Another year, another book! Young People in 1992, the seventh in the series, is now available from the Unit. Responses from 20,218 pupils between the ages of 11-15, who participated in Health Related Behaviour surveys around the country, are included in a weekend over a hundred tables illustrating the activities and behaviours of these young people. The cost is £20.00 including postage.

Several Unit members have helped Carrie (Carolyn Shelley) pilot a new edition (Version 5) of the Primary Health Related Behaviour Questionnaire. If you are interested in discovering health-related facts about the children in your primary school, from the age of 7 upwards, then ask for the Primary Health Related Behaviour Questionnaire pack (price £2), or talk about it to Carrie. Incidentally, she is expecting a sibling for Susannah (ETA April 28th), so we hope that this column carries a birth announcement shortly.

Suey and her team of coders and punchers have been hard at work on Health Related Questionnaire scripts coming in from schools for as far apart as Scotland and the south coast. Major surveys in Essex, Oxford and Durham are happening at the present time, and City Challenge Initiative survey scripts continue to come in. Karen reports a lot of interest in our new School Report service, which is described on page 10. At the end of January she sent letters to all the schools that have used Version 15 of the Health Related Behaviour Questionnaire, and already 78 have requested copies.

Sally has been keeping up with subscription renewals and assisting John and Di with their alcohol questionnaire. They report that the most common reason given by young people for drinking alcohol is 'to get drunk', and that this response becomes more frequent still in older age groups. Many young people also believe that it is alright to refuse a drink, and also quite easy! Is this really true?

There has been a lull in liaison with Cornwall Health Authority about the evaluation for their innovative Smoking Education in Schools project, and with the Health Education Authority regarding the proposed Diploma in Health Education for teachers. We have all been refining the Unit's services for the Version 16 questionnaire—the new school report, graphs, and possible improved table format.

Some Unit publications

Young People in 1991.£20.00

The latest of our annual reports, with results from 23,928 young people between the ages of 12 and 16 who completed the Health Related Behaviour Questionnaire.


The latest of our annual reports, with results from 20,218 young people between the ages of 11 and 15 who completed the Health Related Behaviour Questionnaire.

Video pack: 'The Extra Guest'.£12.50 (Excluding VAT)

This was developed to support alcohol education in secondary schools. The well-received video depicts a teenage party, and the materials include background information, suggestions for use, worksheet masters and overhead transparencies.

Schoolchildren and drugs in 1987.£2.50

The survey by young people of 'illegal' drugs, based on the reported behaviour of 18,814 boys and girls between the ages of 11 and 16, is described.

We teach them how to drink!£2.50

Analysis of young people's most frequent sources of alcohol.

People into the Nineties...£6.00 (96 pages; £4 for the set as issued)

The survey of the decade—a study of 123,933 young people between the ages of 11 and 16 over the period 1984-1990.

These prices include postage and packing.
Classifying family type

By these means we classified pupils' dimensions of their family life in terms of support and control, as follows:

Neglecting families were seen to have low support and low control.

Authoritarian or very strict families had high support and high control.

Indulgent families were high on support and low on control.

Warm-directive families were high on both support and control.

How adolescents view their own family situation could influence the extent to which they use alcohol and other substances. In a recent review of separate research reports, we found that both family support and control, as perceived by adolescent respondents, were related to levels of self-reported alcohol use. In the present study, we observed that the more heavily-drinking teenagers are more likely to perceive their family environment as unsupportive or lax, and, in general, both high support and low control were related to heavier drinking.

The survey

However, most of the research reports we reviewed came from the USA, and there are certain differences regarding both alcohol use and family process between our two countries. This in mind, we set out in the summer of 1991 to look at teenage drinking and family life in a large regional study in Humberside, England, using the Adolescent Drinking and Family Life Questionnaire (ADFLQ). However, what started as an alcohol-related study was widened to include smoking and the use of soft and hard drugs by collaborating with the Schools Health Education Unit, which was currently administering the Health Related Behaviour Questionnaire (HRBQ) in some of the schools chosen for our survey.

Since the two questionnaire surveys were run independently, and the HRBQ had already been completed, we had to develop a strategy for merging each individual's two questionnaires. With the permission and co-operation of John Balding and David Rees, and a subset of schools involved in the Yorkshire Region Survey, this was done by adding a group of descriptive variables such as age, the number in the family, and type of residential district, to the ADFLQ. These were then matched with the same variables in the HRBQ in a complex computer program requiring over eight hours of running on the latest equipment. When it had finished, we had 1,045 out of 1,400 individuals uniquely matched on the questionnaires, giving an extremely successful match rate of 82%.

The sample

These 1,045 individuals comprise the sample detailed in this report, consisting of 599 boys (57%) and 486 girls (43%), with 667 pupils in years 8-10 (aged 13-15) and 378 in years 10-11 (aged 14-16).

Similar proportions of boys and girls were classified into each family type. One important point to make here is that actual levels of support and control may vary between males and females, but the perceived level of support and control, from low to high, may be similar. For example, it may be the case that girls are constrained more rigorously by family rules and guidelines about the time to come in at night or about going out alone. However, such actual differences may not become apparent when measuring perceived levels of support and control if girls regard such constraints as normal.

In general terms, the kinds of questions we are interested in about family life and adolescent drinking and substance use are:

- What perceptions do adolescents have about their families?
- How do these perceptions (of family relationships) relate to their own use of alcohol and related substances?

Consumption of alcohol

In this report we look at three self-reported alcohol use behaviours from the ADFLQ:

- Drinking more than once a week
- Usual drinker to get a drink
- Drink by my friends do

Frequency of drinking

Using level of consumption

Amount drunk in the last seven days

Respondents were also asked to indicate which of 11 pre-defined reasons for drinking applied to them, and we also report how these reasons for drinking relate to family life. The reasons were:

- I like the taste
- To escape problems
- To be sociable
- To celebrate
- Because I'm under pressure/stress
- I like the effects
- To get drunk
- To get drunk
- To get drunk
- To get drunk
- To get drunk

On the whole, boys were more likely than girls to report heavy drinking. Moreover, boys categorised under the neglecting family type were the most likely to drink heavily. Moderate drinking was most likely among boys from warm-directive families. For girls, the same picture emerges, although those from authoritative families were also likely to drink more heavily. Interesting family differences were found for the more inappropriate reasons for drinking. For boys, authoritarian and neglecting family types were linked with:

- Drinking to escape problems
- To get drunk
- Because their friends do
- Because of stress
- Because of the effects of alcohol

A similar picture emerges for girls, with more from authoritarian and neglecting family types giving these reasons for drinking:

- Drinking to escape problems
- To boost confidence
- To get drunk
- To get drunk
- To get drunk

Reasons for drinking indicate an individual's attitudes and intentions concerning alcohol. In a recent article we have shown that older adolescents who have inappropriate reasons for drinking are more likely to be heavier drinkers; furthermore, the heavier drinkers are likely to have more reasons for drinking (3). Thus, one's reasons for drinking are important factors in considering alcohol education and treatment programmes. The major question is how positively to encourage the adoption of appropriate reasons for drinking, and thus discourage inappropriate reasons.

Cigarette smoking

Several questions from the HRBQ relating to cigarette use were examined in relation to family life. These were:

- Number of cigarettes smoked yesterday
- Number of cigarettes smoked in the previous week
- Current smoking habit

Expected future smoking habit

Using cigarettes to cope with problems

Clear family differences were found in the relationship between smoking behaviour and family type. Girls tended to smoke more than boys, in contrast to the pattern obtained with the alcohol use behaviours. Girls from all family types were equally likely to report that they smoked, whereas, as with drinking, smoking boys were more likely to be found in authoritarian or neglecting families. The picture for girls is particularly interesting in comparison with
their drinking behaviour, where warm-directive families had a marked positive relation with girls' restrained use of alcohol.

Use of illegal drugs

A comprehensive list of illicit drugs comprised several questions in the HRBBQ. We combined these drugs into the following groups:

- Controlled drugs (cocaine, opiates, heroin)
- Stimulants/sedatives (amphetamines, barbiturates, tranquillizers)
- Hallucinogens (natural, synthetic)
- Cannabis (leaf, resin)
- Ecstasy
- Solvents

We then examined, in relation to family life, four aspects of knowledge or behaviour regarding these substances:

- Did they know anything about them?
- Did they know anyone who had used them?
- Had they ever been offered any of them?
- Had they ever used any of them?

Very few of the pupils admitted using other substances (solvents, cannabis, ecstasy, stimulants or depressants, and 'hard' drugs). But of those who did, more perceived their families as authoritative or neglecting.

Gender differences in family influence

In summary, boys tended to be heavier drinkers, generally in line with gender differences in adult alcohol use. For boys, family type was an important influence on their level of drinking. Girls reported smoking more often, and family type was not an influence on this or other substance use.

How might we explain this contrast? Possibly girls, because of social conventions, face restrictions on their level of drinking. Girls who are heavier drinkers do not have the same social approval as heavy-drinking boys, and therefore cigarettes may offer an alternative resource which is more acceptable. Heavier smoking by girls could be an important, although potentially harmful, 'equal opportunity' drug use strategy.

This difference may also be a factor in the lack of influence of family type on smoking and other substance-use by girls. Drinking in a socially acceptable behaviour — the use of alcohol by adults is generally condoned, as those people who choose not to drink are in the minority, and therefore drinking by young people is a behaviour subject to strong socialisation influence. Smoking, and the use of substances other than tobacco, is less acceptable or even socially proscribed, and so for girls their families may not play as important a role in the socialisation of these behaviours.

Conclusion

Differences in family style seem to be associated with differences in adolescent health behaviours, and these effects can vary in direction and degree from one behaviour to another. At this stage there are only tentative suggestions, requiring further examination with a larger research programme. However, what is clear from the present results is that:

1. Drinking, smoking and other forms of drug-taking are distinct activities, and should not be lumped together, as part of the same 'problem behaviour', by researchers, educationalists, and practitioners.
2. Family type seems to be more influential on drug use by boys than by girls.
3. For boys and girls, the neglecting and authoritative family types are associated with higher use of all types of drug. These types are both low on support, and it may be that support rather than control is the critical factor behind these behaviours.

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