2018

PARENT AND ADOLESCENT REPORTS OF RISKY BEHAVIOR AND THEIR RELATIONSHIP WITH PARENTAL MONITORING IN BLACK SOUTHERN FAMILIES

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PARENT AND ADOLESCENT REPORTS OF RISKY BEHAVIOR AND THEIR RELATIONSHIP WITH PARENTAL MONITORING IN BLACK SOUTHERN FAMILIES

BY

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

IN

PSYCHOLOGY

UNIVERSITY OF RHODE ISLAND
2018

MASTER OF ARTS THESIS

OF

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2018

ABSTRACT

The purpose of this study was to explore the relationship between perceived parental knowledge, perceived parental monitoring and risky behaviors among rural Black adolescents in the United States. The health-risk behaviors of concern were sexual behavior, drug and alcohol usage, and violence. Using a sample of 62 Black parent and adolescents from rural communities, parents' perceptions of adolescent risk behaviors were compared with adolescent reports of risky behaviors. Additionally, the relationship between parental monitoring and knowledge, relative to adolescent self-reported risk was examined. Results indicated that parents possessed a high accuracy regarding their adolescent's engagement in sexual activity, violent behaviors and drug and alcohol use. Parental monitoring however did not predict adolescent engagement in sexual intercourse, violence, drugs, and alcohol use or combined risk.

ACKNOWLEDGMENTS

I would like to say thank you to my major professor, Dr. Gary Stoner for his guidance through this process. His motivation and continued support helped me persevere and facilitated my growth as a researcher. I would also like to thank my thesis members, Dr. Kathleen Gorman and Dr. Bryan Dewsbury, for their support. Thank you for being available and providing thoughtful feedback.

A special thank you goes to all the parents and adolescents that participated in this study. This project would not have been possible without you. Also, a big thank you to all of the organizations and people who helped me in the recruitment process.

I would like to say an extra special thank you to my family. Your support and your prayers have been unwavering. To my parents, thank you for the support both emotionally and financially throughout the years. And a final thank you to Erin and Jen, the JET Plan for Success.

DEDICATION

I dedicate this project to my mother, Inita Davis, who has always pushed me to do my best, work harder, and never give up. Your strength has made me who I am today, and without you, this would not be possible. Mom, thank you for only being a phone call away and telling me what I needed to hear.

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CHAPTER 1

INTRODUCTION

Statement of the Problem

The developmental period of adolescence is marked by a rapid change in cognitive development, parental and peer relationships, and emerging sexuality (Hill & Tyson, 2009; Santrock, 2012). Adolescence and middle school provides new opportunities to engage in risky behaviors. The initiation of risk behaviors during this developmental period can have critical effects on the future of adolescents. For example, early initiation of sexual behaviors often leads to: increased likelihood of having multiple sex partners in within the last year, using alcohol/drugs during sexual intercourse, unprotected sex during most recent sexual experience, and unintended pregnancy (Sandfort, Orr, Hirsch, & Santelli, 2008; Kaplan, Jones, Olson, & Yunzal-Butler, 2013).

Notably, the consequences of engagement in risky behaviors are different for Black adolescents as compared to White adolescents engagement. For example, Black females are more likely than White females to contract gonorrhea and chlamydia (CDC, 2009). There also are racial differences in the use of alcohol and drugs. African American adolescents engage in less alcohol use but higher marijuana use (Lewis et al., 2011). Additionally, African American adolescents appear to experience bullying and violent behaviors at rates that are different from their White adolescent counterparts. One study suggests that African American adolescents report bullying at rates that were almost three times than some national studies (Fitzpatrick, Dulin & Piko, 2007). In addition to differences in rates of risky behavior among youth of different backgrounds, it also is important to consider potential differences as a function of geographic contexts.

Rural America has often been stereotyped as a place free from urban problems such as drug abuse, crime, and poverty (Brown & Waite, 2005). Some recent studies have challenged that perception. Geographic differences are observed in risky sexual behaviors and substance use. For example, teen birth rates are higher in rural counties compared to urban and suburban areas (The National Campaign, 2013). Other studies show an increase in substance use among adolescents living in rural areas (Lambert, Gale, & Hartley, 2008).

In addition to recognizing risky adolescent behavior it also is important to recognize the role that parents may play in prevention of such behavior. For example, parental monitoring has been shown to be a protective factor against engagement in risky behaviors (Crouter & Head, 2002; Li, Feigelman, & Stanton, 2000; Lippold, Coffman, & Greenberg 2013; Lippold, Greenberg, & Feinberg, 2011). However most studies examining parental monitoring have been conducted with youth who live in urban areas. It is less clear if parental monitoring can be viewed as a protective factor against engagement in risky behaviors for minority youth living in rural communities.

Adolescence and adolescent development

Adolescence is a transitional period of development that begins at approximately 10 to 12 years of age and concludes around 18 to 22 years of age (Santrock, 2012). Adolescents encounter changes in biological and cognitive development, relationships with parents and friends, and the emergence of sexuality (Hill & Tyson, 2009; Santrock, 2012). Puberty, which is a rapid period of physical maturation that involves hormonal and bodily changes, signals the beginning of adolescence (Santrock, 2012). The average pubertal sequence for males begins as early as age 10 or as late as age 13 ½ and may end

at age 13 through 17 (Santrock, 2012). For females, puberty can begin between the ages of 9 and 15 (Santrock, 2012). The developmental period of adolescence typically alters the parent-child relationship (Bakken & Brown, 2010; Santrock, 2010), as adolescents push for autonomy or independence away from their parents, which can lead to parent-adolescent conflict (Santrock, 2012). Parent-adolescent conflict escalates during early adolescence and remains moderately stable during high school years (Santrock, 2012).

Adolescents and participation in middle school

Participation in middle school is a critical stage in development for adolescents. The transition from elementary to middle school is abrupt and dramatic. Adolescents transition from being the oldest age group in elementary school to becoming the youngest group in middle school, which is known as the top-dog phenomenon (Santrock, 2012). Perceived social support from teachers, peers, and parents has a major impact on early adolescents. And, perceived parental support has been linked to school-related interest and academic goal orientation for middle school students (Wentzel, 1998). Adolescent perceptions of teacher support in middle school has been linked to class interest and the pursuit of social responsibility (Wentzel, 1998). And finally, perceived peer support has been shown to positively predict prosocial goal pursuit (Wentzel, 1998). Unfortunately, research has found that perceived social and teacher support has been found to decline during the transition to middle school (Martínez, Aricak, Graves, Peters-Myszak, & Nellis, 2011).

Adolescents and risky behaviors

According to the Centers for Disease Control and Prevention (2015), six health-risk behaviors contribute to the leading causes of death, disability, and social problems

among adolescents in the United States. These six health-risk behaviors are: unintentional injuries and violence, sexual behaviors, alcohol and other drug use, tobacco use, unhealthy dietary behaviors, and inadequate physical activity. For the present project, the health-risk behaviors of concern are sexual behavior, drug and alcohol usage, and violence, which are discussed in turn in the following sections.

Sexual behavior

One risk factor associated with poor adolescent outcomes is early sexual behavior. Early sexual behavior is defined as having sexual intercourse before the age of 14 (Kaplan et al., 2013). Youth who engage in early sexual behavior are more likely to engage in other risky sexual behaviors (Kaplan et al., 2013; Sandfort et al., 2008). Early sex is associated with having multiple sex partners in within the year, using alcohol/drugs during sexual intercourse, not using a condom during last sexual experience, unintended pregnancy, having a sexual partners that was over 21 years old, being forced to have sex and physical dating violence (Sandfort et al., 2008; Kaplan et al., 2013).

Black adolescents appear to be affected by the negative consequences of risky sexual behaviors more than their White counterparts. Urban Black and Hispanic adolescents who engaged in sexual intercourse before the age of 15 are more likely to: not use contraceptives, have multiple sexual partners, higher frequency of sexual intercourse, have been pregnant or impregnated someone and have a child (Smith, 1997). Black females are more likely than White females to contract gonorrhea and chlamydia (CDC, 2009). In 2015, birth rates of Hispanic and Black teens were more than twice as high as White teens (Martin, Hamilton, Osterman, Driscoll & Mathews, 2015). Literature additionally suggests that young black males are disproportionately more likely to

become infected with HIV (CDC, 2011) and STIs (CDC, 2014). Variations in risky sexual behavior have additionally been noted across different geographic regions.

Research indicates that risky sexual behavior is increasing in rural communities (Milhausen et al., 2003). The CDC (2000) reported outbreaks of HIV in a small rural town in Mississippi where the median age for HIV-infected females was 16 years old. In New York (1999), a similar outbreak was observed in a rural part of the state. Geographic differences can additionally be observed in teen pregnancy. Teen birth rates are higher in rural counties compared to urban and suburban areas (The National Campaign, 2013). The southern United States currently contains the highest number of teen pregnancy (Kost & Henshaw, 2014).

Drug and Alcohol Use Among Adolescents

A second critical risk factor among adolescents is drug and alcohol use. According to Johnston, O'Malley, Bachman & Schulenberg (2011), substance use among US adolescents is a public health concern because rates remain high and substance initiation, or the introduction of substances, occurs early. Research has found that adolescents can be initiated to substances as early as 13 years old (Johnston et al., 2011). In 2011, Johnston and colleagues found that 16% of 8th graders reported used marijuana at least once, 13% in the prior year, 7% in the prior month, and 1.3% reported daily usage. This study additionally found that 33% of 8th-grade students reported using alcohol in their lifetime and roughly 13% reported being current consumers of alcohol (Johnston et al., 2011).

Early alcohol initiation is linked to risky sexual behaviors in adolescents. Stueve and O'Donnell (2005) found that those who were initiated to alcohol early were more likely to report alcohol problems, multiple sexual partners, unprotected sexual

intercourse, being under the influence of drugs or alcohol during sexual intercourse, and pregnancy. Increased peer alcohol use and alcohol offers are associated with an increase of drinking and drinking-related activities (Schwinn & Schinke, 2014).

Previous research also has found that African American adolescents report lower substance use rates than their non- African American counterparts (Gil, Wagner, & Tubman, 2004). In a study that examined the prevalence of substance use among adolescents researchers found that 60.6 percent of White adolescents reported a prevalence of lifetime alcohol use compared to 46.5 percent of Blacks (Goings, Buttler-Bente, McGovern & Howard, 2016). With that being said, literature suggests that across all racial and ethnic groups substance use increases during adolescence (Harris, Gordon-Larsen, Chantala & Udry, 2006). Lewis et al., (2011), studied substance use among African American adolescents and found lower alcohol use but higher marijuana use in the sample versus a nationwide sample of youth.

As seen with risky sexual behavior, the literature suggests that there are variations in substances use across geographic regions. Lambert, Gale, and Hartley (2008) conducted a study that examined substance use among adolescents and young adults across four geographic regions. The researchers found that rural youth ages 12 to 17 reported higher rates of alcohol, cocaine, inhalants and methamphetamine use than urban youth in the past year. The study also found that rates of binge drinking increased with the degree of rurality. It was also found that rural youth were more likely to have driven under the influence of alcohol or drugs in the past years.

Violence/Bullying

A third significant risk factor among adolescents is violence. Nansel, Overpeck, Haynie, Ruan, and Scheidt (2003) found that being bullied or bullying was consistently related to carrying a weapon, carrying a weapon in school, fighting and being injured in a fight. In schools, adolescents face interpersonal conflicts that include physical violence or the more subtle form of interpersonal conflict that elicits psychological and emotional harm (Batsche, 1997). Relational aggression is defined as, "behaviors that harm others through damage to relationships or feelings of acceptance, friendship or group inclusion" (Crick, Casas, & Ku, 1999). Physical aggression involves behaviors that result in bodily injuries.

Research indicates that school bullying is becoming a major issue for youth, especially in middle school. In 2011 it was estimated that 28% of students in grades sixth through twelfth experienced bullying (Lessne & Harmalkar, 2011). Bullying has been found to occur with greater frequency among middle school students (6th -8th grade) than high school (9th-10th grade) aged youth (Nansel et al., 2001). Males typically experience verbal and physical bullying while females typically experience verbal bullying (taunts and rumors) (Horowitz et al., 2004). Horowitz et al. (2004) found that students are typically teased and bullied in regards to four categories: physical appearance, personality and behavior, family and environment, and school-related factors. Across all four categories, "Being different in any way" was a common theme for being bullied (Horowitz et al., 2004).

In terms of ethnic and racial differences in bullying and violent behaviors the research is less clear. For example, Fitzpatrick and colleagues (2007) examined the

prevalence of bullying among urban African American adolescents and found that African Americans reported bullying at rates that were almost three times higher than some national studies. Conversely, research by Koo, Peguero, and Shekarkhar (2011) found that African American female adolescents were more likely to be victimized at school than White female adolescents. Examining bullying and violent behaviors among African American adolescents is vital because homicide was the leading cause of death for African American males (48.6%) and the second cause of death among African American females (19.1%) ages 15 to 19 in 2014 (CDC, 2014).

In summary, there are several areas of risky behavior that heighten the likelihood of poor adolescent adjustment and outcomes. These include early sexual behavior, drug, and alcohol use, and violent and bullying behaviors. Such concerns warrant careful examination of potential protective factors relating to the risky behaviors previously discussed.

Parent-adolescent-agreement

Few studies have examined parent-adolescent agreement in evaluations concerning health risk behaviors. Gersh and colleagues (2017) examined adolescent and parent perspectives on the engagement in health risk behaviors and found no significant differences between parent and adolescent reports of sexual behavior and alcohol use. However, O'Donnell et al., (2008) found that fewer than 1% of parents reported that their adolescent daughters had consumed alcohol while 22.3% of the female adolescents reported consuming alcohol once or more. Similarly, Berge, Sundell, Öjehagen, Höglund, and Håkansson (2015) found that parents had poor knowledge of their adolescent's drug and alcohol use.

Parental Monitoring /Knowledge

According to Dishion and McMahon (1998), parental monitoring is, "a set of correlated parenting behaviors involving attention to and tracking of the child's whereabouts, activities, and adaptations." Dishion and McMahon (1998) additionally noted that the parent-child relationship is at the foundation of parental monitoring: "a positive parent-child relationship enhances parents' motivation to monitor their child and to use healthy behavior management practices." Unfortunately, measures of parental knowledge have been combined with measures of behavior control and efforts to solicit information. As a result, it has become difficult to determine the singular effects of parent knowledge on adolescent's behavior (Lippold et al., 2013). Research suggests that parental knowledge links parent monitoring behaviors and adolescent outcomes (Lippold. Greenberg, Graham, Feinberg, 2013).

Adolescents whose parents possess high levels of knowledge about the activities of their adolescents are less likely to engage in risky behaviors (Crouter and Head, 2002; Li et al., 2000; Lippold et al., 2013; Lippold et al., 2011). For example, Lippold et al., (2013) conducted a longitudinal study that aimed to explore the relationship between parent knowledge and youth risk behaviors among rural youth. The risky behaviors examined in this study were: youth delinquency, substance abuse, attitudes towards substance use, and antisocial peer relationships. Researchers found that parental knowledge had a significant dampening effect on substance abuse, delinquency, and attitudes towards substance use. Lippold et al., (2013) additionally explored the concordance between mothers' and youths' perceptions of maternal knowledge among rural adolescents and its association with adolescent risk behaviors. The researchers

assembled four dyads based on mothers' and youths' perspectives on maternal knowledge. Adolescents in dyads with high youth and mother perceived knowledge experienced fewer substances use and healthier drug attitudes compared to any other group. Adolescents in dyads with lower perceived maternal knowledge but higher maternal reported knowledge experienced significantly higher levels of delinquency and substance use. Cottrell et al., (2003) compared parent and youth reports of parent monitoring to examine which perceptions were more predictable of adolescent risk behavior. Parent perceptions' of monitoring were found to be inversely related to adolescents drinking, smoking, and sexual involvement.

Parental Monitoring/Knowledge in Black Families. Li et al., (2000) conducted a study that examined the association between perceived parental monitoring, health risk behaviors, and risk perception for urban low-income African American children and adolescents. These researchers found that low levels of youth rated perceived parental monitoring was associated with several health risk behaviors such as: sexual behavior, substance/drug use, drug trafficking, and violent behaviors. Similarly, Yang et al., (2007) explored the relationship between parental monitoring, communication and adolescent involvement in risky behaviors among a sample of low-income urban African Americans adolescents and their parents. For African American males, perceived parental monitoring was negatively associated with "beating someone up," vaginal sex and alcohol use (Yang et al., 2007). For African American females, perceived parental monitoring was negatively associated with fighting, vaginal sex, cigarette, alcohol and drug use (Yang et al., 2007). Results also suggest that African American females who

perceived consistent parental monitoring were less likely to have engaged in vaginal sex at follow up (Yang et al., 2007).

"Black"

In the present study, the term "Black" is used to describe individuals who self-identify as Black or having African descent. The current study is focused on risky behaviors and parental monitoring for the Black race, regardless of ethnicity.

Purpose of the Study

As previously indicated, research has shown that parental monitoring has been found to reduce the likelihood of engagement in risky behaviors. However, it is less clear if parental monitoring could serve as a protective factor against the engagement of risky behaviors for Black adolescents living in rural communities. The purpose of this study was to explore the relationship between perceived parental knowledge, perceived parental monitoring and risky behaviors among rural Black adolescents in the United States. First, parents' perceptions of adolescent risk behaviors were compared with adolescent reports of risky behaviors. Additionally, the relationship between parental monitoring and knowledge, relative to adolescent self-reported risk was examined. Two primary research questions were investigated

Research Questions:

1. To what extent do Black parents assess their adolescent children's engagement in specified risky behaviors in a manner that is consistent with the adolescent's assessments, as indicated by parent and adolescent reports using the Youth Risk Behavior Surveillance System (YRBSS)?

Hypotheses #1: Assessment concordance of adolescent risk by Black parents will vary by degree of adolescent-reported risk.

Hypotheses 1a. Black parents with adolescents whose scores fall into the no-risk category will be most concordant.

Hypotheses 1b. Black parents with adolescents whose scores fall into the some risk category will be moderately concordant.

Hypotheses 1c. Black parents with adolescents whose scores fall into the elevated risk category will be least concordant.

2. Is there a significant relationship between parental monitoring and adolescent risk behaviors, in terms of both (a) combined risk behaviors, and (b) specific risk behavior types, in Black youth?

Hypotheses #2a. High parent monitoring scores will predict lower adolescent risk scores; Low parent monitoring scores will predict high adolescent risk scores.

Hypotheses #2b: Level of parent monitoring will not be differentially related to type of risk behavior.

CHAPTER 2

METHODOLOGY

Participants

The sample consisted of 31 dyads, each consisting of one adolescent and her/his parent, for a total of 62 participants who also self-identified as Black or African American. Parents ranged in age from 30 to 60 years (M=40, SD=7.37) and included females (n=27, 87.1%) and males (n=4, 12.9%). Adolescents ranged in age from 11 to 14 years (M=12.93, SD=.96) and included females (n= 17, 56.7%) and males (n=13, 43.3%). One adolescent did not report their sex. All participants were living in a rural county in the southern United States.

Measures

Parent-adolescent dyads responded to questions regarding risk behavior from the Youth Risk Behavior Surveillance System (YRBSS). Parents additionally completed questions regarding demographic information and parent monitoring. Below is a description of each measure used.

Demographic questions. Parents were asked to indicate various demographic characteristics including age, gender, martial status, highest educational level, religion, household income, disciplinary practices and current occupation (see Appendix A).

Youth Risk Behavior Surveillance System. Youth Risk Behavior Surveillance System (YRBSS) was developed in 1990 by the Centers for Disease Control and Prevention as a way to monitor risky behaviors that contribute to the leading causes of death, disability, and social problems among youth. According to the CDC website, the YRBSS helps, "determine the prevalence of health risk behaviors, and assess whether

health risk behavior increases or decreases over time." The YRBB has six subscales: *unintentional injuries and violence, sexual behaviors (unintended pregnancy, STD/STI's, HIV), alcohol and other drug use, tobacco use, unhealthy dietary behaviors and inadequate physical activity*. The CDC conducted two test-retest reliability studies for this measure in 1992 and 2000. The first study consisted of 1,679 students who were in grades 7-12 (Brener, Collins, Kann, Warren, & Williams, 1995). The YRBSS was administered on two different occasions, which were 14 days apart. Approximately three-fourths of the questions were rated as having moderate to high reliability (kappa-61-100%; Brener, Collins, Kann, Warren, & Williams, 1995). There was no statistically significant difference observed between prevalence estimates from the 1st and 2nd time the questionnaire was administered.

The second test-retest reliability study was conducted from 1991-1994 and included 619 high school students (Brener et al., 2002) . The YRBSS was administered on two different occasions, which were two weeks apart. The researchers found that 10 questions had a kappa of <. 61 % and, “significant differences in the prevalence estimates between time-1 and time-2” (Brener et al., 2002). This indicated that the reliability of these questions was questionable. These questions were either revised or deleted. To date, there are no studies on the validity of self-reported behaviors of the YRBSS, but in 2003 the CDC did review existing literature to explore cognitive and situational factors that might influence the validity of adolescent self-reporting (Brener, Billy, & Grady, 2003). The CDC concluded that although adolescent self-report is affected by both cognitive and situational factors, these factors do not threaten the validity of the YRBSS (Brener, Billy, & Grady, 2003).

For this study, the middle school version of the YRBSS was administered to both parents and adolescents (See Appendix B). The YRBSS given to parents was a modified version of the adolescent YRBSS survey (See Appendix C). This version of the YRBSS obtained knowledge of the parent's perception of their adolescent's risky health behaviors. Parent-adolescent dyads completed the entire (49 questions) questionnaire, however, only the subsections regarding violence, sexual behaviors and drugs and alcohol use were examined for this study. The YRBSS contains questions that require a yes/no answer and questions that offer a range of ages for answers, for these questions the youngest age option (8 years old) was coded as a six while the oldest age option (13 years old or older) was scored as one (See Appendix E). Higher parent ratings indicated greater perceived engagement in risky behaviors while higher adolescent ratings indicated greater engagement in risky behaviors.

Parental Knowledge/Monitoring. Parent perceptions of parental knowledge and monitoring were assessed using an 11-item questionnaire developed for the National Institute of Child Health and Human Development Study of Early Child Care and Youth Development (NICHD SECCYD: See Appendix D). As cited in Davis et al., 2011 Cronbach's alpha was found to be .77 for the paternal monitoring scale. This indicates that the items on this scale are internally consistent. To complete this questionnaire each parent responded to questions on a four-point Likert scale (0= *don't know at all/never* to 3=*know everything/always).* Questions ranged from "I know who my child spends time with" to "do you tell your child what time he/she has to be home on a school night." Higher scores on this measure reflect higher monitoring/knowledge while lower scores reflect low monitoring/knowledge.

Procedure

Prior to study implementation, the University of Rhode Island Institutional Review Board reviewed and approved the study. Participants were recruited using a combination of snowball methods and targeted sampling. Announcements at community centers, phone calls, emails, and professional networks were used to recruit participants. Once participants expressed interest, they were sent a packet that included parent and adolescent instructions, and two copies of consent, assent and parent permission forms that detailed the study goals, and the risks and benefits associated with participation. A resource guide was additionally included in the packet.

Parents were asked to complete both the parent permission and parent consent forms. Then, in a separate room from their child, they completed the Parental Monitoring Survey. Once finished, parents were asked to complete the YRBSS. When completed, parents placed their packet in a large envelope. Parents were then asked to review the "Resource Materials" packet. The "Resource Materials" package provided handouts to assist in a discussion about the topics covered on the survey.

The adolescents were asked to complete the assent form. Then, in a separate room from their parent, they completed the adolescent YRBSS. When completed, adolescents were instructed to place their survey in the large envelope along with their parents.

CHAPTER 3

RESULTS

To begin, participants' demographic information is presented and discussed. Next, correlations among the variables are described. Lastly, the research questions are examined based on the analyzed data.

Participant Demographics

Parents provided personal background information regarding: (a) their highest level of education, (b) household income, and (c) religion. As summarized in Table 1, there was variability in the education level of parents. The majority of parents had completed some level of education including one of the following: General Equivalency Diploma (GED), some college experience or a bachelor's degree. Three parents had completed a master's degree, while none had completed a doctorate. Finally, one parent had a professional certification. Parents reported their household incomes during the past 12 months. There was variability in their incomes, ranging from below the poverty line to what is considered middle class (Table 2). An examination of income level shows that twelve parents report making less than $34,999 per year. There was little variability in regards to religion, a majority (93.55%) of the parents reported to be Christian (see Table 3).

Table 1

Parents' Highest Level of Education

Highest Level of Education	n	%
Less than high school	1	3.23
High school graduate	0	0

GED	7	22.58
Some college, no degree	8	25.81
Associate's degree	3	9.68
Bachelor's degree	8	25.81
Completed some postgraduate	0	0
Master's Degree	3	9.68
Ph.D.	0	0
Graduate or professional degree	1	3.23

Note: N=31

Table 2

Household Income

Income	n	%
$0 to $14,999	2	7.69
$15,000 to $24,999	5	19.23
$25,000 to $34,999	5	19.23
$35,000 to $49,999	3	11.59
$50,000 to $74,999	8	30.77
$75,000 to $99,999	2	7.69
$100,000 or more	1	3.85

Note: N=26

Table 3

Religion

Religion	n	%
Christian/ Non-Catholic	28	90.32
Christian/ Catholic	1	3.23
Other	2	6.45

Preliminary Analyses

Examining Normality. Preliminary analyses were conducted to examine descriptive statistics for each reported health risk behavior. Also, descriptive statistics are presented for parent and adolescent reports of each risky behavior (see Table 4). The data were reviewed to examine whether the necessary assumptions for parametric analyses were met. The skewness and kurtosis of each variable can be seen in Table 4. As shown in Figures 1.1 through 1.6, the histograms of the distributions of adolescent and parent reported health risk behaviors reflect non-normality of the data distributions.

Table 4

Descriptive Statistics for health risk behaviors

Measure	*Mean*	*SD*	*Minimum*	*Maximum*	*Skewness*	*Kurtosis*
Adolescent Sex	.26	.99	0	4	3.63	11.58
Parent Sex	0	0	0	0	*	*
Adolescent Violence	1.19	1.07	0	3	.43	-1.04
Parent Violence	1.03	1.04	0	3	.66	-.74
Adolescent Drug and Alcohol	.65	.98	0	3	1.00	-.714
Parent Drug and Alcohol	.03	.18	0	1	5.43	28.37

Combine Risk	2.10	2.10	0	10	1.71	-1.17
Parental Monitoring	27.77	3.66	22	33	-.28	4.63

*Since all parents reported that their adolescent was not engaging in sexual behavior the variable was reported as a constant.

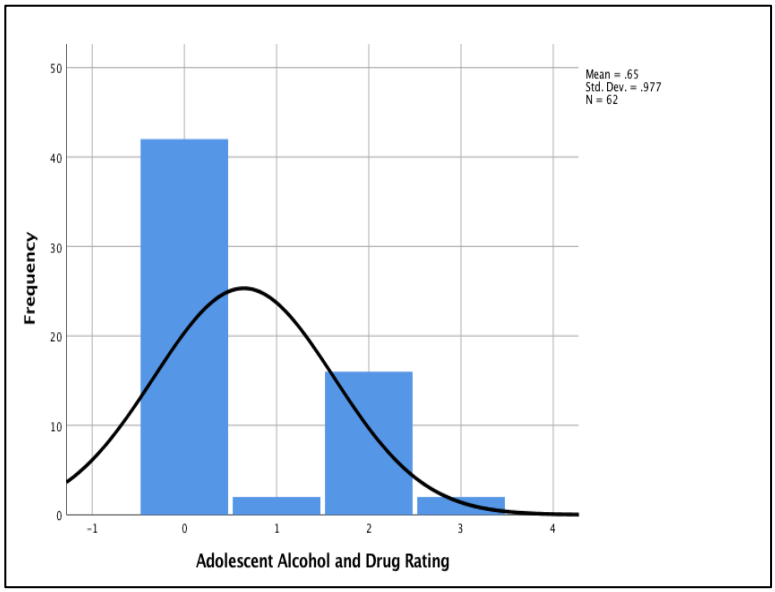

Figure 1.1. Frequency Distribution of Adolescent Alcohol and Drug Rating

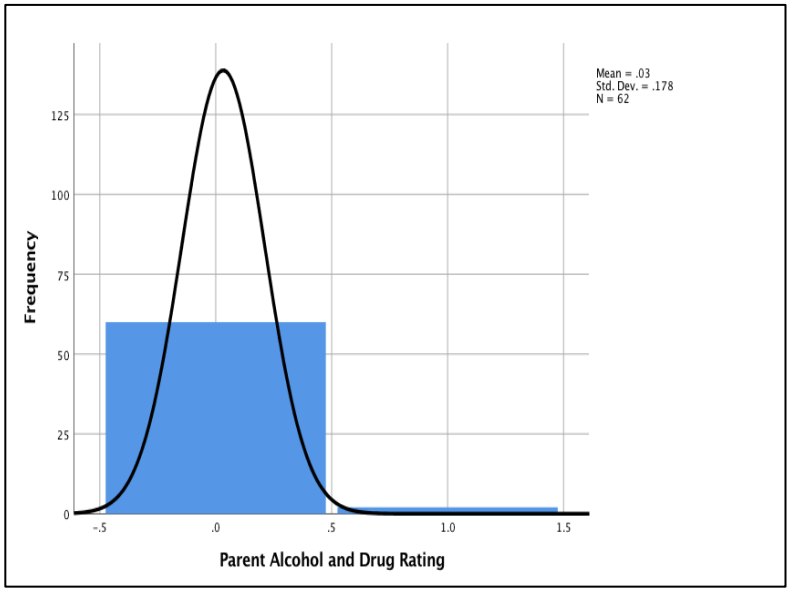

Figure 1.2. Frequency Distribution of Parent Alcohol and Drug Rating

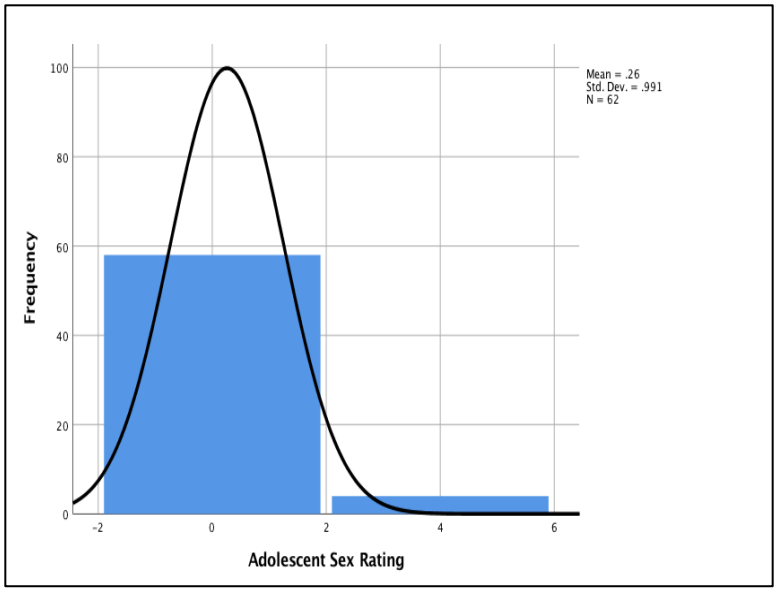

Figure 1.3. Frequency Distribution of Adolescent Sex Rating

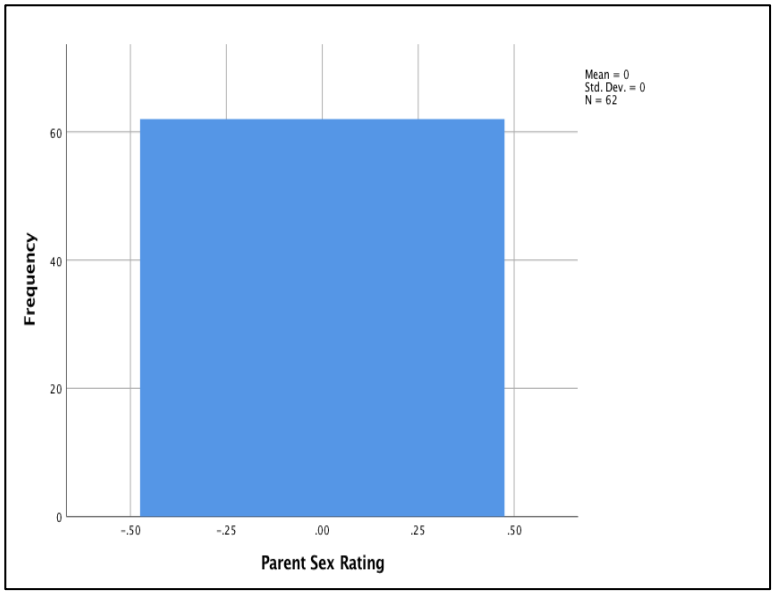

Figure 1.4. Frequency Distribution of Parent Sex Rating

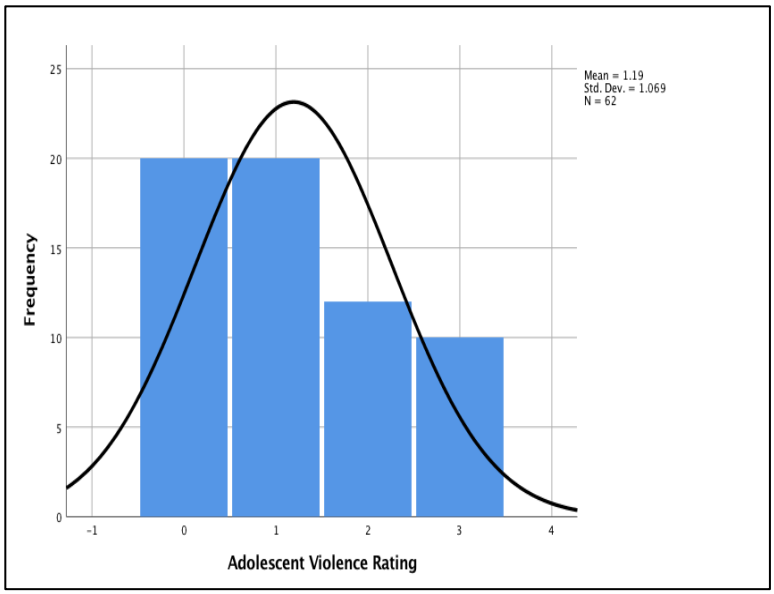

Figure 1.5. Frequency Distribution of Adolescent Violence Rating

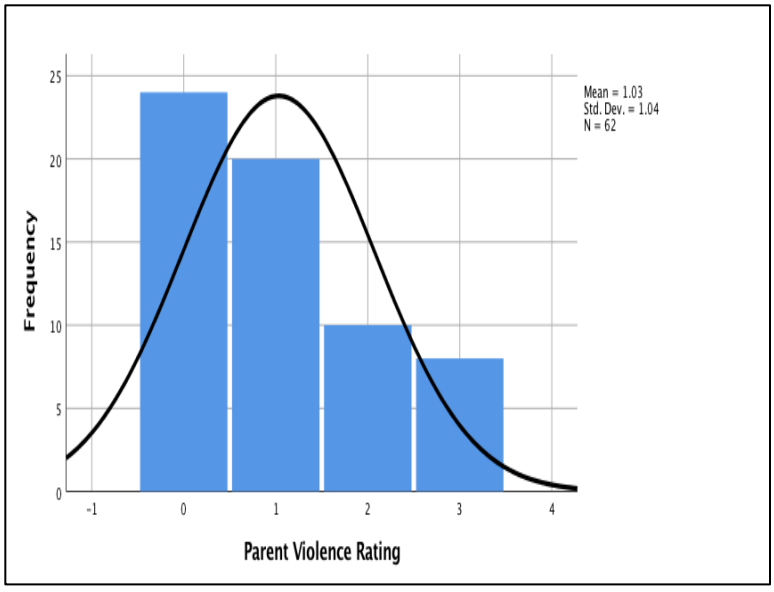

Figure 1.6. Frequency Distribution of Parent Violence Rating

Examining Correlations Between Variables. Correlation analyses were conducted for income, highest degree earned by parent and parent-adolescent reported health risk behaviors (see Table 5). Significant positive correlations were found for parent ratings of violence and adolescent ratings of violence ($r=.79$, $p<.05$). Higher parent ratings of adolescent engagement in violent behavior were associated with higher ratings of adolescents of violent behavior. Adolescent ratings of drug and alcohol use also produced significantly positive correlations with adolescent ratings of violent behaviors ($r=.35$, $p<.01$) and parent ratings of violent behavior ($r=.30$, $p<.05$).

In addition to examining relationships between individual behaviors, a combined adolescent risk score was constructed and analyzed statistically. The combined score consisted of adding all of the adolescent health risk behaviors across the three health risk categories and combining them into a combined score. For example, an adolescent whose score of zero on sexual behavior, two on drugs and alcohol, and one on violent behaviors was combined to be a score of three. This combined risk score was found to be significantly correlated with adolescent ratings of sexual behavior ($r=.62$, $p<.01$). This indicates there was a positive relationship between total combined risky behavior and adolescent reported sexual behavior. The combined risk score also was significantly correlated with adolescent ratings of violent behavior ($r=.71$, $p<.01$). The positive relationship suggests a possible link between combined risky behaviors and adolescent ratings of risk for violent behavior. Another positive correlation was found between combined risk and parent ratings of adolescent violence ($r=.54$, $p<.05$). This relationship again implies a relationship between the two variables. Furthermore, combined risk and adolescent ratings of drug and alcohol use were found to have a positive correlation

(r=.75, p<. 05). These correlations indicate, adolescent ratings of violent behavior, parent ratings of violent behavior, and adolescent ratings of drug and alcohol use are related to and may be influenced by overall engagement in risky behavior across the categories examined.

Household income as reported by parent participants was positively correlated with parental monitoring (r=.37, p<.05) and highest degree earned by parent (r=.59, p<.01). These findings are an indication that as family income increases so does parental monitoring and parent education level. In addition, a positive correlation was found between household income and adolescent ratings of sexual behavior (r=.31, p<.05). This result should be interpreted with caution given that only two adolescents reported engaging in sexual behavior. Household income was negatively correlated with parent ratings of drug and alcohol use (r=-.30, p<.05). This suggests that as household income decreases parent ratings of adolescent drug and alcohol use increase.

Table 5
Correlation Analyses for Variables

Variables	1	2	3	4	5	6	7	8	9	10
1. Adolescent Sex	–									
2. Parent Sex	.[a]	–								
3. Adolescent Violence	.08	.[a]	–							
4. Parent Violence	-.01	.[a]	.79**	–						
5. Adolescent D&A	.23	.[a]	.35**	.30*	–					
6. Parents D&A	-.05	.[a]	.14	-.18	-.12	–				
7. Combine Risk	.62**	.[a]	.71**	.54*	.75*	-.01	–			
8. Monitoring	-.04	.[a]	.18	.17	.25	-.15	.18	-		
9. Degree	.04	.[a]	-.01	.79	-.11	-.22	-.04	.14	-	
10. Income	.31*	.[a]	.01	-.03	.08	-.30*	.15	.37*	.59*	-

****Correlation is significant at < .01 level, * at p < .05 level, a. cannot be computed because one variable is a constant*

Analyses

The primary results of this study are organized and discussed here around the two main research questions. The first question was "To what extent do Black parents assess their adolescent children's engagement in specified risky behaviors in a manner that is consistent with the adolescents assessments, as indicated by parent and adolescent reports using the Youth Risk Behavior Surveillance System (YRBSS)?"

This question examined the concordance between parent ratings of their adolescent's health risk behaviors and the ratings of the adolescents themselves. The researcher proposed to conduct a chi-squared test of independence and three chi-square goodness of fit tests to examine research question 1 and its hypotheses. However, these analyses were not appropriate because the data did not meet the necessary assumptions of normality (see Table 4). Therefore, results for this question are examined on a descriptive level, and reported in the following separate sections for each of three risky behaviors.

Sexual intercourse. Two (6.5%) of the thirty-one adolescent participants reported engaging in sexual intercourse. Both of these adolescent participants reported having sexual intercourse at 13 years or older, having one sexual partner and using a condom during their last sexual encounter. However, every parent (100%) reported believing that her/his adolescent was not engaging in sexual intercourse (see Figure 2). The concordance rate, or the agreement between parent and adolescent reports, was 93.5%.

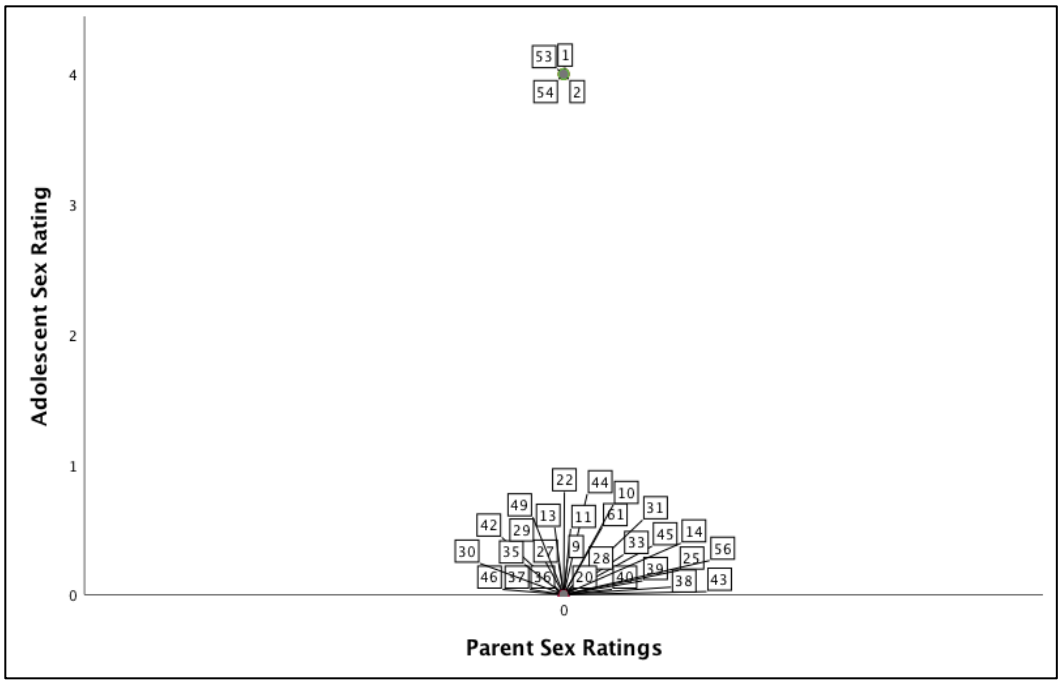

Figure 2. Parent-adolescent dyad ratings of sexual behavior. Each dyad consists of one parent participant and one adolescent participant and is represented by two consecutive numbers (e.g., 1,2; 53,54).

Drugs and Alcohol. No adolescent participants reported using drugs but several reported using alcohol. Of the 31 parent participants, only one reported believing that their adolescent was using drugs or alcohol (see Figure 3). The concordance rate or the agreement between parent and adolescent ratings of alcohol use was 64.5%. As seen in Figure 3, eleven parent-adolescent dyads were not concordant. One parent overestimated their adolescent's alcohol use while 30 parents underestimated their adolescents reported alcohol use. The parent participant with the adolescent whose score fell in the highest alcohol risk believed that their adolescent was not engaging in this risky behavior.

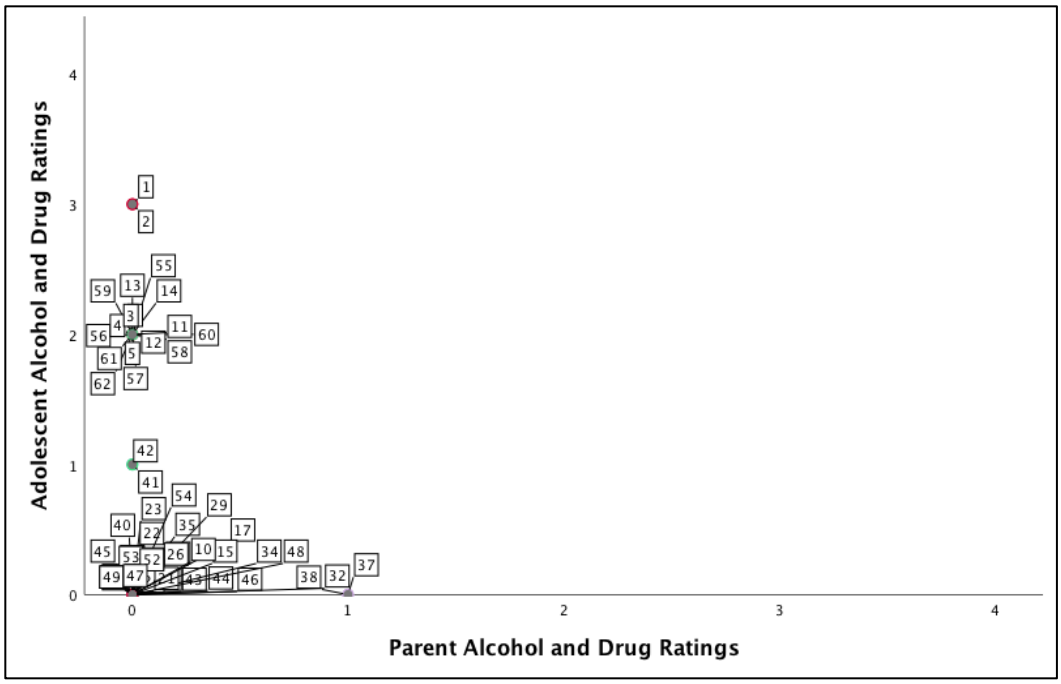

Figure 3. Parent-adolescent dyad ratings of alcohol and drug use. Each dyad consists of one parent participant and one adolescent participant and is represented by two consecutive numbers (e.g., 1,2).

Violence/Bullying. No adolescent reported carrying a weapon of any kind. Adolescent participants did report being in physical fights, being electronically bullied and being bullied on school property. Parent participants of adolescent participants who scores fell in the highest risk group (score of 3) accurately reported or slightly underreported their adolescent's involvement in violent behaviors (see Figure 4). Parent participants of adolescent participants who scores fell in the lowest risk group (score of 0) accurately reported or slightly over-reported their adolescent's involvement in violent behaviors. Eights parents overestimated their adolescents violence behaviors while four parents overestimated adolescents violent behavior. Overall, the concordance rate, or agreement between parent-adolescent dyad ratings of violence/bullying was 61.3%.

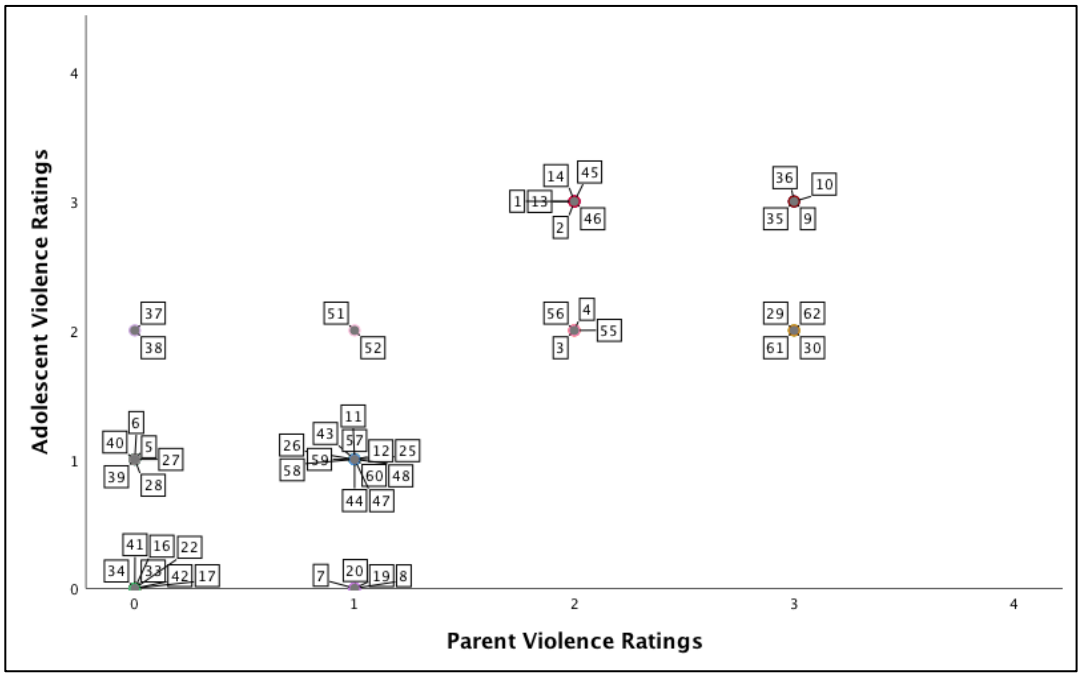

Figure 4. Parent-adolescent dyad ratings of violence. Each dyad consists of one parent participant and one adolescent participant and is represented by two consecutive numbers (e.g., 51,52).

Thus, the rates of parent-adolescent concordance ranged from 93.5% regarding sexual behavior to 64.5% regarding drug and alcohol use to 61.3% regarding violent behavior. These rates suggest that parents may be more accurate and/or sensitive to sexual behavior and alcohol use in their adolescent children.

The second research question was "Is there a significant relationship between parental monitoring and adolescent risk behaviors, in terms of both (a) combined risk behaviors, and (b) specific risk behavior types, in Black youth?"

This question explored the relationship between adolescent ratings of health risk behaviors and parental monitoring. The researcher proposed to conduct four multiple regression analyses to examine question two and its hypotheses. However, as noted

above, the data did not meet the necessary assumptions (see Table 4 and Figures 1.1-1.6). Thus, as an alternative to the multiple regression analyses, data were analyzed using negative binomial regressions because they account for over-dispersion in count data (Cohen, Cohen, West, & Aiken, 2003). Negative binomial regressions carry out a log transformation on dependent variables, which for this study are risk health behaviors. A one-unit increase in the predictor variable (e.g., parental monitoring) represents a log (x) increase in the dependent variable, which is indicated by the regression coefficient estimate. Negative binomial regressions also produce odds ratios[1], which can be used as an index of effect size. Negative binomial regressions were conducted to examine the predictive nature of parental monitoring on adolescent alcohol and drug use, sexual behavior, violence and combined risk.

Parental monitoring and combined risk. Table 6 lists regression coefficients, standard errors, p values, odds ratios and confidence intervals for each health risk behavior. A negative binomial regression analysis was conducted to determine if parental monitoring predicted combined risk (cumulative risk scores). Results suggested no significant results (p=.215, OR=.1.532). This finding suggests that for adolescent participants in this study, parental monitoring did not predict the engagement in health risk behaviors as a whole.

Parental monitoring and individual health risk behaviors. A negative binomial regression was conducted to determine the predictive nature of parental monitoring on sexual intercourse. Regression analysis yielded no significant predictors

[1] Significant odds ratios less than 1.00 indicate that parental monitoring will predict lower odds of adolescent reported health risk behaviors. Odds ratios greater than 1.00 indicate that parental monitoring will predict higher odds of adolescent reported health risk behaviors.

for parental monitoring and adolescent sexual intercourse (p=.586, OR=.297). Likewise, regression analysis did not yield significant results between violent behaviors and parental monitoring (p=.380, OR=.773). As far as adolescent ratings of alcohol and drug use, regression analysis were not significant, although they approached significance (p=.051, OR=3.84). This result can be interpreted as suggesting that in the present sample, higher rates of parental monitoring predicted a higher likelihood of adolescent reported drug and alcohol use.

Table 6
Results from Negative Binomial Regressions

	E	SE	P	OR	CI 95%
Adolescent Violence Rating	.044	.050	.380	.773	-.05-.142
Adolescent Alcohol and Drug Rating	.133	.070	.051	3.824	-.005-.271
Adolescent Sex Rating	-.045	.083	.586	.297	-.209-.118
Combined Risk	.060	.049	.215	1.532	-.035-.156

Note. SE= standard error; CI= confidence interval; OR= odds ratio.

CHAPTER 4

DISCUSSION

In this section, the results of the study will be discussed in relation to the research questions. Next, implications for research and practice will be explored. Limitations of the study will be presented and lastly, future directions for research will be highlighted.

The current study examined parents' knowledge of their adolescents' engagement in risky behaviors. In addition, this study aimed to explore the interaction between parental monitoring and the engagement in health risk behaviors for Black adolescents residing in rural areas. The first research question examined the concordance rate, or the agreement between adolescent and parent participant's ratings of health risk behaviors. Results did demonstrate that parents possessed a high accuracy regarding their adolescent's engagement in sexual activity, violent behaviors and drug and alcohol use. These results are similar to those in a study conducted by Gersh et al., (2017) who found no significant differences between parent and adolescent reports of sexual behavior and alcohol use.

However, these results are dissimilar to many previous findings. For example, Young and Zimmerman (1998) found that parents of middle school students in Tennessee significantly underestimated their adolescent's engagement in carrying a weapon to school, alcohol use, drug use, suicide attempts, and sexual intercourse. In a largely Black sample (75.1%) O'Donnell et el., (2008) found that fewer than 1% of parents reported that their adolescent daughter had drunk alcohol while 22.3% of the girls reported consuming alcohol one or more times. And, Berge, Sundell, Öjehagen, Höglund, and

Håkansson (2015) also found that parents had inaccurate knowledge of their adolescent's drug and alcohol use.

Research question two examined the predictive nature of parental monitoring on the engagement of adolescent reported health risk behaviors. Counter to what was hypothesized, results demonstrate that parental monitoring did not predict adolescent engagement in sexual intercourse, violence/bullying, drugs, and alcohol use or combined risk. These findings run counter to previous research, which found low levels of parental monitoring predicted sexual behavior, substance abuse, violent behaviors (Li et al., 2000; Yang et al., 2007) and alcohol use (Yang et al., 2007).

In both of these latter studies, the focus was on Black adolescents living in urban areas and researchers examined parental monitoring from the adolescents perspective. Similarly, Lippiod et al., (2010) found that with rural adolescents and parents higher levels of maternal knowledge were only associated with positive adolescent outcomes when both youth and mothers reported high levels of maternal knowledge. In the present study, it is possible that only examining parental monitoring from the parent perspective lead to an overestimation of parental monitoring.

The current results may have been influenced by multiple factors. Neighborhood types may affect the relationship between parental knowledge and engagement in health risk behaviors. For example, Jones and colleagues found that parental monitoring increased in families that lived in neighborhoods that were characterized as urban versus rural neighborhoods. Neighborhood characteristics could have an impact on just how protective parental knowledge is against the engagement in health risk behaviors possibly

explaining why in the present work parental monitoring was not found to be significant against the engagement in health risk behaviors.

Research also suggests that rurality could have an effect on parental knowledge. In many rural areas there are rich social networks where adolescents are known by many adults and many non-relative adults may have a sense of responsibility for youth in the community (Lippiod et al., 2010), or "it takes a village to raise a child" mentality. This rich social network can potentially lead to sharing of information among adults about adolescents/children, and could help explain the high rates of accuracy between parent and adolescent reports of engagement in health risk behaviors.

Another factor, parental religiosity, could have affected the results of this study as well. Brody and Flor (1998) found that parental religiosity had an effect on parenting. These researchers found that greater maternal religiosity among rural African American mothers was directly linked to increased maternal involvement in school activities, higher quality mother-child relationships and more use of "no non-sense parenting." Brody and Flor (1998) characterized "no non-sense parenting" as parenting with high levels of control and affection. Higher involvement and "no non-sense parenting" could account for lower adolescent reported engagement in risky behaviors than what is typically found.

It is important to note that some of the questions on the YRBSS may have been more difficult for parents and adolescents to answer truthfully. For example, answering questions regarding bullying may have carried less stigma than answering questions about sexual behavior.

Limitations

The study is not without limitations. The sample size for this study was relatively small. After approximately 18 months of data collection, only half of the projected number of participants had been recruited. Researchers consider certain populations "hard-to-reach" meaning the population is "difficult for researchers to access" (Sydor, 2013). In this regard, individuals and families that are African American are considered to be a "hard-to-reach" population in research. Further information regarding the meaning of "hard-to-reach" can be gleaned from Bonevski et al., (2014), who conducted a systematic review exploring strategies to improve research with diverse groups. The authors discussed some common barriers that "hard-to-reach" individuals face. For example, some common barriers to the engagement in research by diverse groups are lack of trust, fear of authority, perceived harm of research, mistreatment, cultural beliefs, low health literacy and no benefits for participation.

To reach these individuals and populations, Bonevski and colleagues (2014) suggest using variations in recruitment efforts and incorporating community groups and organizations throughout the study. For the current study, the researcher worked with local churches to recruit participants. Prior to recruiting data at churches, the researcher spoke with church leaders to gain their support. Once church leaders agreed to support the project, the researcher worked with a member of the church to plan recruitment. Having community partnerships and working with peer recruiters has been suggested to combat the barriers of lack of trust and fear of authority (Bonevski et al., 2014).

Bonevski and colleagues (2014) systematic review also suggests that "hard-to-reach" individuals can often believe that there are no benefit participations. To help

eliminate this belief, a "commitment to give back" is suggested. While there were no monetary rewards parent participants did receive a resource packet with handouts to assist in a discussion about the topics covered on the survey.

Because the data did not meet the necessary assumptions of normality, the first research question and hypotheses were examined on a descriptive level. The researcher was not able to fully examine the relationship between concordance rate of adolescent-parent dyads and the degree of adolescent-reported risk.

It is important to note that a large majority of the adolescent sample did not endorse engagement in sexual activity, violent behaviors or alcohol use. It is unclear how these low levels of risky behavior affected parent accuracy. The high levels of parent accuracy found in this study could truly be parent knowledge or luck.

As stated above, this study examined parental monitoring from the perception of the parent. Parental monitoring as reported by the parent was relatively high among all parents. Research by Li et al., (2000) and Yang and colleagues (2007) found that parental monitoring had an effect on the engagement in risky behaviors but examined parental monitoring from the adolescent perspective. Furthermore, Lippiod and colleagues (2010) found parental knowledge to only be associated with less risky behaviors when both adolescents and mothers reported high levels of maternal knowledge. These studies suggest that adolescents and parents may have different perceptions of the monitoring that is occurring. Future research should seek to incorporate both adolescent and parent reports of monitoring.

When examining the questions on the YRBSS, it was found that the questions regarding sexual intercourse did not specifically mention participation in oral sex.

Adolescents are often unclear if oral sex "counts" as sexual intercourse. It is unknown if adolescents considered oral sex when answering the questions surrounding sexual behaviors. Future research should strive to include an all-encompassing definition of what is considered sexual intercourse.

A majority of the sample was recruited from churches or community organizations that were afflicted with churches. Having adolescent and parents participate in this study in their local churches could have affected their willingness to disclose behavior that could possibly go against their religious beliefs. The social desirability of certain answers over others could have also been at play. Furthermore, while religion is a major aspect in many rural Black families, it would be naïve to believe that all rural Black families are religious. Future studies should be conducted and include non-religious rural Black families to see if the results are generalizable to all rural Black families.

Implications

Despite the study's limitations, the work conducted and its results provide some insight on rural Black parents perceptions of their adolescent's engagement in health risk behaviors. Also, the work provides information on parental monitoring and the engagement of health risk behaviors among this population. Results suggest that rural Black adolescents are engaging in health risk behaviors at an early age. Creating more awareness of the early onset of these risk behaviors among rural Black adolescents is important for parents and school staff. This is because awareness of the emergence of health risk behaviors at an early age can lead to better prevention efforts.

Results did not show that parental monitoring predicted lower engagement in health risk behaviors. However, results did show that rural Black parents are relatively aware of their adolescent's engagement in risky behaviors. Extrapolating these results to a sample of 1,000 parents we would see that 935 of 1000 parents would be found to accurately report their adolescents engaged in sexual behaviors, 645 of 1000 parents would be found to accurately report engagement in drugs and alcohol and 631 of 1000 parents who would accurately reported engagement in violent behaviors. This extrapolation implies that in a rural middle school with 1000 Black students more than half of their parents would be knowledgeable of their adolescents engagement in risky behaviors.

Conversely, the extrapolations provided above can be interpreted from the "other side of the coin" so to speak. It is concerning that 65 of 1000 parents would inaccurately estimate adolescent engagement in risky sexual behavior. And, 355 would inaccurately predict drug and alcohol use. Finally 369 of 1000 would inaccurately report adolescent engagement in violent behavior. Taken from this perspective, then, there is a need for prevention and intervention methods in schools and communities to support parent practices that could lead to increased knowledge, prevention, and safety efforts.

Parents are typically the ones identifying and providing access to health services so, it is critical that they are aware of their adolescent's participation in risky behaviors. Generally speaking, medical professionals and clinicians tend to rely on parent reports when assessing the engagement in risky health behaviors. While this study did show a high concordance rate between parents and adolescents professionals should rely on adolescent report over parent report.

Future Directions

The present study adds to our information base about parent's knowledge of their adolescent's engagement in risky behaviors and the interaction between parental monitoring and the engagement in health risk behaviors for Black adolescents residing in rural areas. Black adolescents who reside in rural communities are frequently left out of studies that examine parental monitoring and Black adolescents.

This study is among the first to explore parental perceptions of adolescent engagement in health risk behaviors among a rural Black sample. Furthermore, the study contributes to the limited knowledge of parental monitoring and the engagement in health risk behaviors among Black youth who reside in rural America. Future research should examine the role that rurality and religion play in parental practices among rural Black parents. Given that the current study did not find a relationship between parental perceptions of parental monitoring and health risk behaviors, future studies should examine perceived parental monitoring from the adolescents perspective or both the parent and adolescent perspective.

The mistreatment of African American's in research studies has long been documented. Historical events coupled with current health care issues have aided in distrust among the African American community and researchers. When working with African American participants researchers should be aware of the mistrust and other barriers that might affect African American's participation in research. It is also suggested that researches be aware of their biases and actively work to ensure that these biases do not affect their research. To increase participation of African American participants, it is suggested that researchers work with leaders in the community and

becoming as immersed in the community as possible. It could also be useful for researchers to explain the importance of their study and why African American participation is critical.

Conclusion

According to the U.S. Census Bureau, more than six million adolescents live in rural areas (2014). Rural America has as long been stereotyped as a place free from drug abuse, crime, and poverty (Brown and Waite, 2005). We are now becoming aware that the same issues that plague urban communities can be seen in rural communities as well. Black youth living in rural areas often face chronic poverty, parental employment status change, limited educational opportunities, interpersonal and institutional racism, and difficulty in accessing medical care. The current study sought to assess the influence of parental monitoring on the impact of three health risk behaviors, which included sexual intercourse, violence/bullying and drug and alcohol use. While results did not show that parental monitoring predicted the engagement in health risk behaviors results did show that rural Black parents are relatively aware of their adolescent's reported engagement in health risk behaviors.

Appendix A
Demographic Questions

Age_____

What is your gender?
Female
Male

What is your marital status?
A. Single (never married)
B. Married
C. Living with partner
D. Separated
E. Widowed
F. Divorced

Religion (circle one)
A. Christian/ Non-Catholic
B. Jewish
C. Muslim
D. Christian/ Catholic
E. Other_____

What is the highest degree or level of education you have completed?
A. Less than high school
B. High school graduate
C. GED
D. Some college, no degree
E. Associate's degree
F. Bachelor's degree
G. Completed some postgraduate
H. Master's degree
I. Ph.D.
J. Graduate or professional degree

What was your total household income during the past 12 months?
A. $0 to $ 14,999
B. $15,000 to $24,999
C. $25,000 to $34,999
D. $35,000 to $49,999
E. $50, 000 to $74, 999
F. $75, 000 to $99,999
G. $100,000 or more

How many hours per week do you USUALLY work at your job?

A. 35 hours a week or more
B. Less than 35 hours a week
C. I am not currently employed

What best describes the type of organization you work for?

A. Factory
B. Non-profit (religious, arts, social assistance, etc.)
C. Government
D. Health Care
E. Education
F. Other

Which of the following most closely matches your job title?

A. Intern
B. Entry Level
C. Analyst / Associate
D. Manager
E. Senior Manager
F. Director
G. Vice President
H. Senior Vice President
I. President or CEO
J. Owner

Please indicate how many biological and adopted children you have

A. Biological Children _____
B. Adopted Children _____

Who generally disciplines your child?

Does your child get disciplined by people other then their parents? If so, who?

Who lives in your household with your child?

If you suspected that your child had a mental heath issue who would you seek for help and why?

Appendix B
2015 Middle School Youth Risk Behavior Survey

This survey is about health behavior. It has been developed so you can tell us what you do that may affect your health. The information you give will be used to improve health education for young people like yourself.

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do.

Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported.

Make sure to read every question. Fill in the ovals completely. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

1. How old are you?
A. 10 years old or younger
B. 11 years old
C. 12 years old
D. 13 years old
E. 14 years old
F. 15 years old
G. 16 years old or older

2. What is your sex?
A. Female
B. Male

3. In what grade are you?
A. 6th grade
B. 7th grade
C. 8th grade
D. Ungraded or other grade

4. Are you Hispanic or Latino?
A. Yes
B. No

5. What is your race? **(Select one or more responses.)**
A. American Indian or Alaska Native
B. Asian
C. Black or African American
D. Native Hawaiian or Other Pacific Islander
E. White

The next 4 questions ask about safety.

6. **When you ride a bicycle,** how often do you wear a helmet?
A. I do not ride a bicycle
B. Never wear a helmet
C. Rarely wear a helmet
D. Sometimes wear a helmet
E. Most of the time wear a helmet
F. Always wear a helmet

7. **When you rollerblade or ride a skateboard**, how often do you wear a helmet?
A. I do not rollerblade or ride a skateboard
B. Never wear a helmet
C. Rarely wear a helmet
D. Sometimes wear a helmet
E. Most of the time wear a helmet

F. Always wear a helmet

8. How often do you wear a seat belt when **riding** in a car?
A. Never
B. Rarely
C. Sometimes
D. Most of the time
E. Always

9. Have you ever ridden in a car driven by someone who had been drinking alcohol?
A. Yes
B. No
C. Not sure

The next 3 questions ask about violence-related behaviors.

10. Have you ever carried **a weapon**, such as a gun, knife, or club?
A. Yes
B. No

11. Have you ever been in a physical fight?
A. Yes
B. No

12. Have you ever been in a physical fight in which you were hurt and had to be treated by a doctor or nurse?
A. Yes
B. No

The next 2 questions ask about bullying. Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.

13. Have you ever been bullied **on school property**?
A. Yes
B. No

14. Have you ever been **electronically** bullied? (Count being bullied through e-mail, chat rooms, instant messaging, websites, or texting.)
A. Yes
B. No

The next 3 questions ask about attempted suicide. Sometimes people feel so depressed about the future that they may consider attempting suicide or killing themselves.

15. Have you ever **seriously** thought about killing yourself?
A. Yes
B. No

16. Have you ever made a **plan** about how you would kill yourself?
A. Yes
B. No

17. Have you ever **tried** to kill yourself?
A. Yes
B. No

The next 7 questions ask about tobacco use.

18. Have you ever tried cigarette smoking, even one or two puffs?
A. Yes
B. No

19. How old were you when you smoked a whole cigarette for the first time?
A. I have never smoked a whole cigarette
B. 8 years old or younger
C. 9 years old
D. 10 years old
E. 11 years old
F. 12 years old
G. 13 years old or older

20. During the past 30 days, on how many days did you smoke cigarettes?
A. 0 days
B. 1 or 2 days
C. 3 to 5 days
D. 6 to 9 days
E. 10 to 19 days
F. 20 to 29 days
G. All 30 days

21. During the past 30 days, on the days you smoked, how many cigarettes did you smoke **per day**?
A. I did not smoke cigarettes during the past 30 days
B. Less than 1 cigarette per day
C. 1 cigarette per day
D. 2 to 5 cigarettes per day
E. 6 to 10 cigarettes per day
F. 11 to 20 cigarettes per day
G. More than 20 cigarettes per day

22. During the past 30 days, how did you **usually** get your own cigarettes? (Select only

one response.)
A. I did not smoke cigarettes during the past 30 days
B. I bought them in a store such as a convenience store, supermarket, discount store, or gas station
C. I got them on the Internet
D. I gave someone else money to buy them for me
E. I borrowed (or bummed) them from someone else
F. A person 18 years old or older gave them to me
G. I took them from a store or family member
H. I got them some other way

23. During the past 30 days, on how many days did you use **chewing tobacco, snuff, or dip,** such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?
A. 0 days
B. 1 or 2 days
C. 3 to 5 days
D. 6 to 9 days
E. 10 to 19 days
F. 20 to 29 days
G. All 30 days

24. During the past 30 days, on how many days did you smoke **cigars, cigarillos, or little cigars**?
A. 0 days
B. 1 or 2 days
C. 3 to 5 days
D. 6 to 9 days
E. 10 to 19 days
F. 20 to 29 days
G. All 30 days

The next 2 questions ask about electronic vapor products, such as blu, NJOY, or Starbuzz. Electronic vapor products include e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens.

25. Have you ever used an electronic vapor product?
A. Yes
B. No

26. During the past 30 days, on how many days did you use an electronic vapor product?
A. 0 days
B. 1 or 2 days
C. 3 to 5 days
D. 6 to 9 days
E. 10 to 19 days
F. 20 to 29 days
G. All 30 day

The next 2 questions ask about drinking alcohol. This includes drinking beer, wine, wine coolers, and liquor such as rum, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of wine for religious purposes.

27. Have you ever had a drink of alcohol, other than a few sips?
A. Yes
B. No

28. How old were you when you had your first drink of alcohol other than a few sips?
A. I have never had a drink of alcohol other than a few sips
B. 8 years old or younger
C. 9 years old
D. 10 years old
E. 11 years old
F. 12 years old
G. 13 years old or older

The next 2 questions ask about marijuana use. Marijuana also is called grass or pot.

29. Have you ever used marijuana?
A. Yes
B. No

30. How old were you when you tried marijuana for the first time?
A. I have never tried marijuana
B. 8 years old or younger
C. 9 years old
D. 10 years old
E. 11 years old
F. 12 years old
G. 13 years old or older

The next 4 questions ask about other drugs.

31. Have you ever used **any** form of cocaine, including powder, crack, or freebase?
A. Yes
B. No

32. Have you ever sniffed glue, breathed the contents of spray cans, or inhaled any paints or sprays to get high?
A. Yes
B. No

33. Have you ever taken **steroid pills or shots** without a doctor's prescription?
A. Yes
B. No

34. Have you ever taken a **prescription drug** (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription?

The next 4 questions ask about sexual intercourse.

35. Have you ever had sexual intercourse?
A. Yes
B. No

36. How old were you when you had sexual intercourse for the first time?
A. I have never had sexual intercourse
B. 8 years old or younger
C. 9 years old
D. 10 years old
E. 11 years old
F. 12 years old
G. 13 years old or older

37. With how many people have you ever had sexual intercourse?
A. I have never had sexual intercourse
B. 1 person
C. 2 people
D. 3 people
E. 4 people
F. 5 people
G. 6 or more people A. Yes
B. No

38. The **last time** you had sexual intercourse, did you or your partner use a condom?
A. I have never had sexual intercourse
B. Yes
C. No

The next 2 questions ask about body weight.

39. How do **you** describe your weight?
A. Very underweight
B. Slightly underweight
C. About the right weight
D. Slightly overweight
E. Very overweight

40. Which of the following are you trying to do about your weight?
A. **Lose** weight
B. **Gain** weight
C. **Stay** the same weight
D. Iam **not trying to do anything** about my weight

The next question asks about eating breakfast.

41. During the past 7 days, on how many days did you eat **breakfast**?
A. 0 days
B. 1 day
C. 2 days
D. 3 days
E. 4 days
F. 5 days
G. 6 days
H. 7 days

The next 5 questions ask about physical activity.

42. During the past 7 days, on how many days were you physically active for a total of **at least 60 minutes per day**? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard some of the time.)
A. 0 days
B. 1 day
C. 2 days
D. 3 days
E. 4 days
F. 5 days
G. 6 days
H. 7 days

43. On an average school day, how many hours do you watch TV?
A. I do not watch TV on an average school day
B. Less than 1 hour per day
C. 1 hour per day
D. 2 hours per day
E. 3 hours per day
F. 4 hours per day
G. 5 or more hours per day

44. On an average school day, how many hours do you play video or computer games or use a computer for something that is not school work? (Count time spent on things such as Xbox, PlayStation, an iPod, an iPad or other tablet, a smartphone, YouTube, Facebook or other social networking tools, and the Internet.)
A. I do not play video or computer games or use a computer for something that is not school work
B. Less than 1 hour per day
C. 1 hour per day
D. 2 hours per day
E. 3 hours per day
F. 4 hours per day
G. 5 or more hours per day

45. In an average week when you are in school, on how many days do you go to physical education (PE) classes?
A. 0 days
B. 1 day
C. 2 days
D. 3 days
E. 4 days
F. 5 days

46. During the past 12 months, on how many sports teams did you play? (Count any teams run by your school or community groups.)
A. 0 teams
B. 1 team
C. 2 teams
D. 3 or more teams

The next 3 questions ask about other health-related topics.

47. Has a doctor or nurse ever told you that you have asthma?
A. Yes
B. No
C. Not sure

48. On an average school night, how many hours of sleep do you get?
A. 4 or less hours
B. 5 hours
C. 6 hours
D. 7 hours
E. 8 hours
F. 9 hours
G. 10 or more hours

49. During the past 12 months, how would you describe your grades in school?
A. Mostly A's
B. Mostly B's
C. Mostly C's
D. Mostly D's
E. Mostly F's
F. None of these grades
G. Not sure

This is the end of the survey. Thank you very much for your help.

Appendix C
Youth Risk Behavior Survey (YRBSS) Parent Version

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do.

Completing the survey is voluntary. Whether or not you answer the questions will not affect you or your child. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the types of people completing this survey. The information will not be used to find out your name. No names will ever be reported.

Make sure to read every question. Circle your answer completely. When you are finished, follow the instructions of the person giving you the survey.

6. **When your child rides a bicycle,** how often do they wear a helmet?
A. They do not ride a bicycle
B. Never wear a helmet
C. Rarely wear a helmet
D. Sometimes wear a helmet
E. Most of the time wear a helmet
F. Always wear a helmet

7. **When your child rollerblades or rides a skateboard**, how often do they wear a helmet?
A. They do not rollerblade or ride a skateboard
B. Never wear a helmet
C. Rarely wear a helmet
D. Sometimes wear a helmet
E. Most of the time wear a helmet
F. Always wear a helmet

8. How often does your child wear a seat belt when **riding** in a car?
A. Never
B. Rarely
C. Sometimes
D. Most of the time
E. Always

9. Has your child ever ridden in a car driven by someone who had been drinking alcohol?

A. Yes
B. No
C. Not sure

The next 3 questions ask about violence-related behaviors.

10. Has your child ever carried **a weapon**, such as a gun, knife, or club?
A. Yes
B. No

11. Has your child ever been in a physical fight?
A. Yes
B. No

12. Has your child ever been in a physical fight in which they were hurt and had to be treated by a doctor or nurse?
A. Yes
B. No

The next 2 questions ask about bullying. Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.

13. Has your child ever been bullied **on school property**?
A. Yes
B. No

14. Has your child ever been **electronically** bullied? (Count being bullied through e-mail, chat rooms, instant messaging, websites, or texting.)
A. Yes
B. No

The next 3 questions ask about attempted suicide. Sometimes people feel so depressed about the future that they may consider attempting suicide or killing themselves.

15. Has your child ever **seriously** thought about killing themselves?
A. Yes
B. No

16. Has your child ever made a **plan** about how they would kill themselves?
A. Yes
B. No

17. Has your child ever **tried** to kill themselves?
A. Yes

B. No

The next 7 questions ask about tobacco use.

18. Has your child ever tried cigarette smoking, even one or two puffs?
A. Yes
B. No

19. How old was your child when they smoked a whole cigarette for the first time?
A. They have never smoked a whole cigarette
B. 8 years old or younger
C. 9 years old
D. 10 years old
E. 11 years old
F. 12 years old
G. 13 years old or older

20. During the past 30 days, on how many days did your child smoke cigarettes?
A. 0 days
B. 1 or 2 days
C. 3 to 5 days
D. 6 to 9 days
E. 10 to 19 days
F. 20 to 29 days
G. All 30 days

21. During the past 30 days, on the days your child smoked, how many cigarettes did your child smoke **per day**?
A. They did not smoke cigarettes during the past 30 days
B. Less than 1 cigarette per day
C. 1 cigarette per day
D. 2 to 5 cigarettes per day
E. 6 to 10 cigarettes per day
F. 11 to 20 cigarettes per day
G. More than 20 cigarettes per day

22. During the past 30 days, how did your child **usually** get their own cigarettes? (Select only **one** response.)
A. They did not smoke cigarettes during the past 30 days
B. They bought them in a store such as a convenience store, supermarket, discount store, or gas station
C. They got them on the Internet
D. They gave someone else money to buy them for me
E. They borrowed (or bummed) them from someone else
F. A person 18 years old or older gave them to them
G. They took them from a store or family member
H. They got them some other way

23. During the past 30 days, on how many days did your child use **chewing tobacco, snuff, or dip,** such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, or Copenhagen?
A. 0 days
B. 1 or 2 days
C. 3 to 5 days
D. 6 to 9 days
E. 10 to 19 days
F. 20 to 29 days
G. All 30 days

24. During the past 30 days, on how many days did your child smoke **cigars, cigarillos, or little cigars**?
A. 0 days
B. 1 or 2 days
C. 3 to 5 days
D. 6 to 9 days
E. 10 to 19 days
F. 20 to 29 days
G. All 30 days

The next 2 questions ask about electronic vapor products, such as blu, NJOY, or Starbuzz. Electronic vapor products include e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens.

25. Has your child ever used an electronic vapor product?
A. Yes
B. No

26. During the past 30 days, on how many days did your child use an electronic vapor product?
A. 0 days
B. 1 or 2 days
C. 3 to 5 days
D. 6 to 9 days
E. 10 to 19 days
F. 20 to 29 days
G. All 30 days

The next 2 questions ask about drinking alcohol. This includes drinking beer, wine, wine coolers, and liquor such as rum, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of wine for religious purposes.

27. Has your child ever had a drink of alcohol, other than a few sips?
A. Yes
B. No

28. How old was your child when they had their first drink of alcohol other than a few sips?
A. They have never had a drink of alcohol other than a few sips
B. 8 years old or younger
C. 9 years old
D. 10 years old
E. 11 years old
F. 12 years old
G. 13 years old or older

The next 2 questions ask about marijuana use. Marijuana also is called grass or pot.

29. Has your child ever used marijuana?
A. Yes
B. No

30. How old was your child when they tried marijuana for the first time?
A. They have never tried marijuana
B. 8 years old or younger
C. 9 years old
D. 10 years old
E. 11 years old
F. 12 years old
G. 13 years old or older

The next 4 questions ask about other drugs.

31. Has your child ever used **any** form of cocaine, including powder, crack, or freebase?
A. Yes
B. No

32. Has your child ever sniffed glue, breathed the contents of spray cans, or inhaled any paints or sprays to get high?
A. Yes
B. No

33. Has your child ever taken **steroid pills or shots** without a doctor's prescription?
A. Yes
B. No

34. Has your child ever taken a **prescription drug** (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription?
A. Yes
B. No

The next 4 questions ask about sexual intercourse.

35. Has your child ever had sexual intercourse?
A. Yes
B. No

36. How old was your child when they had sexual intercourse for the first time?
A. They have never had sexual intercourse
B. 8 years old or younger
C. 9 years old
D. 10 years old
E. 11 years old
F. 12 years old
G. 13 years old or older

37. With how many people has your child ever had sexual intercourse?
A. They have never had sexual intercourse
B. 1 person
C. 2 people
D. 3 people
E. 4 people
F. 5 people
G. 6 or more people

38. The **last time** your child had sexual intercourse, did they or their partner use a condom?
A. They have never had sexual intercourse
B. Yes
C. No

The next 2 questions ask about body weight.

39. How would **your child** describe their weight?
A. Very underweight
B. Slightly underweight
C. About the right weight
D. Slightly overweight
E. Very overweight

40. Which of the following would your child say they are trying to do about their weight?
A. **Lose** weight
B. **Gain** weight
C. **Stay** the same weight
D. I am **not trying to do anything** about my weight

The next question asks about eating breakfast.

41. During the past 7 days, on how many days did your child eat **breakfast**?
A. 0 days

B. 1 day
C. 2 days
D. 3 days
E. 4 days
F. 5 days
G. 6 days
H. 7 days

The next 5 questions ask about physical activity.

42. During the past 7 days, on how many days was your child physically active for a total of **at least 60 minutes per day**? (Add up all the time your child spent in any kind of physical activity that increased their heart rate and made them breathe hard some of the time.)
A. 0 days
B. 1 day
C. 2 days
D. 3 days
E. 4 days
F. 5 days
G. 6 days
H. 7 days

43. On an average school day, how many hours does your child watch TV?
A. They do not watch TV on an average school day
B. Less than 1 hour per day
C. 1 hour per day
D. 2 hours per day
E. 3 hours per day
F. 4 hours per day
G. 5 or more hours per day

44. On an average school day, how many hours does your child play video or computer games or use a computer for something that is not school work? (Count time spent on things such as Xbox, PlayStation, an iPod, an iPad or other tablet, a smartphone, YouTube, Facebook or other social networking tools, and the Internet.)
A. They not play video or computer games or use a computer for something that is not school work
B. Less than 1 hour per day
C. 1 hour per day
D. 2 hours per day
E. 3 hours per day
F. 4 hours per day
G. 5 or more hours per day

45. In an average week when your child is in school, on how many days do they go to

physical education (PE) classes?
A. 0 days
B. 1 day
C. 2 days
D. 3 days
E. 4 days
F. 5 days

46. During the past 12 months, on how many sports teams did your child play? (Count any teams run by your child's school or community groups.)
A. 0 teams
B. 1 team
C. 2 teams
D. 3 or more teams

The next 3 questions ask about other health-related topics.

47. Has a doctor or nurse ever told your child that they have asthma?
A. Yes
B. No
C. Not sure

48. On an average school night, how many hours of sleep does your child get?
A. 4 or less hours
B. 5 hours
C. 6 hours
D. 7 hours
E. 8 hours
F. 9 hours
G. 10 or more hours

49. During the past 12 months, how would you describe your child's grades in school?
A. Mostly A's
B. Mostly B's
C. Mostly C's
D. Mostly D's
E. Mostly F's
F. None of these grades
G. Not sure

This is the end of the survey. Thank you very much for your help.

Appendix D

Parental Monitoring Scale

How much do you know about:
1. Who your child spends time with?
2. How your child spends his/her free time?
3. How your child spends his/her money?
4. Where your child goes right after school?
5. Where your child goes throughout the day on the weekend?
6. Problems your child is having at school?
(Answers: Don't know at all, Know a little bit, Know a lot, Know everything)

7. Do you tell your child what time he/she has to be home on school nights?
8. Do you tell your child what time he/she has to be home on weekend nights?
9. If your child didn't come home by the set time, would you know?
10. If you aren't home and your child leaves the house, does your child leave a note or call to say where
he/she is going?
11. When you aren't at home, does your child know how to get in touch with you?
(Answers: Never, Sometimes, Often, Always)

Appendix E

For questions that produce yes or no answers the answer choice of yes will be coded as one while the answer choice no will be coded as zero. *For example:*

35. Have you ever had sexual intercourse?

A. Yes (1)

B. No (0)

The YRBSS additionally contains questions that offer a range of ages for answers, for these questions the youngest age option (8 years old) was coded as a six while the oldest age option (13 years old or older) was scored as one. *For example:*

36. How old were you when you had sexual intercourse for the first time?

A. I have never had sexual intercourse (0)

B. 8 years old of younger (6)

C. 9 years old (5)

D. 10 years old (4)

E. 11 years old (3)

F. 12 years old (2)

G. 13 years old or older (1)

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