programs should target all forms of drug abuse, including the use of tobacco, alcohol, marijuana, and inhalants.

Prevention programs should include skills to resist drugs when offered, strengthen personal commitments against drug use, and increase social competency (e.g., in communications, peer relationships, self-efficacy, and assertiveness), in conjunction with reinforcement of attitudes against drug use.

Prevention programs for adolescents should include interactive methods, such as peer discussion groups, rather than didactic teaching techniques alone.

Prevention programs should include a parents’ or caregivers’ component that reinforces what the children are learning—such as facts about drugs and their harmful effects—and that opens opportunities for family discussions about use of legal and illegal substances and family policies about their use.

Prevention programs should be long-term, over the school career with repeat interventions to reinforce the original prevention goals. For example, school-based efforts directed at elementary and middle school students should include booster sessions to help with critical transitions from middle to high school.

Family-focused prevention efforts have a greater impact than strategies that focus on parents only or children only.

Community programs that include media campaigns and policy changes, such as new regulations that restrict access to alcohol, tobacco, or other drugs, are more effective when they are accompanied by school and family interventions.

Community programs need to strengthen norms against drug use in all drug abuse prevention settings, including the family, the school, and the community.

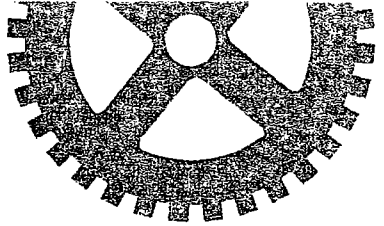
Schools offer opportunities to reach all populations and also serve as important settings for specific subpopulations at risk for drug abuse, such as children with behavior problems or learning disabilities and those who are potential dropouts.

Prevention programming should be adapted to address the specific nature of the drug abuse problem in the local community.

The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.

Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive.

Effective prevention programs are cost-effective. For every dollar spent on drug use prevention, communities can save 4 to 5 dollars in costs for drug abuse treatment and counseling.



Risk and Protective Factors

Q: What are risk factors and protective factors?

Studies over the past two decades have tried to determine the origins and pathways of drug abuse—how the problem starts and how it progresses. Several factors have been identified that differentiate those who use drugs from those who do not. Factors associated with greater potential for drug use are called “risk” factors, and those associated with reduced potential for such use are called “protective” factors.

Risk and protective factors encompass psychological, behavioral, family, and social characteristics.

Our research has revealed that there are many risk factors for drug abuse, each representing a challenge to the psychological and social development of an individual and each having a differential impact depending on the phase of development. For this reason, those factors that affect early development in the family are probably the most crucial, such as:

- chaotic home environments, particularly in which parents abuse substances or suffer from mental illnesses;
- ineffective parenting, especially with children with difficult temperaments and conduct disorders; and
- lack of mutual attachments and nurturing.

Other risk factors relate to children interacting with other socialization agents outside of the family, specifically the school, peers, and the community. Some of these factors are:

- inappropriate shy and aggressive behavior in the classroom;
- failure in school performance;
- poor social coping skills;
- affiliations with deviant peers or peers around deviant behaviors; and
- perceptions of approval of drug-using behaviors in the school, peer, and community environments.

Certain protective factors also have been identified. These factors are not always the opposite of risk factors. Their impact also varies along the developmental process. The most salient protective factors include:

- strong bonds with the family;
- experience of parental monitoring with clear rules of conduct within the family unit and involvement of parents in the lives of their children;
- success in school performance;
- strong bonds with prosocial institutions such as the family, school, and religious organizations; and
- adoption of conventional norms about drug use.

Other factors—such as the availability of drugs, trafficking patterns, and beliefs that drug use is generally tolerated—also influence the number of young people who start to use drugs.

Q: How can prevention planners use risk and protective factors to develop programs?

The study of factors and processes that increase the risk of using drugs or protect against the use of drugs has identified the following primary targets for prevention intervention: family relationships, peer relationships, the school environment, and the community environment. Some of the factors in each domain are briefly described below. Each of these domains can be a setting for deterring the initiation of drug use through increasing social- and self-competency skills, adoption of prosocial attitudes and behaviors, and awareness of the harmful health, social, and psychological consequences of drug abuse.

Prevention efforts can enhance protective factors and move toward reversing or reducing risk factors.

Family Relationships. Prevention programs can enhance protective factors among young children by teaching parents skills for better family communication, discipline, firm and consistent rulemaking, and other parenting skills. Research also has shown that parents need to take a more active role in their children's lives, including talking with them about drugs, monitoring their activities, getting to know their friends, and understanding their problems and personal concerns.

Peer Relationships. Prevention programs focus on an individual's relationship to peers by developing social-competency skills, which involve improved communications, enhancement of positive peer relationships and social behaviors, and resistance skills to refuse drug offers.

The School Environment. Prevention programs also focus on enhancing academic performance and strengthening students' bonding to school, by giving them a sense of identity and achievement and reducing the likelihood of their dropping out of school. Most curriculums include the support for positive peer relationships (described above) and a normative education component designed to correct the misperception that most students are using drugs. Research has found also that when children understand the negative effects of drugs (physical, psychological, and social) and when they perceive their friends' and families' social disapproval of drug use, they tend to avoid initiating drug use.

The Community Environment.

Prevention programs work at the community level with civic, religious, law enforcement, and governmental organizations to enhance antidrug norms and prosocial behavior through changes in policy or regulation, mass media efforts, and communitywide awareness programs. Community-based programs might include new laws and enforcement, advertising restrictions, and drug-free school zones—all designed to provide a cleaner, safer, drug-free environment.

Educating children about the negative effects of drugs, especially the most immediate adverse effects in their lives, is an important element in any prevention program. In addition, helping children become more successful in school behavior and performance helps them form strong prosocial bonds with their peers, the school, and the community.

"[You need] top-down and bottom-up support for prevention... You need support from every level including the mayor, the clergy, the education leaders, and citizens at all levels."

A NATIONAL COALITION LEADER

Q: What are the highest-risk periods for drug use among youth?

For most children, research has shown that the vulnerable periods are transitions, when they grow from one developmental stage to another, or when they experience difficult life changes, such as moving or divorce. Exposure to risks can start even before a child is born; this is one reason that mothers are advised to abstain from drugs during pregnancy.

"We need to know what recent surveys show and the implications for areas like ours. It would also be helpful if we had more up-to-date information about the effects of drugs on women and their offspring."

A COMMUNITY LEADER

When young adults go on to college or get married or enter the workforce, they again face new risks from alcohol and other drug abuse in their new adult environments.

Because risks appear at every transition from infancy through young adulthood, prevention planners need to develop programs that provide support at each developmental stage.

The first big transition for children is when they leave the security of the family and enter school. When they advance from elementary school to middle school or junior high, they often face social challenges, such as learning to get along with a wider group of peers. It is at this stage, early adolescence, that children are likely to encounter drug use for the first time.

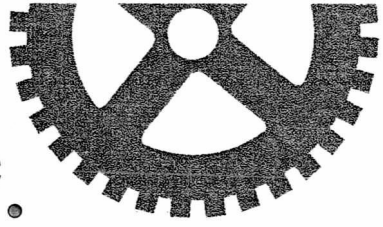
Later on, when they enter high school, young people face social, psychological, and educational challenges as they prepare for the future, and these challenges can lead to use and abuse of alcohol, tobacco, and other drugs.

Q: When does drug use start, and how does it proceed?

Studies indicate that children most often begin to use drugs at about age 12 or 13, and many researchers have observed young teens moving from the illicit use of legal substances (such as tobacco, alcohol, and inhalants) to the use of illegal drugs (marijuana is usually the first). The sequence from tobacco and alcohol use to marijuana use, and then, as children get older, to other drugs, has been found in almost all long-term studies of drug use. The order of drug use in this progression is largely consistent with social attitudes and norms and the availability of drugs. But it cannot be said that smoking and drinking at young ages are the cause of later drug use.

Nor does this sequencing imply that the progression is inevitable. It does say that for someone who ever smoked or drank, the risk of moving on to marijuana is **65 times higher** than that for a person who never smoked or drank. The risk of moving on to cocaine is **104 times higher** for someone who smoked marijuana at least once in his or her lifetime than for a person who never did (*these figures are from an analysis of 1991–1993 data from the National Household Survey on Drug Abuse*).

Scientists have hypothesized several reasons for this observed progression, including a possible biological cause. The research also suggests social or behavioral causes, such as early involvement with antisocial, drug-using people. Indeed, all these possibilities could play a part.



Drug Abuse Prevention in the Community

Q: How can community leaders assess the level of risk for drug abuse in the community?

To assess the level of risk, it is important to:

- assess the extent of drug use and community awareness of the problem;
- gain an understanding of the community's culture and how that culture is affected by drug use;
- consult with community leaders working in drug abuse and related areas; and
- learn about efforts already under way to address the problem.

Then, a more formal process of identifying problems and assessing community needs can begin.

"The most important elements in community prevention programs are strategies, tools, and information about drug abuse problems. What are the drugs? How are they used?"

A NATIONAL COALITION LEADER

Many tools have been tested in research and can be used to assess the community's drug problem. For example, drug abuse epidemiologists have used:

- household and school surveys;
- methods to collect available information from health departments, hospitals, drug abuse treatment facilities, law enforcement agencies, and school systems;
- ethnographic studies, which use a systematic, observational process to describe behaviors in natural settings, such as urban heroin use, and also document the perspectives of the individuals under observation; and
- more informal methods, such as convening focus groups with representatives of drug-using subpopulations to determine what is going on in the community.

Each of these methods has advantages and disadvantages, so NIDA recommends, if resources allow, the use of multiple strategies to assess community risk to provide the best information possible. The information obtained in this early assessment can help community leaders make sound decisions about programs and policies and will contribute to later evaluation efforts.

Q: How can community leaders judge the effectiveness of current prevention efforts?

With the growing problem of adolescent drug use, shrinking resources, and limited expertise in evaluation, the task of assessing current program effectiveness and planning for future needs may appear daunting.

Many communities can undertake formal evaluations by working with their local universities to obtain help in developing and implementing well-designed evaluation strategies. These strategies try to track drug use among the young people who have been reached by the program and compare those results with drug use among a control group (*young people of similar characteristics who have not been involved with the program*).

“The major obstacle is the difficulty of demonstrating the benefits of prevention. People in the prevention field are always under a lot of pressure to show results.”

A STATE PREVENTION LEADER

Another approach is for communities to conduct a structured review of current prevention programs to determine, first, whether the programs in place were tested according to rigorous scientific standards during their development; and second, whether these incorporate the basic principles of prevention that have been identified in research.

The following checklist can assist in determining whether specific programs include research-based prevention principles:

PREVENTION PRINCIPLES FOR COMMUNITY PROGRAMS

- ✓ *To be comprehensive, does the program have components for the individual, the family, the school, the media, community organizations, and health providers? Are the program components well integrated in theme and content so that they reinforce each other?*
- ✓ *Does the prevention program use media and community education strategies to increase public awareness, attract community support, reinforce the school-based curriculum for students and parents, and keep the public informed of the program's progress?*
- ✓ *Can program components be coordinated with other community efforts to reinforce prevention messages (for instance, can training for all program components address coordinated goals and objectives)?*
- ✓ *Are interventions carefully designed to reach different populations at risk, and are they of sufficient duration to make a difference?*
- ✓ *Does the program follow a structured organizational plan that progresses from needs assessment through planning, implementation, and review to refinement, with feedback to and from the community at all stages?*
- ✓ *Are the objectives and activities specific, time-limited, feasible (given available resources), and integrated so that they work together across program components and can be used to evaluate program progress and outcomes?*

PREVENTION PRINCIPLES FOR SCHOOL-BASED PROGRAMS

- ✓ *Do the school-based programs reach children from kindergarten through high school? If not, do they at least reach children during the critical middle school or junior high years?*
- ✓ *Do the programs contain multiple years of intervention (all through the middle school or junior high years)?*
- ✓ *Do the programs use a well-tested, standardized intervention with detailed lesson plans and student materials?*
- ✓ *Do the programs use age-appropriate interactive teaching methods (modeling, roleplaying, discussion, group feedback, reinforcement, extended practice)?*
- ✓ *Do the programs foster prosocial bonding to the school and community?*
- ✓ *Do the programs have these components:*
 - *teach social competence (communication, self-efficacy, assertiveness) and drug resistance skills that are culturally and developmentally appropriate;*
 - *promote positive peer influence;*
 - *promote antidrug social norms;*
 - *emphasize skills-training teaching methods; and*
 - *include an adequate "dosage" (10 to 15 sessions in year 1 and another 10 to 15 booster sessions)?*
- ✓ *To maximize benefits, do the programs retain core elements of the effective intervention design (see p. 16)?*
- ✓ *Is there periodic evaluation to determine whether the programs are effective?*

PREVENTION PRINCIPLES FOR FAMILY-BASED PROGRAMS

- ✓ *Do the family-based programs reach families of children at each stage of development?*
- ✓ *Do the programs train parents in behavioral skills to:*
 - *reduce conduct problems in children;*
 - *improve parent-child relations, including positive reinforcement, listening and communication skills, and problemsolving;*
 - *provide consistent discipline and rulemaking; and*
 - *monitor children's activities during adolescence?*
- ✓ *Do the programs include an educational component for parents with drug information for them and their children?*
- ✓ *Are the programs directed to families whose children are in kindergarten through 12th grade to enhance protective factors?*
- ✓ *Do the programs provide access to counseling services for families at risk?*

Q: How can community leaders motivate the community to take action and implement new prevention programs?

“We need to rebuild the parents movement... to get concerned parents involved again and give them the information needed... the most up-to-date information about what drugs do to people.”

A NATIONAL PREVENTION LEADER

Establishing a community coalition of key leaders from public- and private-sector organizations can provide the impetus for action. This coalition can hold communitywide meetings, develop a public education campaign, and attract sponsors for a comprehensive drug abuse prevention strategy.

Research has shown that programs can use the media to raise public awareness about the seriousness of a community's drug problem and help get drug abuse on the public agenda. Using local data and speakers from the community helps demonstrate that the drug problem is real and that action is needed.

Q: How can program planners be sure prevention strategies are in line with community needs?

Once the community is alerted to its drug problem, the community group needs to develop a comprehensive plan that links prevention strategies with the needs of the community.

The plan should include:

- assessment of the community problem;
- identification of the most important risks that can be addressed and/or protective factors that can be strengthened;
- resources identified to assist in further planning and implementation (see “Selected Resources” section); and
- designation of the key players and programs to be involved.

As part of the plan, decisions must be made about what additional services are needed for any programs already under way in the community. These can include more intensive law enforcement, new policies on alcohol and tobacco sales, school programs designed to alter attitudes about drug use, and interventions with parents who are drug users.

Q: How can a community take a promising model program and implement it effectively?

Recognizing that each community has unique qualities that must be addressed if prevention programs are to succeed, researchers have been building models that might be adapted to different circumstances and different populations. Several of the most tested models (*e.g., Life Skills, Strengthening Families, and Project STAR*) are currently being delivered as part of a research program in settings with minority populations and in rural and urban environments. Researchers are also testing how to shape these interventions to address those differences while maintaining the intervention's original effectiveness.

As these interventions are adapted to meet the community's needs, it is important to recognize that greater effectiveness is achieved when a program retains the core elements of the original research-based intervention, including its basic structure, content, and delivery.

Some examples of these Core Elements are:

Structure—How the program is organized and constructed—

e.g., the necessary number of sessions and boosters; critical age or description of the target audience (middle school students; parents);

Content—The most important informational and/or educational components of the program—e.g., inclusion of both peer refusal skills and social norm development in curricula; inclusion of family communications training in family programs; and

Delivery—How the program is given to and received by the audience—e.g., are teachers well trained to deliver the curriculum with monitoring and assistance to maintain fidelity to the program's core elements; do family programs use the best approaches to recruit families at risk.

Q: How can evaluation help community leaders assess their own progress and the progress against the drug problem in the community?

Conducting evaluations of community prevention programs can be challenging and difficult. Many community leaders have consulted with local university faculty members and other evaluation experts to design evaluation procedures.

Some of the problems in evaluations result from errors in the evaluation design, so that the findings do not show a clear relationship between the program and the outcomes. Were the results truly

attributable to the program's effects and not some other source, such as other community events or the maturation of the target groups?

Some of the pitfalls of evaluation can be avoided by consulting with experts who can guide the evaluation design by:

- using tested data collection instruments;
- obtaining good baseline—"before intervention"—information;
- using control or comparison groups of people who did not receive the intervention but whose characteristics are similar to those of the people who did receive it;
- monitoring the quality of program implementation;
- making sure that postintervention followup includes a large percentage of the target population; and
- using appropriate statistical methods to analyze the data.

The evaluation process should answer all the questions:

- What was done in the program?
- How was the program carried out?
- Who participated in it?
- Was the program implemented as intended?
- Did the program achieve what was expected?
- Did the program produce the desired long-term effects?

"Drug abuse is a preventable behavior. Drug addiction
is a treatable disease."

PARTNERSHIP FOR A DRUG-FREE AMERICA

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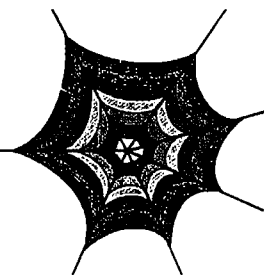
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CYFAR Children, Youth, and Families At Risk

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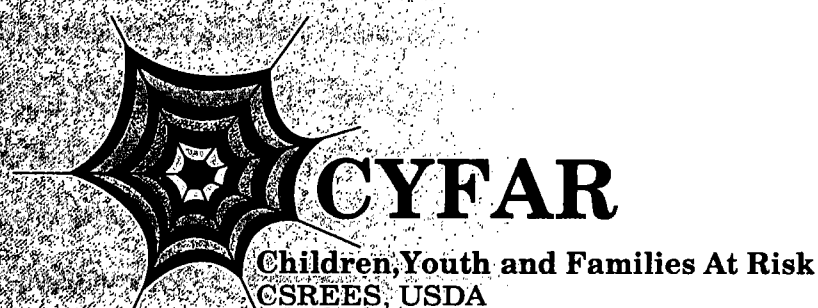
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Virginia Cooperative Extension

Continuity, Success, and Survival of
Community-Based Projects:

The National Youth At Risk Program Sustainability Study

Lydia I. Marek, Jay A. Mancini and Donna J. Brock



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behaviors

Tobacco Weekly Report – 1/28/00

Tobacco -- Trends in Teen Smoking. There are several indications, including from new data released this week, that teen smoking is now declining after rising for many years. First, a survey of 8th, 10th, and 12th graders conducted by the University of Michigan released recently shows modest declines in all three grades (for example, smoking declined among 8th graders from 19.4 percent in 1997 to 17.5 percent in 1999). Second, a new national survey released this week by the American Legacy Foundation found that 28.4 percent of 9th-12th graders smoked cigarettes, significantly lower than the 36.4 percent found by a different national survey in 1997. While certain methodological differences make these surveys not exactly comparable, the data do seem to indicate a decline in teen smoking (we should know more in the spring when the 1999 data from the survey which found the 36.4 percent rate in 1997 comes out). In general, we would expect a drop in smoking rates given the recent price increases from the state settlement, and such data should help bolster our argument for the tobacco price increases in our budget.

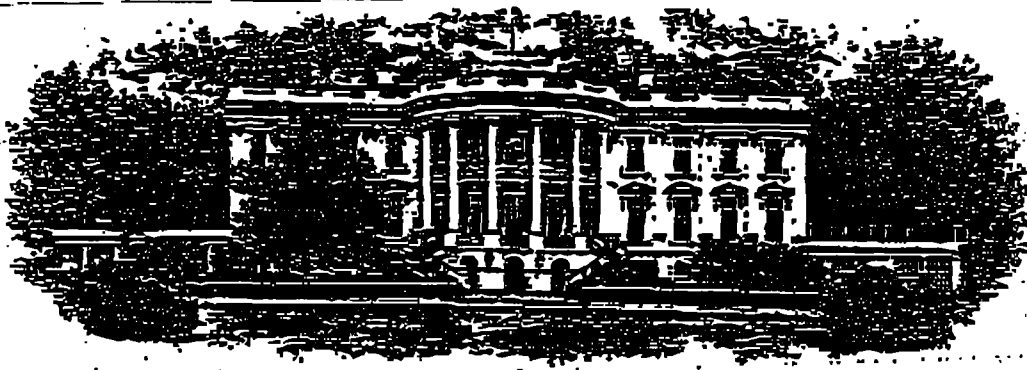
There was also some disturbing news in the report released this week. While to date, national studies have shown African American students smoke at much lower rates than other students, this survey, which is the first to include a nationally representative sample of middle school students, found cigarette smoking prevalence among African American 6th-8th graders (9.0 percent) was similar to their white (8.8 percent) and Hispanic (11.0 percent) counterparts. Overall, the survey found 12.8 percent of middle school students and 34.8 percent of high school students currently use some form of tobacco (cigarettes, smokeless, cigars, pipes, bidis (flavored cigarettes), or kreteks, (clove cigarettes)). The survey was sponsored by the American Legacy Foundation, the charitable foundation created by multi-state tobacco settlement, with technical assistance from the Centers for Disease Control and Prevention.

I am -
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Ann

YOUTH TOBACCO USE^{1,2}
30 day prevalence (95% C.I.)

Grade / Age	1991	1992	1993	1994	1995	1996	1997	1998	1999
8th									
MTFP ⁴	14.6 (+1.2)	15.5 (+1.2)	16.6 (+1.3)	18.5 (+1.4)	19.1 (+1.4)	21.0 (+1.4)	19.4 (+1.3)	19.1 (+1.3)	17.5
YRBS									
NYTS									14.6 (+2.0)
9th									
MTFP									
YRBS	23.2 (+3.6)		27.8 (+2.3)		31.2 (+1.7)		33.4 (+5.1)		
NYTS									24.1 (+2.3)
10th									
MTFP ⁴	20.8 (+1.5)	21.5 (+1.5)	24.6 (+1.6)	25.5 (+1.6)	27.9 (+1.6)	30.4 (+1.7)	29.7 (+1.7)	27.6 (+1.7)	25.7
YRBS	25.2 (+3.0)		28.0 (+3.3)		33.1 (+3.8)		35.3 (+4.1)		
NYTS									27.1 (+1.7)
11th									
MTFP									
YRBS	31.6 (+4.0)		31.1 (+3.2)		35.8 (+3.6)		36.6 (+3.6)		
NYTS									29.7 (+4.1)
12th									
MTFP ⁴	28.2 (+1.7)	27.7 (+1.6)	29.7 (+1.6)	31.4 (+1.7)	33.5 (+1.7)	34.0 (+1.8)	36.6 (+1.8)	35.1 (+1.8)	34.6
YRBS	30.1 (+4.3)		34.5 (+3.8)		38.2 (+3.5)		39.6 (+4.9)		
NYTS									35.0 (+1.6)
Middle School									
NYTS (Grades 6-8)									9.2 (+1.6)
High School									
YRBS (Grades 9-12)	27.5 (+2.7)		30.5 (+1.9)		34.8 (+2.2)		36.4 (+2.3)		
NYTS (Grades 9-12)									28.4 (+2.7)
12-17 year olds									
NHSDA ³	20.9	18.4	18.5	18.9 (+1.4)	20.2 (+1.5)	18.3 (+1.4)	19.9 (+1.3)	18.2	
Footnotes:									
MTFP: Monitoring the Future Project, Survey Research Center, Institute for Social Research, University of Michigan									
YRBS: Youth Risk Behavior Survey, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control									
NYTS: National Youth Tobacco Survey, American Legacy Foundation in collaboration with the CDC Foundation, scientific and technical support from the Centers for Disease Control.									
NHSDA: National Household Survey on Drug Abuse, Office of Applied Studies, SAMHSA									
1. MTFP, YRBS, NYTS are school based surveys. NHSDA is a household survey.									
2. The NHSDA methodology changed in 1994. Examination of trends in this survey before 1994 may not be reliable.									
3. CI's are not available for NHSDA 1991-1993, because of adjustments that were made to the estimates to improve their comparability with estimates based on the new 1994 version of the NHSDA instrument. 1998 CI's are not available.									
4. CI's are not available MTFP 1999.									

(770) 448-5701
CDC office on Smoking
& Health
Dr. Michael Erikson



The White House
Office of Public Liaison

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GIRL SCOUTS OF THE USA TAKE ON YOUTH VIOLENCE
*Senator Kit Bond (R-MO) Announces Funding for
Youth Anti-Violence Project*

Washington, D.C. — Senators Christopher "Kit" S. Bond (R-MO), Barbara A. Mikulski (D-MD) and Kay Bailey Hutchison (R-TX) joined the Girl Scouts of the USA today in announcing \$5 million in federal funding for a break-through youth anti-violence and conflict resolution program. GSUSA's *P.A.V.E.* (Project Anti-Violence Education) *The Way* project is a comprehensive violence prevention and intervention program that will create a nationwide coalition to give young people the skills they need to diffuse violence at a personal and community-wide level.

"I am thrilled that Missouri will provide the testing ground for the *P.A.V.E. The Way* project," said Senator Bond. "The entire nation will benefit from our statewide coalition of Girl Scout councils that will target youth who are at high risk for violent behavior or victimization and share their best practices throughout the country."

"Our dream is that conflict and violence in our society be erased—particularly in schools and other places where our young people gather. Project 'P.A.V.E. the Way' is an important and innovative step toward making this happen, said Marsha Johnson Evans, National Executive Director of Girl Scouts of the USA. "Today, with this incredible \$5-million dollar grant we will be able to not only make a difference in the lives of girls, but also impact the fundamental fabric of our society and how it deals with violence."

Studies have identified several indicators that increase a young person's chances of becoming a victim or perpetrator of violence, including illiteracy, dropping out of school, living in poverty, lacking skills for employment, becoming an unmarried parent or lacking appropriate role models. Studies also show an increase in female criminal activity involving personal and property damage. The Girl Scout organization is in an important position to do something about this trend.

- more -

GSUSA**10-27-99****P. 2**

P.A.V.E. will speak to the mounting evidence and growing public concern that it is imperative for our society to seriously address the issues related to the violence that is so prevalent today. Through programs based on girls working in partnership with adult volunteers to meet community needs, this project will offer girls a core set of developmental and social skills that will help them resist and reduce violence in their lives.

P.A.V.E. THE WAY WILL BEGIN AS A PILOT PROJECT IN MISSOURI and later be implemented nationwide. THE ELEVEN GIRL SCOUT COUNCILS IN MISSOURI WILL FORM A STATEWIDE COALITION AS THEY CREATE AND IMPLEMENT COMPREHENSIVE VIOLENCE PREVENTION AND INTERVENTION PROJECTS THAT ARE TAILORED TO THEIR RESPECTIVE COMMUNITY NEEDS..

Girl Scouts of the USA is the world's pre-eminent organization for girls, with a membership of more than 3.6 million girls and adults. Today, as when founded in 1912, GSUSA helps cultivate values, social conscience and self-esteem in young girls, while also teaching them critical life skills that will enable them to succeed as adults. In Girl Scouting – and its special girl-only environment – girls discover the fun, friendship and power of girls together.

###

**GIRL SCOUTS****Girl Scouts of the USA****PROJECT ANTI-VIOLENCE EDUCATION (PAVE) THE WAY****Point of Contact:**

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GIRL SCOUTS PAVE (PROJECT ANTI-VIOLENCE EDUCATION) THE WAY

There is mounting evidence and growing public concern that it is imperative for our society to seriously address the issues related to violence so prevalent today. We need to help our youth be strong and resilient through positive experiences that assure they see a future of hope and promise. Studies have identified several indicators that increase a young person's chances of becoming a victim or a perpetrator of violence. These indicators include, but are not limited to: illiteracy, not attending school and lacking skills for employment, living in poverty, becoming an unmarried parent, or lacking appropriate parental or other positive role models. Of particular concern to organizations such as the Girl Scouts is the fact that female crime activity involving personal and property damage has been on the rise over the past seven years.

Girl Scouts plays a vital role in offering girls a core set of developmental and social skills that will help them to resist and reduce violence in their lives and have a positive impact on their families, friends and communities. Through the experience of time-tested Girl Scout program girls and young women can develop a stronger sense of self worth and competence, learn to relate to others with understanding and respect and take a leadership role in making their communities safer.

Girl Scouts Can Make a Significant Difference

With 2.6 million girls and over 850,000 volunteer adults, including over 98,000 girls and 28,000 adults in the state of Missouri. Girl Scouts is committed to being a significant leader in the creation and implementation of programs for youth that can counteract the growing problem of violence and its impact on young people. According to the latest state profiles of child well-being compiled by the Annie Casey Foundation, 14% of children nationwide and 10% of children in Missouri are living in families considered to be at risk because of factors such as family income, single parent household, unemployment and welfare.

We have documented success in building the personal strength and sound values that equip young people to become competent and responsible adults, and an unequivocal commitment to assure that all girls can benefit from the experience we offer. And, we have a track record of success in collaborative efforts and programs with nationwide potential. A growing body of research validates the tremendous value of the Girl Scout experience. When young people have the opportunity to learn and practice leadership, communication, problem solving in an atmosphere that promotes the appreciation of diversity and a

commitment to values, they are less likely to succumb to negative pressures. The Girl Scout Violence Intervention Project, Operation Safe Neighborhood, Girl Scouts Beyond Bars are projects that have already demonstrated the unique and effective role we can play in countering the real and potential violence in their lives.

Girl Scouts of the U.S.A. is proposing a new model program that builds on the proven strengths of the Girl Scout Program and the successful violence intervention projects it already has in place. P.A.V.E. (Project Anti-Violence Education) the Way, a youth anti-violence project will be based on girls working in partnership with adult volunteers to meet community needs.

FROM STATEWIDE TO NATIONWIDE

P.A.V.E. the Way will empower a statewide coalition of the eleven Girl Scout councils in Missouri to create and implement comprehensive violence prevention and intervention programs in their respective communities. Using current national data, GSUSA will work with each of the councils to identify which indicators are most critical to address and then develop a plan to respond to compelling concerns. The development of these project plans would be guided by experts in the fields of youth development, crime prevention and project design including participation in comprehensive workshops and on-going collaboration with the national organization of Girl Scouts.

Girl Scout councils participating in P.A.V.E. the Way projects will be required to demonstrate broad, long-range community support for their efforts. This will necessitate collaborations with businesses, religious institutions, local law enforcement agencies, schools and other organizations with which a linkage is deemed important to project success.

Girl Scouts of the USA will:

- ▼ Provide experts to work directly with councils in the development of projects and evaluation tools.
- ▼ Develop basic resource kits for all councils.
- ▼ Assist Girl Scout councils targeting areas with youth who are at high risk for violent behavior or victimization.
- ▼ Assist Girl Scout councils in creating projects designed to counter the high risk factors identified in their communities.
- ▼ Prepare and distribute replication manuals to take the project nationwide.

- ▼ Evaluate the various approaches to violence prevention and select successful models for nationwide replications.

Girl Scout councils will:

- ▼ Foster long-term coalitions with other similarly motivated groups in their communities.
- ▼ Engage youth in activities that build resilience and the capacity to be leaders in positive community changes.
- ▼ Recruit and train adult volunteers.
- ▼ Provide conflict resolution tools for youth age 10 to 17.
- ▼ Assist youth in assessing community needs and develop service projects that engage adult volunteers and young people in addressing critical issues.

Key Project Components

- ▼ Community collaboration
- ▼ Education – activities will focus on interpersonal skill development, self esteem, conflict resolution alternatives to violence, and community responsibility
- ▼ Youth capacity building – girls will work in partnerships with adults to build skill
- ▼ Adult volunteerism – adults will be trained to act as leaders and partners with youth
- ▼ Community-service
- ▼ Expansion to other Girl Scout councils, in partnership with other organizations, to facilitate replication and adaptation

Projected Collaborations

National Crime Prevention Council
Office of the Juvenile Justice, Department of Justice

Proposed Budget \$1,100,000

Support to councils for state projects	\$550,000
Training conferences	\$50,000
Project Materials for statewide distribution to	
Girls	\$100,000
Adults	\$50,000
Professional honorariums	\$20,000
Replication Manual	\$30,000
GSUSA national support.....	\$200,000
Evaluation.....	\$100,000

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Theme issue: The Add Health Study

Add HEALTH: BACKGROUND AND OVERVIEW

By CHRISTINE A. BACHRACH

The National Longitudinal Survey of Adolescent Health, known as Add Health to its many friends and data users, began with a congressional directive in the 1993 NIH Revitalization Act. Congress instructed NICHD to:

Conduct a study for the purpose of providing information on the general health and well-being of adolescents in the United States, including, with respect to such adolescents, information on –

1. the behaviors that promote health and the behaviors that are detrimental to health; and
2. the influence on health of factors particular to the communities in which the adolescents reside.¹

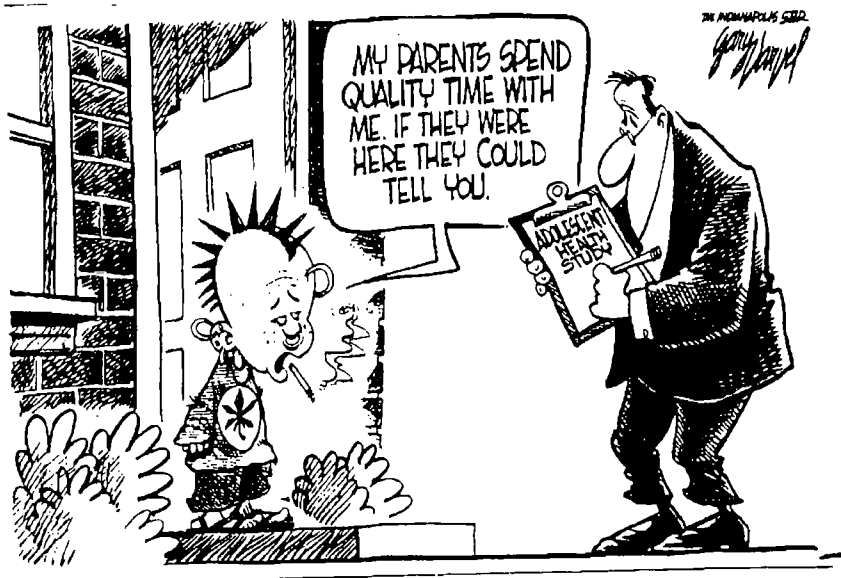
The directive to examine “factors particular to ... communities” was important. It coincided with a newly published report from the National Research Council² that highlighted the profound and deleterious changes in the environments shaping adolescents’ lives, and called for research on the ways in which these environments influenced health, development, and well-being. By

1993, much research had accumulated that examined adolescent health at the individual level, but few studies had examined the effects of families, peers, schools, and communities. Of those few that had, even fewer had measured the social environment directly, rather than through the perceptions of the adolescent. NICHD saw an opportunity to respond to the Congressional Directive and create a scientific resource that could truly advance our understanding of the social environmental factors that influence adolescent health.

In March 1994, NICHD awarded a grant to conduct the Add Health study to the University of North Carolina (UNC). The Principal Investigator was Dr. J. Richard Udry, Kenan Professor of Sociology and Maternal and Child Health. Dr. Udry had assembled a team of researchers from institutions all over the United

States: David Rowe of the University of Arizona, James Jaccard of the University at Albany (SUNY), Robert Blum and Michael Resnick of the University of Minnesota, John Billy and William Grady of Battelle, and Peter Bearman, Kathie Harris, Karl Bauman and others at the University of North Carolina. Adapting a model research design developed for an earlier study of teen sexual behavior, Udry and his colleagues proposed to carry out a comprehensive study of the effects of social context on adolescent health in the United States.

The Add Health design provided for a representative sample of youth



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¹ Public Law 103-43, Title X, Subtitle D, Section 1031, June 10, 1993.

² Panel on High Risk Youth, CBASSE. *Losing Generations: Adolescents in High-Risk Settings*. Washington D.C.: National Academy Press, 1993.

Christine Bachrach is Chief, Demographic and Behavioral Sciences Branch, National Institute of Child Health and Human Development, National Institutes of Health.

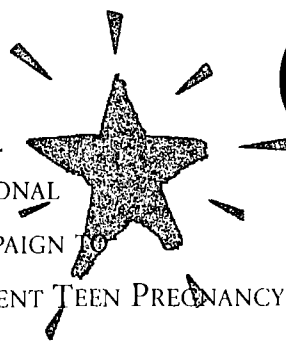
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THE
NATIONAL
CAMPAIGN TO
PREVENT TEEN PREGNANCY



Campaign

Update

SUMMER 2000

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New Campaign Publications on Contraception

Our first priority should always be to encourage teens to delay sexual activity — to protect their physical health, their emotional health, and their opportunities for the future. In fact, the vast majority of parents and teens believe that school-age teens should remain abstinent. However, no matter how much support we give young people to say “no,” many will still become sexually active. And most parents and teens agree that sexually active teens should have access to contraception so that they will be protected from pregnancy and disease.

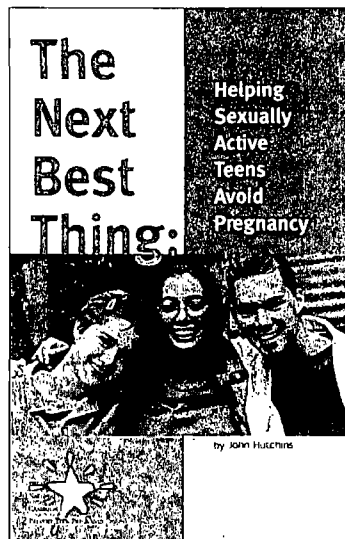
The National Campaign has recently published *The Next Best Thing: Helping Sexually Active Teens Avoid Pregnancy*, by John Hutchins, a reader-friendly pamphlet that highlights what the National Campaign considers the most compelling issues in the challenge to convince sexually active teens to use contraception consistently and carefully. Based on research and on what the National Campaign has learned from talking

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to parents, teens, and professionals around the nation, *The Next Best Thing* makes a number of observations, including:

- Teaching teens about contraception does not make them more likely to have sex.
- Giving sexually active teens access to contraception is necessary but not sufficient. Teens must be highly motivated to protect themselves.

continued on page 8



INSIDE:

Teens need their parents as much as toddlers do...
see pg. 10



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Lachyman

The impact of caring and connectedness on adolescent health and well-being

M. D. RESNICK,¹ L. J. HARRIS² and R. W. BLUM³

¹Division of Health Management and Policy, ²National Adolescent Health Resource Centre and ³Division of General Pediatrics and Adolescent Health, University of Minnesota, Minneapolis, Minnesota, United States

Abstract This study of over 36 000 7th–12th grade students focused on protective factors against the quietly disturbed and acting out behaviours, which together represent the major social morbidities of adolescence. Multivariate models developed separately for girls and boys repeatedly demonstrated the protective function of caring and connectedness in the lives of youth, particularly a sense of connectedness to family and to school. A sense of spirituality, as well as low family stress (referring to poverty, unemployment, substance use and domestic violence) also functioned as protective factors. Measures of caring and connectedness surpassed demographic variables such as two parent vs single parent family structure as protective factors against high risk behaviours. Interventions for youth at-risk must critically examine the ways in which opportunities for a sense of belonging may be fostered, particularly among youth who do not report any significant caring relationships in their lives with adults.

Key words: adolescent health; caring; protective factors; resiliency.

Numerous reports have documented the shift from biological to social causes of morbidity and mortality among adolescents. These trends belie the traditional view that adolescence is a time of optimal health and well-being.^{1–7} Other trends, particularly the rising proportion of children and adolescents living in poverty, patterns of school drop out and poor school performance, disaffection, alienation, and the pervasive impact of racism and limited economic opportunities lend urgency to the need for communities to respond to the health and social needs of their youth, and for policy makers and funders to help assure a better fit between health and social programmes and the youth problems they are intended to address.^{8–16}

In 1986, a National Invitational Conference on the Health Futures of Adolescents was convened with support from the Maternal and Child Health Bureau in Washington DC. The goal of that conference was:

to identify the major health related concerns that will face youth through the year 2000, delineate the present state of knowledge in each of the major issues, and develop a blueprint for the next 15 years for research, demonstration programming and training.¹⁷

The report on that conference which was published in the November 1988 supplement of the *Journal of Adolescent Health Care* featured the recommendations of seven work groups, compiled from the 136 experts participating in the conference from the fields of public health, medicine, clinical and developmental psychology, social ecology and health education, nursing nutrition, sociology and social work. One key recommendation which cross-cut the work group reports was the need for development of comprehensive population-based studies of

adolescent health problems, concerns, risk behaviours and resiliency so that prevention and intervention programmes could be responsive to the most salient issues affecting youths within communities. Further, it was recommended that interventions aimed at promoting adolescent health and reducing risk behaviours respond to the clustering of those behaviours, with an understanding that social morbidities tend to co-occur, contrary to the assumptions of narrowly defined categorical programmes.¹⁸ On an international scale, the same proposal was incorporated as a top priority in the recommendations of the Scientific and Technical Advisory Group to the Adolescent Health Section of the World Health Organization. This recommendation emphasized the value of developing comprehensive, population based studies of adolescent health and risk behaviours so that communities, states and nations could prioritize among adolescent health issues, identify protective factors that reduce the likelihood of health compromising behaviours, and move effectively to promote the well-being of adolescents at greatest risk.¹⁹

In the United States, the Maternal and Child Health Bureau funded a major initiative called the Adolescent Health Database Project, to demonstrate the feasibility of establishing a statewide database of health status indicators, risk behaviours, and adolescent health concerns. This project enabled the development, testing, and widespread use of a standardized instrument (the Adolescent Health Survey) in order to develop a comprehensive adolescent health database for programme and policy development, planning and research purposes. The survey has been administered to over 60 000 adolescents nationally, including statewide surveys in Minnesota, Alaska, Delaware, and a national survey of rural, reservation based American Indian youth. The purpose of this comprehensive assessment of adolescent health, risk behaviours and resiliency factors is to provide valid, timely information to key decision makers and information users, including legislators, health, social service,

and education professionals, youth workers, parents, and others involved with or on behalf of youth.

The primary vehicle for dissemination of information obtained from these surveys has been the development of local feedback reports to each participating school or community, as well as publications designed for professional, scholarly audiences.²⁰⁻²⁷ These have been augmented by the development of numerous specialty reports in the form of monographs that have been distributed to thousands of decision makers at the state, regional, national and international levels.²⁸⁻³³ Data from the Adolescent Health Survey have been utilized for advocacy, curriculum, programme and policy development at the state and national levels, and for grant writing by community based agencies that have utilized the survey data to identify key health issues among adolescents, prioritize among them, and seek funding to initiate or further develop services for youth.

More recently, attention is being turned to analyses of these large scale datasets that focus on *resiliency* and *protective factors* in the lives of young people. Much of scientific inquiry in adolescent health has traditionally focused on the correlates of problemness or pathology. Here, a focus on resiliency means that inquiry is directed toward understanding *success* and *well-being*, identifying those factors that buffer against the stresses of everyday life that might otherwise result in adverse physical, social or psychological outcomes for youth.³⁴⁻³⁸ Longitudinal studies of resiliency have incorporated biological, psychological, familial, and broader social variables into models that predict who, in adolescence or adulthood will be characterized by high functional effectiveness and life satisfaction. A repeated finding in these analyses has been the centrality of caring relationships between children and adults, including relationships within and outside the family, for the development of resilient adolescents and young adults.^{39,40}

This focus on caring as a protective factor presents an important direction for programmes, policy and practice. The shift toward social morbidities among young people means that the major threats to their health and well-being are increasingly rooted in the organization, economics, opportunities and expectations of everyday life. This means that the search for protective factors against a variety of adverse outcomes must include an understanding of adolescents' social relationships and feelings of connections to others as they experience and live the developmental changes of their physical, social and psychological selves. Unfortunately, the presence of nurturing relationships between adults and children cannot be treated as a given. Rather, problems stemming from youth disaffection and alienation are seen as a growing by-product of post-modern society. Sociologist Phillip Slater made the observation over 20 years ago that three human desires are deeply and uniquely frustrated by Western culture.⁴¹ These include:

(1) The desire for *community*—the wish to live in trust and fraternal co-operation with one's fellows in a total and visible collective entity.

(2) The desire for *engagement*—the wish to come directly to grips with social and interpersonal problems and to confront on equal terms an environment which is not composed of ego-extensions.

(3) The desire for *dependence*—the wish to share responsibility for the control of one's impulses and the direction of one's life.

Reflecting these sentiments, Michael Lerner describes the misguided emphasis on individuality in Western culture, which, like Slater, he regarded as frustrating the deeply felt yearning for

connectedness between people, working to create meaning and happiness in the context of an interdependent community of human beings.⁴²

With these perspectives as a framework, the current analysis focuses on the experience of caring and connectedness as protective, nourishing factors in the biographies of young people. Put another way, does the experience of caring, and the feeling of connectedness to others demonstrably result in greater well-being, and correspondingly less health compromising behaviours among teenagers? This report describes recent secondary analyses of the Minnesota Adolescent Health Survey, including an examination of protective factors against two clusters of risk behaviours (acting out behaviours and quietly disturbed behaviours) that characterize the predominant morbidities of youth.

METHODS

The datasource for this analysis is the Minnesota Adolescent Health Database, derived from a sample of 36 254 7th–12th grade public school students throughout Minnesota who completed the Adolescent Health Survey. This comprehensive questionnaire elicits self-report information from adolescents in the following areas: demographic and biographical data; relationships with family, friends and other adults; school performance and conduct; personal worries and concerns; body image; help seeking and utilization of services; nutrition and eating behaviour; disordered eating; sexual behaviours; sexual orientation; substance use; mental health and suicidal involvement; physical and sexual abuse; anti-social behaviours; other risk-taking behaviours.

Questionnaire development, content, and psychometric properties of scales and indices are described in other publications.^{20,21,23-28} Schools were selected through a multi-stage stratified cluster sampling design, stratified by school district size, with random sampling occurring within each stratum for each grade level. In each school, all students within designated grades were asked to complete the questionnaire within a classroom setting. Trained survey administrators were available to answer questions, to ensure standardized test administration, and to protect confidentiality.

Scales and risk behaviour clusters

Initial work on the dataset focused on development and refinement of measures to be used in subsequent analyses related to caring and connectedness. Standard data reduction and scaling techniques were used to develop psychometrically robust indicators of key constructs including six separate measures related to caring as well as aggregated scales of caring and connectedness. These measures were tested for internal consistency, construct validity and examined for their distributional properties. Final, usable scales and indicators were created as both continuous and ordinal measures, to facilitate their use in cross-tabular form and in multivariate analyses (Harris, L., Resnick, M. D., Rosenwinkel, K., and Blum, R. W., Technical Report on the Adolescent Health Survey: Psychometric Properties of Scales and Indices. Minneapolis: University of Minnesota Adolescent Health Training Program, 1990, unpubl. data).

Drawing upon theoretical and empirical work that has identified the co-occurrence of high-risk behaviours among adol-

escents, composite variables were created to tap the major morbidities of adolescents as behavioural clusters.^{13,43–46} Nine individual scales were subject to factor analysis, identifying two broader clusters of risk behaviours, each with factor loadings of 0.5 or greater (noted in parentheses after each variable name). These clusters included *Acting Out Behaviours* and *Quietly Disturbed Behaviours*. Acting out behaviours included poly-drug use (0.737), school absenteeism (0.684), risk of unintentional injury (0.677), (e.g. drinking and driving, not wearing seatbelts, use of motorcycles or all-terrain vehicles without a helmet, driving in the back of open pick-up trucks), pregnancy risk (0.606), (including risk of either becoming pregnant or causing a pregnancy, based on a scaled combination of frequency of sexual intercourse and type and frequency of contraceptive use), and delinquency risk (0.556). Quietly disturbed behaviours included poor body image (–0.800), disordered eating (0.785), (binging, deliberately vomiting as a strategy for weight loss, chronic dieting, fear of loss of control of eating), emotional stress (0.686), and suicidal involvement (0.514), (ideation or actual attempts). Generally, boys were more characterized by the acting out behaviours, girls by the quietly disturbed behaviours, although there was cross-over by gender, particularly among girls. For example, of those girls who exhibited two or more quietly disturbed behaviours, 80% were at high risk for at least one acting out behaviour. Of those engaging in two or more acting out behaviours, 65% also engaged in at least one quietly disturbed behaviour. Some 80% of students fell into the high-risk category for at least one of the behaviours, with about 10% at high-risk for four or more behaviours.

With the completion of scale development and assessment of the clustering of high-risk behaviours, the identification of protective factors for each cluster was accomplished through the development of four discriminant function models, permitting a multivariate identification of variables that best sort or differentiate comparison groups. Protective factors were separately assessed for boys and girls against each of the two clusters of high risk behaviours. Particular attention was directed to the presence of measures of caring and connectedness as salient protective factors across each of these analyses. It was hypothesized that in comparison with demographic variables, the indicators related to caring and connectedness would emerge as more powerful protective factors against high-risk behaviours.

RESULTS

Results are presented for the four stepwise discriminant models which describe protective factors in the order of their explanatory power. As noted in Table 1, a common set of factors in each of the four discriminant models related to various aspects of connectedness. As hypothesized, these measures were more powerful protective factors than demographic variables against both clusters of high-risk behaviours, for both boys and girls.

Among girls, the most powerful protective factor against the quietly disturbed behaviours was family connectedness, referring to adolescents who indicated they enjoyed, felt close to and cared for by family members. This variable alone explained 12.5% of variance in group classification. School connectedness, the second explanatory variable in the stepwise equation, referred to students who enjoyed school, experiencing a sense of belonging and connectedness to it (which did not always correspond with high academic performance). Family stress,

the third explanatory variable, was a composite measure of parental unemployment, poverty, domestic violence, and parental substance use, with low family stress functioning as a protective factor. Spiritual connectedness referred to those students who defined themselves as spiritual or religious individuals. The last factor, age, was positively related to risk, with younger adolescents indicating less involvement in quietly disturbed behaviours than their older counterparts. Together, these five variables correctly classified 71.8% of adolescents, including close to 9 in 10 of those at low risk for quietly disturbed behaviours (Table 2).

A similar set of explainer variables functioned as protective factors against the acting out behaviours for girls, as described in Table 3. In addition, the last variable to remain in the stepwise model indicated that girls in two parent families were less likely than those in single parent families to be involved in acting out behaviours. These five variables correctly classified 71.2% of girls, including close to 8 in 10 at high risk for acting out behaviours.

Among boys, three protective factors against the quietly disturbed behaviours were identified, including family connectedness, school connectedness, and low family stress. These

Table 1 Protective factors against acting out and quietly disturbed behaviours for girls and boys

Acting out behaviours Protective factors for girls	Quietly disturbed behaviours Protective factors for girls
School connectedness	Family connectedness
Younger age	School connectedness
Family connectedness	Low family stress
Religious/spiritual connectedness	Religious/spiritual connectedness
Low family stress	Younger age
Two parent family	
Protective factors for boys	Protective factors for boys
School connectedness	Family connectedness
Family connectedness	School connectedness
Religious/spiritual connectedness	Low family stress
Younger age	
Low family stress	
Two parent family	

Table 2 Stepwise summary of protective factors against quietly disturbed behaviours for girls

Quietly disturbed behaviours	Wilk's lambda	Significance	Stand. coeff.
Family connectedness	0.875	0.000	0.77952
School connectedness	0.860	0.000	0.27358
Low family stress	0.853	0.000	–0.23513
Religious/spiritual connectedness	0.849	0.000	0.19494
Younger age	0.845	0.000	–0.17490
Prediction results for quietly disturbed behaviours—females			
Actual group	Low-risk group		High-risk group
Low risk for quietly disturbed behaviours	531	88.5%	69 11.5%
High risk for quietly disturbed behaviours	190	60.1%	126 39.9%
Overall correct group classification: 71.8%			

Table 3 Stepwise summary of protective factors against acting out behaviours for girls

Acting out behaviours	Wilk's lambda	Significance	Stand. coeff.
School connectedness	0.904	0.000	0.53162
Younger age	0.844	0.000	-0.53705
Family connectedness	0.815	0.000	0.26806
Religious/spiritual connectedness	0.800	0.000	0.25709
Low family stress	0.790	0.000	-0.16463
Two parent family	0.785	0.000	0.16346
Prediction results for acting out behaviours—females			
Actual group	Low-risk group		High-risk group
Low risk for acting out behaviours	244	60.7%	158 39.3%
High risk for acting out behaviours	105	20.6%	405 79.4%
Overall correct group classification: 71.2%			

Table 4 Stepwise summary of protective factors against quietly disturbed behaviours for boys

Quietly disturbed behaviours	Wilk's lambda	Significance	Stand. coeff.
Family connectedness	0.938	0.000	0.79544
School connectedness	0.923	0.000	0.41262
Low family stress	0.916	0.000	-0.30368
Prediction results for quietly disturbed behaviours—males			
Actual group	Low-risk group		High-risk group
Low risk for quietly disturbed behaviours	621	72.0%	242 28.8%
High risk for quietly disturbed behaviours	34	36.0%	61 64.0%
Overall correct group classification: 71.2%			

Table 5 Stepwise summary of protective factors against acting out behaviours for boys

Acting out behaviours	Wilk's lambda	Significance	Stand. coeff.
School connectedness	0.911	0.000	0.67260
Family connectedness	0.889	0.000	0.27990
Religious/spiritual connectedness	0.875	0.000	0.29284
Younger age	0.864	0.000	-0.22208
Low family stress	0.858	0.000	-0.16725
Two parent family	0.855	0.000	0.14786
Prediction results for acting out behaviours—males			
Actual group	Low-risk group		High-risk group
Low risk for acting out behaviours	233	64.9%	126 35.1%
High risk for acting out behaviours	153	33.5%	304 66.5%
Overall correct group classification: 65.8%			

correctly classified 71.2% of boys overall, including 72% of those at low risk for quietly disturbed behaviours, and 64% of those at high risk.

The final discriminant model for acting out behaviours in boys included the full set of variables found in the girls' model for this behaviour cluster. School connectedness was the single most powerful variable in the equation, with two parent family entering as the last explanatory variable in the model.

DISCUSSION

Protective factors were identified for quietly disturbed and acting out behaviours, representing two clusters of health compromising behaviours that encompass the major social morbidities of adolescents. Separate analyses were conducted for boys and girls. Across all four models, measures of caring and connectedness predominated as protective factors. While family structure and socio-economic status are both prominent in popular explanations of high-risk behaviours among youth (expressed most frequently as concern about the 'breakdown' of families and family values, particularly among resource-deprived families), socio-economic status did not remain in any of the models, meaning that adolescents could not be differentiated as low or high-risk for quietly disturbed and acting out behaviours on the basis of their families' socio-economic status, after the preceding variables were taken into account. As far as two parent vs single parent status was concerned, two parent family composition proved to be the weakest, though significant, explanatory variable in the models describing protective factors against the acting out behaviours. Results indicated that boys and girls from two parent families were somewhat less likely to be involved in such behaviours than their counterparts from single parent families.

The most powerful protective factors across models were family and school connectedness. What is striking about the family connectedness variable is that this factor referred to a sense of belonging and closeness to family, in whatever way family was comprised or defined by the adolescent. Thus, the centrality of families in the promotion of well-being among young people was reaffirmed, but without specifying the form or composition that families must take in order to serve this protective function. At the core of family connectedness is the adolescent's experience of being connected to at least one caring, competent adult in a loving, nurturing relationship. Similar results have been reported by investigators assessing resiliency and well-being among youth who otherwise would be expected to be at high risk for multiple adverse health and social outcomes.⁴⁷⁻⁵²

School connectedness was the most salient protective factor for both boys and girls against the acting out behaviours, second in importance after family connectedness for the quietly disturbed behaviours. These findings underscore the importance of schools as a primary source of connectedness with adults, and with the broader community as perceived and experienced by the adolescent. The analysis does not reveal whether a sense of connectedness with school resides in relationships with particular teachers, coaches, or other personnel, or through a generalized feeling of belonging within the overall school environment. With school connectedness superseding family connectedness as a protective factor against the acting out behaviours, we infer that schools can and do play a vital role in

reducing the likelihood of health-jeopardizing behaviours among girls and boys by providing a sense of belonging that may not also be provided by other sources such as family or peers. Supporting this inference from cross-sectional data is the fact that academic remediation is foremost among intervention strategies directed at reducing the risk of such acting out behaviours as teenage pregnancy and juvenile delinquency.^{10-12,53,54} But the findings also suggest that academic performance is but one component of this sense of connectedness, since the underlying construct was composed of both an indicator of typical school performance and attitude toward school. Thus, for students who may not be academically proficient, and for whom there may be only marginal room for improvement, it is particularly important that schools provide vehicles that promote a sense of belonging, by providing opportunities to develop and demonstrate other forms of competency, including work-study, technical skills, and involvement in visual, musical and dramatic arts. The salience of school connectedness as a protective factor against adolescent high-risk behaviours strengthens the arguments of educators, health officials, and youth advocates that there must be closer collaboration between the health and education sectors in order to promote both the well-being and educability of young people.^{10,55,56}

The importance of religious or spiritual connectedness in these multivariate assessments is consistent with other analyses that have demonstrated that adolescents who describe themselves as more religiously observant or affiliated with religious institutions are less likely to engage in high-risk behaviours than their counterparts.⁴³ This finding suggests the important roles that parents and religious institutions can play in fostering spirituality in young people, as well as a sense of belonging and connectedness with religious institutions which can enable positive peer and adult relationships and social experiences.⁵⁷

There are important research questions that flow from these analyses. Specifically, at what point in the life trajectory of an adolescent are the protective effects of caring and connectedness simply too late? In other words, if a young person has been socialized in a climate of uncertainty, fear and disaffection, can adult connectedness, positive environmental consistency, and the nurturance of confidence and competence, which are all the hallmarks of successful interventions, overcome the impetus toward distress and self-destructive behaviours? Paediatrics as a field has always maintained that early intervention is preferable over addressing serious needs after-the-fact. In public health, primary prevention is far superior to secondary prevention, given the opportunity for early identification and intervention with people at risk. So, for health and social service professionals, educators, youth workers and parents, the critical intervention question becomes: in the absence of opportunities or initiatives for primary prevention of the social morbidities of youth, what 'package' of interventions will be most effective beyond the point of primary prevention, when young people have already embarked on behaviours that seriously increase the likelihood of 'rotten outcomes'? We know from the literature on programmes for youth at risk, that for interventions to successfully deter adolescents away from destructiveness and lowered lifelong effectiveness, the intervention must be as intense as the need itself.⁹ Our analyses indicate that fostering a sense of caring and connectedness between adolescents and adults should be an integral part of interventions designed to promote resiliency and protective factors, increase adolescents' competency and effective functioning, and promote a sense of meaningful place in the world. How this should best be done for

very high-risk youth populations, in our view, frames the pre-eminent human services delivery questions for the 1990s. Such questions are reminiscent of the treatment-outcome models generated in pharmacy, medicine, and mental health research over the past decade: what kinds of interventions or experiences, provided to which group of adolescents, result in optimal outcomes? In other words, what works best with whom?

While these analyses identify caring and connectedness as essential components of health promotion, we recognize, as Mechanic recently noted, that love alone cannot rectify a lifetime of neglect.⁵⁸ Caring, while extraordinarily important in the lives of young people, is not a substitute for correcting fundamental threats to health, rooted in the economic disparities that have become increasingly manifest due to both deliberate government policies and a shifting economic infrastructure that strains the ability of families and individuals to thrive or function. In fact, the sense of disaffiliation of growing numbers of young people, noted with alarm by many commentators,¹⁸ is accentuated by trends in the economy which make it increasingly harder for families to earn sufficient income with benefits, to meet the costs of housing, food, and everyday living. Our models point to the protective function of low family stress, and each of the elements of family stress measured within this construct, including unemployment, substance abuse and domestic violence, are directly associated with economic deprivation. Once deficits in connectedness as well as heightened levels of family stress were adjusted or accounted for, socio-economic status did not enter into the multivariate assessments of protective factors against health-compromising behaviours. But lifting families out of poverty remains a most feasible strategy for health promotion that can be addressed on the policy level. As an age group, economic hardship is most keenly felt by the young. Recently released Census Bureau data in the United States underscore the widening economic gap between old and young people spawned during the 1980s, showing that, as a group, elderly people generally held their own during the economic fluctuations of the decade, while the nation's children increasingly slipped into poverty. Of those who became poor in the decade of the 1980s, 25% were under 18 years of age, while one in 25 was age 65 or older, owing in good measure to the indexing of Social Security payments to inflation⁵⁹ and the fact that the United States made a deliberate decision to eliminate poverty in a large proportion of the elderly population through age-related entitlements. No similar commitment has been made to children and youth.

The need for redress of this economic disparity was clearly articulated in the United States by the National Commission on Children in its call for progressive economic policies that would benefit children, youth, and families.⁶⁰ This bipartisan proposal represents an important step beyond the popular political rhetoric that explains poverty and its accompanying morbidities for children and youth with a conservative moral determinism that exclusively blames those at highest risk for their own predicament, with the accompanying assertion that as far as remedy is concerned, 'nothing works'.⁶¹ But the salience of caring and connectedness as protective factors against the social morbidities of adolescents also suggests that more than an economic determinism is needed to promote adolescent health and well-being. We maintain that while reducing the prevalence of poverty must remain an enduring goal for pro-child and pro-family policy, those who craft and implement interventions to reduce the quietly disturbed and acting out behaviours must also deliberate on how and whether the

elements of their interventions address the underlying need for adolescent *belonging*. With the urge toward connectedness representing one of our deepest human desires,⁴² caring as a conscious, explicit quality must pervade the people and programmes that seek to optimize the life course of adolescents, particularly those at highest risk.

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