THE RELATIONSHIP OF TRUST, PARENTAL AND

PEER SUPPORT RELATIONSHIPS, AND HEALTH

RISK BEHAVIORS IN COLLEGE STUDENTS

By

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CHAPTER I

INTRODUCTION

This research looks at college students' relationships with their peers and families, and the extent to which these relationships are related to the college students' behavior. More specifically, I investigated whether the perceived adequacy of social support students have from those relationships is related to their level of trust and whether either is related to high risk health behaviors. Parents of college students would like to believe that their children's decisions and moral reasoning are based on familial influence but students spend a large amount time outside of their homes, around their peers and cannot help being influenced by their peers' decisions and moral reasoning.

I examined high risk health behaviors related to tobacco and drug use, alcohol consumption, and sexual behaviors. Previous researchers found that both family and peer relationships influence whether college students engage in positive or negative health behaviors and in specific drug use, alcohol consumption, and sexual, behaviors. Unknown is whether and how much students' health behaviors are related to the amount of trust students have or their perception of the support they receive from family and/or peer relationships.

Statement of the Problem

In the United States (US), drug and alcohol use and sometimes sexual behaviors among youth leads to serious behavioral, social and health problems. The actual engagement in the operationally defined behaviors is a risk to adverse health and safety conditions.

Purpose of the Study

In this study I addressed health risk behaviors in relation to college students' trust in others and their perception of the adequacy of social support from family or friends. The purpose of this study was to determine whether and to what extent college students' trust and perception of social support from peers and family/parents are related to college student health behaviors related to risky sexual behaviors and the use or tobacco, drugs and/or alcohol. Variables included in the study were perception of social support from family, relationship with peers, and significant others, generalized trust in relationships, and high risk health behaviors.

Significance of the Study

Findings of the study may add to counselors' understanding of how to decrease high risk health behavior and increase positive risk behavior. Further, through this research I hoped to gain a better understanding for future research of the impact that family and peers and relationship trust may have on individual behaviors of college age students and how to get people to engage in positive health behaviors. In this study, I investigated the relationships of the variables by using correlational analysis. In additional analyses, I used independent group t-tests and ANOVAs to determine whether there were differences in perceived adequacy of social support and trust in others

between those who did not engage in high risk behaviors and those who did or engaged in higher levels of risk

The theoretical framework that guided this study was the resource model. The resource model proposes that health is a positive, multidimensional process, that health status and perceptions of health influence behavior are directed by a person's implicit or explicit definition of health. The major concepts within the resource model are social resources, health resources, and health behaviors. The model proposes that health behaviors have multiple dimensions and that different types of health behaviors may have different correlations or causes. As indicted by Harber, Yeung, and Iacovelli (2011), psychosocial resources include social support, self-worth, self-esteem, self-efficacy, hope, optimism, perceived control, and self-disclosure. Those who enjoy ample resources experience challenges as less subjectively disturbing, and also display more effective coping in the face of adversity. I also considered The Health Belief Model (HBM) (Sheeran and Abraham, 1996) which contains associations of variables which are considered relevant for explaining or predicting health-seeking behaviors. Action in the HBM is guided by (1)Perceived Susceptibility and Severity-Beliefs about the impact of illness and its consequences, (2) Perceived Benefits- Health motivation, or readiness to be concerned about health matters, (3) Perceived Barriers- Beliefs about the consequences of health practices and about the possibilities and the effort to put them into practice, (4) Cues to action, and (5) Self-Efficacy- Beliefs and health motivation are conditioned by socio-demographic variables and by the psychological characteristics of the person. Sharma (2011) indicted that "The Health Belief Model is one of the first theories

developed exclusively for health-related behaviors. Although the labeled a "model," the

HBM meets all the criteria for a behavioral theory (p.3)."

Limitations

A limitation to the study is that there is not much research that looks beyond

adolescent years and trust as a factor in familial and peer relationships. The use of a self-

report survey methods and not actual observation of student behavior is an additional

issue because study participants may not accurately report their behavior, and may have

rendered the findings, especially those related to high risk health behaviors. There may

have also been a reluctance to honestly answer questions that in some cases would be an

admission of illegal activity, despite the guarantee of anonymity. Since this is a survey

and not an experimental study, there cannot be a conclusion on any causative

relationships. Additionally, there is limited research on the psychometric properties of

the YRBSS and information is limited on the reliability and validity. Furthermore, it is

possible for a person whom has had more or less trust in their life to trust the researcher

more or less, which may reflect how they response. Results cannot be generalized

beyond the students at the university who participate in this study.

Definition of Terms

Trust. Trust plays an important role in interpersonal behavior and is defined and

conceptualized in a number of ways. Trust has been shown to facilitate the sharing of

information and encourage cooperation (Butler, 1999; McAllister, 1995). Many

researchers define trust first as a reliance on another person (Curral & Judge, 1995) and

further indicate that trust unfolds in risky contexts in which outcomes are uncertain with

the possibility of adversity. According to McAllister (1997), trust represents confidence

in another person in a context in which the individuals are interdependent on each other but in which risks are plausible. Additionally, Mayer, Davis, and Schoorman (1995) posited that when individuals demonstrate trust, they anticipate they will be the recipient of some beneficial act, but do not monitor or control the benefactor. They are thus vulnerable to the actions of this person. Rousseau, Sitkin, Burt, and Camerer (1998) defined trust as a psychological state compromising the intention to accept vulnerability based upon the positive expectations of the intentions or behavior of another. Trust is the intention to accept vulnerability, meaning the decision to show trust involves a situation of risk and interdependence. For the purpose of this study, I defined trust as reliance on another person in risky contexts, specifically contexts in which the outcome is uncertain (Currall & Judge, 1995).

Family. Edwards and Graham (2009) assert that, "Conceptions of family have evolved from structural characterizations of family in which individuals are connected primarily through legal and biological ties to transaction-based definitions in which family is conceived as a group of intimates who create a sense of shared identity (p. 192)." For this current study I considered whether or not characteristic tasks of family life are performed and refer to role-based definition in which the fulfillment of particular roles, duties, functions, or obligations is the principle attribute of the definition of family and can be performed by anyone. Based on a citation by Edwards and Graham (2009), I defined family as "a psychosocial group constituted by at least one adult member and one or more others who work as a group toward mutual need fulfillment, nurturance, and development (p. 193)."

Peer relationships. According to Kram and Isabella (1985), "Peer relationships function as to provide a variety of developmental benefits (p. 116)." For the purpose of this study, I defined peer relationships in terms of psychosocial functions where peers are able to provide confirmation to each other through sharing perceptions, values, beliefs, and can provide friendship (Kram & Isabella, 1985).

High risk behaviors. For this study, I defined high risk behaviors as a set of presumed cause-effect dynamics that place an individual in danger of future negative outcomes. As stated by McWhirter, McWhirter, McWhirter, and McWhirter (2007), "At risk designates a situation that can be anticipated in the absences of intervention (pg. 6)." Risky behaviors in reference to sex may be engaging in unprotected sex which leads to the possible transmission of sexually transmitted infections, disease, and virus, not being aware of the HIV status of a partner, multiple sexual partners during a certain time, pregnancy, and a larger amount of sexual partners. The effects are extreme serious health consequences that may be irreversible and/or incurable. Risky behaviors for all other drugs other than alcohol are the use of tobacco, cannabis, stimulants, inhalants, narcotics (opiates), sedative-hypnotics, and hallucinogens.

Heavy Episodic Drinking. Heavy Episodic Drinking (HED) is a health issue that should be taken seriously on college campuses. When an individual consumes large amounts of alcohol, (five or more drinks in one sitting for males and four or more drinks in one sitting for females) in a relatively limited amount of time that patter of alcohol use is defined as HED (Venegas, Cooper, Naylor, Hanson, & Blow, 2012).

The effects on overall behavior are the way that they influences behavior by limiting ability and disinhibition where people behave in ways they would not normally

behave. I assumed that family and peer relationships are not equally influential on whether a student engages in high risk health behaviors. I expected that college student behaviors are significantly related to the extent of trust they have in others.

Research Questions

1. Is there a relationship between generalized trust and the adequacy of perceived support received from family?

2. Is there a relationship between generalized trust and the adequacy of perceived support received from friends?

3. Is there a relationship between how much an individual trusts (family/friends/significant others) and his/her engagement in high risk health behaviors (heavy episodic drinking, tobacco use, marijuana use, and sex)?

    a. Is there a relationship between how much an individual trusts (family/friends/significant others) and his/her reported heavy episodic drinking?

    b. Is there a relationship between how much an individual trusts (family/friends/significant others) and his/her reported tobacco use?

    c. Is there a relationship between how much an individual trusts (family/friends/significant others) and his/her reported marijuana use?

    d. Is there a relationship between how much an individual trusts (family/friends/significant others) and his/her reported high risk sexual behavior?

4. Is there a relationship between adequacy of perceived support from family and engagement in high risk health behaviors (heavy episodic drinking, tobacco use, marijuana use, and sex)?

   a. Is there a relationship between adequacy of perceived support from family and engagement in heavy episodic drinking?

   b. Is there a relationship between adequacy of perceived support from family and engagement in tobacco use?

   c. Is there a relationship between adequacy of perceived support from family and engagement in marijuana use?

   d. Is there a relationship between adequacy of perceived support from family and engagement in sexual risk behaviors?

5. Is there a relationship between adequacy of perceived support from peers and engagement in high risk health behaviors (heavy episodic drinking, tobacco use, marijuana use, and sex)?

   a. Is there a relationship between adequacy of perceived support from peers and engagement in heavy episodic drinking?

   b. Is there a relationship between adequacy of perceived support from peers and engagement in tobacco use?

   c. Is there a relationship between adequacy of perceived support from peers and engagement in marijuana use?

   d. Is there a relationship between adequacy of perceived support from peers and engagement in sexual risk behaviors?

6. Is there a relationship between adequacy of perceived support from significant others and engagement in high risk health behaviors (heavy episodic drinking, tobacco use, marijuana use, and sex)?

    a. Is there a relationship between adequacy of perceived support from significant others and engagement in heavy episodic drinking?

    b. Is there a relationship between adequacy of perceived support from significant others and engagement in tobacco use?

    c. Is there a relationship between adequacy of perceived support from significant others and engagement in marijuana use?

    d. Is there a relationship between adequacy of perceived support from significant others and engagement in sexual risk behaviors?

Hypotheses

1. There will not be a relationship between generalized trust and the perceived adequacy of support received from family.

2. There will be a positive relationship between generalized trust and the adequacy of perceived support received from friends.

3. There will be a positive relationship between how much an individual trusts and their engagement in high risk health behavior.

    a. There will be a positive relationship between how much an individual trusts (family/friends/significant others) and his/her reported heavy episodic drinking.

    b. There will be a positive relationship between how much an individual trusts (family/friends/significant others) and his/her reported tobacco use.

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c. There will be a positive relationship between how much an individual trusts (family/friends/significant others) and his/her reported marijuana use.

d. There will be a positive relationship between how much an individual trusts (family/friends/significant others) and his/her reported sex risk behaviors.

4. There is not a relationship between the adequacy of support from family and engagement in high risk health behaviors (heavy episodic drinking, tobacco use, marijuana use, and sex).

   a. There is no relationship between the adequacy of support from family and engagement in heavy episodic drinking.

   b. There is no relationship between the adequacy of support from family and engagement in tobacco use.

   c. There is no relationship between the adequacy of support from family and engagement in marijuana use.

   d. There is no relationship between the adequacy of support from family and engagement in sex risk behaviors.

5. There is a positive relationship between adequacy of support from peers and engagement in high risk health behaviors (heavy episodic drinking, tobacco use, marijuana use and sex).

   a. There is a positive relationship between adequacy of support from peers and engagement in heavy episodic drinking.

b. There is a positive relationship between adequacy of support from peers and engagement in tobacco use.

c. There is a positive relationship between adequacy of support from peers and engagement in marijuana use.

d. There is a positive relationship between adequacy of support from peers and engagement in sexual risk behaviors.

6. There is a positive relationship between adequacy of support from significant others and engagement in high risk health behaviors (heavy episodic drinking, tobacco use, marijuana use, and sex).

a. Individuals who engage in heavy episodic drinking will have a high social support from significant others compared to those who do not engage in heavy episodic drinking.

b. Individuals who engage in heavy episodic drinking will have a high social support from significant others compared to those who do not engage in tobacco use.

c. Individuals who engage in heavy episodic drinking will have a high social support from significant others compared to those who do not engage in marijuana use.

d. Individuals who engage in heavy episodic drinking will have a high social support from significant others compared to those who do not engage in sexual risk behaviors.

CHAPTER II

REVIEW OF LITERATURES

In the following literature review, I reviewed links between health behaviors, propensity to trust, and social support systems. I examined trust in social support system interactions, and the extent to which it is related to behavior and decisions. For the purpose of this study, I defined high risk behaviors as a set of presumed cause-effect dynamics that place an individual in danger of future negative outcomes. I am measuring risk in terms of alcohol consumption, tobacco use, marijuana use, and sex behaviors. One dimension of risk taking is the physical, meaning that a person enjoys doing adventurous things and taking chances even though, or perhaps because, physical danger is involved; and may sometimes disregard physical dangers. A social dimension is when a person is socially brash and willing to risk embarrassment or loss of esteem to further goals. The person may be willing to express themselves freely, in ideas, clothing, and so on, if the occasion warrants it. An ethical dimension may be if a person is willing to compromise standards, one's own or society's when the issue or circumstances warrants it (Jackson, Hourany, & Vidmar, 1972). McWhirter, et al. (2007) found that often times the scope of problematic behaviors is linked to the use of tobacco and alcohol, with both being considered "threshold" or "gateway" substances to more illicit drugs.

Jackson, Hourany, and Vidmar (1972) hypothesized that there is no general risk-taking disposition because risk taking varies within the individual from task to task and that subjects may perceive themselves as being risky when in fact they are not, which may explain why certain self-report personality measures and behavioral measures have been shown not to correlate, and additionally that risk taking may be multidimensional. Slovic (1964) suggested that risk taking may be a multidimensional concept and that researchers should systematically explore the contributions of expected value, variance, and probability to a person's risk-taking propensities across a variety of gambling situations. According to Abbott-Chapman, Denholm, and Wyld (2008) Relationships with parents, peers, professionals and the wider community are part of the socio-environmental contextual mix and the type and level of risk-taking is expressive of social norms and group membership.

Familial Influences

Family history is an important risk factor to consider in association with the use of substances. As cited by McWhirter et al. (2007), "Research consistently identifies family factors, such as parenting styles, as central to the etiology of multiple problem behavior outcomes, including early-onset substance use (Webster-Stratton, 1997, p.148)." Nanda and Konnur (2006) showed that "Parental attitudes and presence of drugs such as alcohol may expose a child to use drugs at an earlier age (p. 711)." Chen and Thompson (2007) write that it is imperative for healthcare providers to facilitate discussions on what to expect physically and psychologically during adolescence with preadolescents and parents in annual regular check-ups or whenever appropriate. Their findings provide necessary resources for parents to help them know how to better communicate with their

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children, who become adolescents, and then adults. If parents want to create a positive experience they should practice withholding judgment, strive to be honest in conversations with their children, and express their opinions attentively. Haglund and Fehring (2010) found associations of religiosity, sexual education and family structure with risky sexual behaviors among adolescents and young adults. There examinations were important to explore because religious beliefs and practices are usually influenced by parents and social influences are influenced by peers. In 2004, Wilson and Donenberg described that the quality of parent–teen communication was associated with adolescent sexual risk-taking and the consequences of early/naïve sexual experiences. Behaviors are closely associated with family ties, despite influences by peers in child and adolescent years. Abbott-Chapman et al. (2008) cited (Hayes et. al, 2004 and Graham et. al, 2006) reporting that "a significant minority of parents may themselves be norm breakers and may tolerate activities such as under-age drinking of alcohol in the hope that this will 'condition' their child early to be able to resist drinking to excess (p. 613)." From the study of Wilson and Donenberg (2004) it can be further discussed whether or not families discuss the socioeconomic, educational consequences, and health related consequences of behaviors.

Peer Influences

Peer interventions that focus on youth peer groups may be the most effective for preventing and treating substance use and associated problems because peers often provide information, shape attitudes, social context, and rationales and make drugs available. Peer pressure plays a major role in the influences and decision of a young person's decision to use drugs. Friends are both a source of fun and recreation and often

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participate in or support mutually shared activities and will often self-disclose as a way of showing support. Gottlieb and Bergen (2010) suggested that perceived and or received support from the perspective of the provider, the recipient, or both and described how people measure the availability of supportive resources in an effort to learn more about what people look for in a "good friend". It is known that friends are the sources of fun and recreation but in this study I looked at the extent of "good friend" influences. Poulson, Eppler, Satterwhite, Wuensch, and Bass (1998) report that females with strong religious beliefs consumed less alcohol and were less likely to engage in risky sexual behavior than were female with weaker religious convictions. Among the males, religious conviction was not significantly correlated with alcohol consumption or risky sexual behavior, but alcohol consumption and inconsistent use of condoms and multiple sexual partners were significantly correlated.

Relationships and Trust

Humans are bombarded with both intentional and unintentional attempts to alter their behavior or attitudes through persuasion. It can be questioned whether or not those relationships determines whether persuasion is successful or not. According to Weiten, Lloyd, Dunn, and Hammer (2009) trust affects our attitudes/beliefs (thoughts and judgments) and feelings (the positivity and negativity of one's feelings about an issue as well as how strongly one feels about it) about people and ideas. Psychologists assume that attitudes predict behavior. Two sub factors they believe make a communicator credible are expertise and trustworthiness. In making decisions people consider who (source factor)—credibility, expertise, trustworthiness, likability, attractiveness, and similarity; what (message factor)—fear appear vs. logic, one-sided versus two-sided

argument, repetition; by what means (channel factor)—in person, internet, phone, media; and to whom (receiver factor)—personality, expectations, preexisting attitudes.

Canty-Mitchell and Zimet (2000) described social support as "a multifaceted construct which includes such diverse notions as the extent of the social network, the provision of instrumental support, and the perception of support adequacy (p. 392)." According to McWhirter, McWhirter, McWhirter, and McWhirter (2007), substance use is often linked to social influences and treatment is most effective when prevention strategies involve families, schools, and the community.

Risk Taking. Cook et al., (2005), suggested based on their findings that risk taking is a critical element in trust building for Americans and that it is important to distinguish trusting behavior from cooperation and to measure them separately; they suggested that it is important to study trust and trust building in relation to social cooperation and explored how and why people may be influenced by others. They further indicated that it is important to explore dealing with the conformity and compliance pressures of parents and peers and whether or not someone conforms when they are uncertain of how to behave or are afraid of being criticized or rejected. Potard, Courtois, and Rusch (2008) proposed that the degree the predominance of risky sexual behavior during adolescence is the result of social influence, in particular that of peers, according to the perception of their attitudes and sexual behavior and reveals that the perception of peers is associated with a higher frequency of sexual initiation and commitment, including oral sex, but also commitment to protected sex.

Individual Differences. Trustworthy behaviors are related to the underlying individual differences. Desiderato and Crawford (1995) reported that failure to disclose

past risky sexual behavior was common and that alcohol may play in role in contributing to whether or not condoms will are used. They further emphasized that alcohol lowers inhibitions and perhaps with a little family and peer group encouragement condom used will become second nature. Guilamo-Ramos, Jaccard, Dittus, and Bouris (2006) found weak correspondence between how expert, trustworthy, and accessible mothers thought they were on the one hand and how their sons and daughters characterized them on the other. Knowing how children characterize their parents allows for research into why they do and how we can change the accessibility of parents in relation to peers. The tendency to trust others has been found to be a key component in general adjustment. With the unique roles that family members and friends play in the people's lives, it seems that there is a reason to explore the differential experience of trust in a broader range of interpersonal relationships. It is important to measure trust as it is experienced in differing types and levels of relationships (Couch, Adams, & Jones, 1996).

Health Behaviors. Health Behaviors can be positive and negative. Hair, Park, Ling and Moore (2009) identified four "risk profiles": a high-risk group (those who report high levels of participation in numerous behaviors), a low-risk group (those who engage in very few risky behaviors), and two moderate risk-taking groups and that characteristics of negative behaviors were predictive of negative outcomes. Negative are the physiological consequences of drug use vary with the drug and may be felt for hours or for days. Brown and Vanable (2007) describe the prevalence of alcohol use among college students and describe how it may contribute to elevated rates of sexual risk taking. Drinking is prevalent on and around college campuses, with both women and men reporting that they engage in binge drinking with the intention of getting drunk.

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Chen, Thomas, and Morrison-Beedy (2010) examined the need for multifaceted prevention programs that address factors related to family, peer and neighborhood influence as well as individual factors among sexually active adolescents. They describe significant associations among risky sexual behavior, drug use, and delinquent behaviors. Alcohol has variety of side effects, some more problematic than others. The side effects can contribute to reckless sexual behavior, which can affect the health of an individual and the people around them. Coleman and Cater (2005) looked at how alcohol consumption can affect the likelihood of risky sex in adolescents. Zapolski, Cyders, and Smith (2009) further described different personality traits that put individuals in positions to engage in hasty action and went on to describe such traits.

Coping Strategies. Gil (2005) expressed that people cope in many different ways. Coping strategies vary in their adaptive values; some are helpful, some are counterproductive. The purpose of this study was to examine the extent to which differences in risky sexual behavior between males and females is mediated by their personality traits and coping styles. Patel, Yoskowitz, and Kaufman's (2007) work is relevant to my research because the behavioral changes that minimize the risk of developing AIDS are fairly straight forward, although making the changes is often much easier said than done. They examine the nature of the relationship between comprehension of sexual situations and decisions about risky sexual behavior by young adults. They found that high- and low-risk individuals have a specific set of beliefs about safer sex practices, and they selectively process and comprehend a sexual situation differently. They explored possible misconceptions about HIV/AIDS and whether some individuals have unrealistic ideas about the transmission others downplay the risk and

naively assume how things are transmitted may come about. Reimuller, Shadur, and Hussong (2011) examined the moderating effects of parenting on the temporal relationship between negative affect and subsequent alcohol use in adolescents as an indicator of self-medication and offers provisional support for parental support as a moderator of the relation between daily negative affect and alcohol use. Tanner, Carlson, Raymond, and Hopkins (2008) examined parents' reactions to advertisements that promote abstinence education programs and described how parents are more likely to intend to communicate with their children.

     Gender Roles. Leech (2010) examined the association between gender role attitudes and risky sexual behavior among young women. Leech (2010) found that engaging in casual sex is risky for both male and females but it is my belief that females are at a higher risk. Without practicing safe and responsible sex females are more likely to become pregnant, they risk contracting sexually transmitted disease is increased with multiple partners. The information from this study has sparked my interest in the attitude that women have about risky behavior in comparison to men. Lewis, Lee, Patrick, and Fossos (2007) reported gender-specific perceptions of risky sexual behavior norms among college students and their relationship with one's own sexual behavior. They found that students perceive that others engaged in more risky sexual behavior than they do and that perceived norms were positively associated with one's own behavior.

     Risk factors that lead to substance abuse among youth are complex and multiple, and there are a number of environmental factors that contribute to drug use including poverty, racisms, community and interpersonal violence, lack of educational and job opportunities, the dissolution of communities, and interpersonal and family problems.

"…many authors have assumed that risk taking is a general psychological disposition, that is, individuals are inclined to varying degrees to take risks and that this tendency is generalizable across situations and types of risks (Jackson et al., p. 483, 1972)."

Personality Traits. Fulton, Marcus, and Payne (2010) focused on the association between psychopathic personality traits and risky sexual behavior. They stated that risky sexual behavior may require both opportunity (associated with Fearless Dominance in men) and a combination of poor judgment and impulsive behavior (associated with Impulsive Antisocialism in both men and women). They explored the idea that engaging in risky behavior may be influenced by personality and not just opportunity alone. Through research we may be able to find ways to modify impulsive behavior and limit the opportunities for risky behavior. Miller, Lynam, Zimmerman, Lofan, Leukefel and Clayton (2004) reported the relations between the five major personality domains and the results of the study suggest that personality can make a valuable contribution to our understanding of several risky sexual behaviors. Again, they looked at personality differences and the influences personality may have on engaging in risk behaviors. According to Quinn and Fromme (2010), self-regulation may be especially important when individuals have easy access to alcohol and freedom to pursue sexual opportunities. Their research relates to my research because drinking is a widely endorsed and encouraged social ritual in our culture because of advertisement. Advertisement and the media typically portray drinking alcohol as cool, sexy, sophisticated, and harmless and exploring views of young adults is critical in uncovering how they believe it influences their lives. Zwane, Mngadi, and Nxumalo (2004) explored adolescents' views regarding

risky sexual behavior, recommending positive reinforcement for responsible sexual

behavior.

CHAPTER III

METHODOLOGY

Participants

There were 178 participants from a large public university and its affiliates in

Oklahoma. Of the 178 participants, three participants did not answer any questions and

were removed. Of the 175 remaining participants three people answered demographic

questions and nothing else. All of the three participants that answered demographic

questions and nothing else were female. There were 172 valid participants. Participants

were from a pool of students who use the SONA (Sona Systems: Human Subject Pool

Management Software; http://www.sona-systems.com/) site ran by the College of

Education for students seeking credit for participation in studies. Students either received

class credit or extra credit for their participation as determined by course instructors.

Participants on the SONA site self-disclose their gender, ethnicity, and educational status,

year in college, college of major, and age to gain access to the research site. The sample

size of and selection of participants were considered because of availability, convenience,

and ease of study.

There were 117 (68%) who identified as female, 55 (32%) who identified as male

and none (0%) who indicated "other" gender. Most of the participants were between

18-21 years of age, 89 (61.7%). Forty-one were between 22-25 (23.8%) years of age.

Forty-two participants were 26 or older (24.4%). Race, ethnicity, first generation, and

international student status are displayed in Table 1. Unexpectedly, almost one-third

(32.6%) of the sample were graduate or professional students as shown in Table 2.

Table 1

Race, Ethnicity, International Student Status, and First Generation College Student by

Gender

Race	Male	Female	Total
African American or Black	15 (27.3%)	9 (7.7%)	24 (14%)
American Indian or Alaskan Native	3 (5.5%)	5 (4.3%)	8 (4.7%)
Asian	0 (0%)	4 (3.4%)	4 (2.3%)
Native Hawaiian or Pacific Islander	1 (1.8%)	_____	1 (.6%)
European American or White	34 (61.8%)	91 (77.8%)	125 (72.7%)
Two or More Races	2 (3.6%)	8 (6.8%)	10 (5.8%)
Total	55 (100%)	117 (100%)	72 (100%)

Ethnicity	Male	Female	Total
Hispanic, Latino, or Spanish Origin	1 (1.8%)	5 (4.3%)	6 (3.5%)
Not Hispanic, Latino, or Spanish Origin	53 (98.4%)	112 (95.7%)	165 (95.9%)
Total	54 (100%)	117 (100%)	171 (100%)

International Student	Male	Female	Total
Yes	1 (1.8%)	5 (4.3%)	6 (3.5%)
No	54 (98.2%)	112 (95.7%)	166 (96.5%)

	Total	55 (100%)	117 (100%)	172 (100%)

1st Generation College Student	Male	Female	Total
Yes	14 (25.5%)	28 (23.9%)	42 (24.4%)
No	41 (74.5%)	89 (76.1%)	130 (75.6%)
Total	55 (100%)	117 (100%)	172 (100%)

Other demographic information for the total sample and by gender is displayed in Tables 2, 3, and 4. The year in college, involvement in student organization, membership in Greek organizations and religious affiliation is reported in Table 2. The housing or living situation of participants in the sample and their mode of transportation is displayed in Table 3. Whether other family members are in college is shown in Table 4.

Table 2

Year in School, Club or Organization Involvement, Greek and Religious Affiliations by Gender

Year in School	Male	Female	Total
Freshman	6 (10.9%)	7 (6.0%)	13 (7.6%)
Sophomore	5 (9.1%)	22 (18.8%)	27 (15.7%)
Junior	14 (25.5%)	32 (27.4%)	46 (26.7%)
Senior	9 (16.4%)	13 (11.1%)	22 (12.8%)
Senior +	3 (5.5%)	5 (4.3%)	8 (4.7%)
Graduate/Professional	18 (32.7%)	38 (32.5%)	56 (32.6%)
Total	55 (100%)	117 (100%)	172 (100%)

Clubs or Organizations	Male	Female	Total
Yes	23 (41.8%)	67 (57.3%)	90 (52.3%)
No	32 (58.2%)	50 (42.7%)	82 (47.7%)
Total	55 (100%)	117 (100%)	172 (100%)

Greek Affiliation (Fraternity/Sorority)	Male	Female	Total
Yes	11 (20%)	33 (28.2%)	44 (25.6%)
No	44 (80%)	84 (71.8%)	128 (74.4%)
Total	55 (100%)	117 (100%)	172 (100%)

Religious Affiliation	Male	Female	Total
Yes	49 (89.1%)	97 (82.9%)	146 (84.9%)
No	6 (10.9%)	20 (17.1%)	26 (15.1%)
Total	55 (100%)	117 (100%)	172 (100%)

Table 3

Housing Situation and Mode of Transportation by Gender

Housing Situation	Male	Female	Total
Campus w/ Friend	9 (16.4%)	17 (14.5%)	26 (15.1%)
Campus w/ Relative	_____	1 (.9%)	1 (.6%)
Campus w/ Partner	_____	3 (2.6%)	3 (1.7%)
Campus w/ Other Person	2 (3.6%)	5 (4.3%)	7 (4.1%)
Off Campus w/ Friend	21 (38.2%)	31 (26.5%)	52 (30.2%)
Off Campus w/ Relative	4 (7.3%)	5 (4.3%)	9 (5.2%)
Off Campus w/ Partner	12 (21.8%)	29 (24.8%)	41 (23.8%)

	Male	Female	Total
Off Campus w/ Other Person	5 (9.1%)	11 (9.4%)	16 (9.3%)
Fraternity or Sorority House	2 (3.6%)	14 (12%)	16 (9.3%)
Total	55 (100%)	116 (99.1%)	171 (99.4%)
*Missing System		1 (.9%)	1 (.6%)
Total	55 (100%)	117 (100%)	172 (100%)

Mode of Transportation	Male	Female	Total
Self	48 (87.3%)	99 (84.6%)	147 (85.5%)
Public Transportation	3 (5.5%)	6 (5.1%)	9 (5.2%)
Not Applicable	4 (7.3%)	12 (10.3%)	16 (9.3%)
Total	55 (100%)	117 (100%)	172 (100%)

Table 4

Immediate Family Members in College by Gender

Family Members in College	Male	Female	Total
Yes	27 (49.1%)	46 (39.3%)	73 (42.4%)
No	28 (50.9%)	71 (60.7%)	99 (57.6%)
Total	55 (100%)	117 (100%)	172 (100%)

Participants were asked to complete three questionnaires and a demographic information sheet. All data was collected on the web using self-report questionnaires. Questionnaires were used to measure trust, the adequacy of support from parents and peers, drug and alcohol use, and sexual activity. Operational definitions of trust, support,

and engagement in high risk health behaviors were determined by using the instruments described below (copies of each are provided in the appendices).

Measures

      The Trust Inventory. I used the Trust Inventory (Couch, 1996) which was designed to measure and assess the confidence, dependence, and trust, in one's network, both a general trust for others and trust in specific others. The Trust Inventory is the first instrument to measure global and relational trust simultaneously (Couch & Jones, 1997). The assessment was normed on 1, 229 participants who consisted of undergraduate college students, with a majority of White students who were uninvolved in romantic relationships at the time of their participation (Couch et al., 1996). It partitions trust into Partner Trust (Specific Relationship Partners) and Generalized Trust. There are 40 (2 subscales, with 20 items each) items. Items are rated on a 5-point Likert-type scale ranging from strongly disagree (1) and strongly disagree (5). There were 17 reverse-scored items; 12 Partner Trust subscale items and 5 Generalized Trust subscale items. Partner Trust was defined as trust or confidence in a romantic partner or in one's romantic relationship and Generalized Trust defined as the tendency to entertain positive assumptions about people-in-general, or to attribute positive characteristics to "human nature" (Couch & Jones, 1997). The Partner Trust subscale asked questions such as "I generally believe what my partner tells me," and the Generalized Trust subscale asked questions such as "I almost always believe what people tell me." The alpha reliability was .92 for the Partner Trust subscale and .91 for the Generalized Trust subscale (Couch et al., 1996). For the current sample, alpha reliability for the Trust Inventory overall was .922. For the Partner Trust subscale, alpha= .929; for the Generalized Trust subscale,

alpha=.870. For analysis in this study, unless otherwise indicated I used the Total Trust

score.

The Multidimensional Scale of Perceived Social Support. The

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, and Farley,

1988) is a 12-item , one-dimensional tool to measure how one perceives the adequacy

their social support system, including an individual's sources of support from three

different sources- family, friends, and significant other. The MSPSS asks questions such

as "My family really tries to help me", I have special person who is a real source of

comfort to me", and "I can count on my friends when things go wrong." Items are rated

on a 7-point Likert-type scale ranging from strongly disagree (1) to very strongly agree

(7). The assessment can be self-administered and takes about five minutes to complete.

The alpha (α) scores for the scale and subscales as a whole ranged from .85 to .91 for

internal reliability (Zimet et al., 1988). Test-retest values ranged from .72 to .85 (Zimet,

Powell, Farley, Werkman, 1990). For the current sample, alpha reliability for the MSPSS

overall was .961. For the Significant Other subscale, alpha= .942; for the Family

subscale, alpha=.932; for the Friends subscale, alpha=.955.

The Youth Risk Behavior Surveillance Survey. The Youth Risk Behavior

Surveillance Survey (Centers for Disease Control) was designed to monitor health risk

behaviors that contribute to the leading causes of death and disability in six categories of

priority health-risk behaviors among youth: behaviors that contribute to unintentional

injuries and violence; tobacco use, alcohol and other drug use; sexual behaviors that

contribute to unintended pregnancy and sexually transmitted diseases, including HIV

infection; unhealthy dietary behaviors; and physical inactivity , plus obesity and asthma

(A Guide to Conducting Your Own Youth Risky Behavior Survey, 2009, p.1)." The norms of the survey are based on a nationally representative sample of students in grades nine and twelve in the United States. For the purpose of this study I focused on tobacco, drug and alcohol use, and sexual behavior. More specifically, I asked respondents to only answer the tobacco, drug, alcohol and sexual behavior questions of the YRBS. Further, only the following questions were used in the analyses because positive answers represented the greatest risk:

1. During the past 30 days, on the days you smoked how many cigarettes did you smoke per day?

2. During the past 30 days, on how many days did you smoke cigarettes?

3. During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours(For Males)?

4. During the past 30 days, on how many days did you have 4 or more drinks of alcohol in a row, that is, within a couple of hours(For Females)?

5. During the past 30 days, how many times did you use marijuana?

6. During the past 3 months, with how many people did you have sexual intercourse?

"The YRBS is a comprehensive adolescent health survey that has been administered biennially in the USA since 1991with a nationally representative sample of both public and private high school students (Springer, Kelder, Orpinas, & Baumler, 2007, p.72)." There is no reliability information available for the survey.

Procedure

The university's Institutional Review Board for the Protection of Human Subjects (IRB) approved this research study which consisted of a survey by a self-selection

process of participants. I needed a sample size of at least 125 participants based on

factors such as the number of assessments and subscales used in the study (Gay, Mills,

and Airasian, 2009). The procedure for collecting data was to put the surveys on

Qualtrics, provided by the College of Education, which linked to a survey posted on

SONA (Sona Systems: Human Subject Pool Management Software; http://www.sona-

systems.com/). Qualtrics is online survey software (http://www.qualtrics.com/). SONA

is an online program that provides an easy method for participants to sign up for studies.

After a student logs in to the system, they can view a list of available studies and any

restrictions and sign up for the study. The students received either extra credit or

research credit from their class instructor.

The data was kept on Qualtrics secure server, for which the Oklahoma State

University College of Education has a license. The data was transferred to a PSAW 18

data file. Consent to participate was electronic with no identifying information. Data is

reported in aggregate, with no information left to personally identify participants as

someone who even participated in this research. The data will be saved five years after

publication of the results, as is expected by the American Psychological Association.

This de-identified data will be kept on the investigator's password protected computer,

and on her advisor's password protected computer. The survey took about 30 minutes to

complete.

Analysis of Data

The current PASW 18 statistical program was used to analyze data. I used

descriptive statistics to describe the participants and mean scores and correlations to

analyze relationships between scale scores. I used t-tests for independent groups to test

differences in high and low heavy episodic drinking, marijuana use, and smoking tobacco with trust and perceived social support. I used Analysis of Variance (ANOVA) to test for differences among the scores for perceived social support and trusts to three levels of sexual risk behavior.

CHAPTER IV

RESULTS

Test of Hypotheses

The correlation matrix and means for scales and subscales are displayed in Table 5. To test hypothesis 1 (there will not be a relationship between trust and perceived adequacy of support received from family) correlations were computed between total scores for the Trust and the Multidimensional Subscale of Perceived Social Support from family. Hypothesis 1 was not supported because there was a relationship between generalized trust and support received from family as shown in Table 5.

To test hypothesis 2 (there will be a positive relationship between trust and the adequacy of perceived support received from friends) correlations were computed between total scores for the Trust and the Multidimensional Subscale of Perceived Social Support from friends. As indicated below in Table 5, hypothesis 2 was upheld and there was a significant positive relationship between trust and the adequacy of perceived support received from friends.

Table 5

Summary of Intercorrelations, Means, and Standard Deviations for Scores on the

Multidimensional Scale of Perceived Social Support, Trust Inventory, and Their

Subscales

Measure	1	2	3	4	5	6	7
1. MPSSTOT	___	.922**	.901**	.895**	.378**	.346**	.277**
2. MSPSS_SO	.922**	___	.762**	.756**	.395**	.419**	.214**
3. MSPSS_FAM	.901**	.762**	___	.676**	.282**	.254**	.213**
4. MSPSS_FRI	.895**	.756**	.676**	___	.354**	.278**	.323**
5. Trust Total	.378**	.395**	.282**	.354**	___	.377**	.778**
6. Trust Partner	.346**	.419**	.254**	.278**	.877**	___	.381**
7. Trust Generalized	.277**	.214**	.213**	.323**	.778**	.381**	___
M	71.66	24.07	24.00	23.59	146.02	72.28	73.52
SD	12.92	4.483	4.969	4.805	19.280	13.052	9.945

Note. **. Correlation is significant at the 0.01 level (2-tailed).

$p < 0.01$ (2-tailed)

To test hypotheses 3a, 3b, 3c, 3d, there will be a positive relationship between how much people trust and their engagement in high risk health behavior (3a alcohol-- heavy episodic drinking; 3b tobacco use; 3c marijuana use, and 3d sexual behavior), correlations were conducted between generalized trust and engaging in high risk behavior of heavy episodic drinking, tobacco, marijuana, and sexual behavior. Heavy episodic drinking for males is 5 or more drinks in one sitting and for females 4 or more drinks in

one sitting. A new variable, heavy episodic drinking was defined as 5 or more drinks for males in one sitting and 4 or more drinks for females in one sitting. Tobacco used in the last 30 days, marijuana used in the last 30 days, and sexual risk behavior based on the number of sexual partners in the last 30 days. None of the hypotheses were upheld. There was not a positive significant relationship between any risk behaviors and trust. There was a negative relationship for alcohol and sexual behavior. Heavy episodic drinking (r= -.155, p=.047), tobacco use (r= -.034, p=.666), marijuana use (r= -.062, p=.427), and sexual partners (r= -.068, p=.387). There was a negative relationship between the generalized trust subscale and the number of sexual partners in the last 3 months (r=-.232, p=.002).

To test hypothesis 4, there is not a relationship between perceived adequacy of support from family and engagement in high risk health behaviors, correlations were conducted between perceived support from family and engaging in high risk health behaviors of heavy episodic drinking, tobacco, marijuana, and sexual behavior. Tobacco used in the last 30 days, marijuana used in the last 30 days, and sexual risk behavior based on the number of sexual partners in the last 30 days. The hypothesis was supported for the high risk behaviors: heavy episodic drinking (r= .099, p=.100), tobacco use (r= .018, p=.811), marijuana use (r= -.003, p=.966), and sexual partners (r= -.120, p=.119); in other words there was no relationship between perceived adequacy of support from family members and engagement in high health risk behaviors.

To test hypothesis 5, there is a positive relationship between perceived adequacy of support from peers and engagement in high risk health behaviors, and hypothesis 6, there is a positive relationship between perceived adequacy of support from significant

others and engagement in high risk health behaviors, correlations were conducted between perceived support from peers (or for hypothesis 6, perceived social support from significant others) and engaging in high risk health behaviors of heavy episodic drinking, tobacco, marijuana, and sexual behavior. Neither of the hypotheses were upheld. For hypothesis 5 the relationship for perceived social support from friends and health risk behaviors, no relationship was found: heavy episodic drinking (r= -.076, p=.323), tobacco use (r= .083, p=.278), marijuana use (r= .062, p=.417), and sexual partners (r= -.073, p=.341). Likewise, no relationships were found between perceived social support from significant others and engagement in high risk health behaviors: heavy episodic drinking (r= -.029, p=.708), tobacco use (r= .017, p=.824), marijuana use (r= -.022, p=.776), and sexual partners (r= -.090, p=.243).

Additional Analyses

There were few students in this sample who engaged in high risk behavior. For example, 28 of the 55 men reported never having five or drinks of alcohol in a row. Fifty-six point four percent (56.4%) of women reported never drinking four or more drink of alcohol in a row. Eighty-nine point five percent (89.5%) of the total sample smoked no cigarettes in the last 30 days. Eighty-nine percent (89%) of the total sample did not use marijuana in the last 30 days. Thirty-four point three percent (34.3%) had either never had sexual intercourse or not had sexual intercourse in the last 3 month. Fifty-five point. two percent (55.2%) only had sexual intercourse with one person in the last 3 months. New variables denoting high versus low risk behavior or in the case of sexual behavior three levels of risk (no sexual behavior, only one partner, two or more partners)

were created. For this analysis heavy episodic drinking is considered alcohol 5 or more

drinks in one sitting.

      Risk Behaviors and Trust. I conducted t tests for independent groups to

determine if there were differences in scores on the Generalized Trust Subscale of the

Trust Inventory between students engaging in the high risk drinking of alcohol, use of

tobacco or the use of marijuana. As displayed in Table 6, no significant differences were

found. I conducted a one-way ANOVA to test for differences between students who

engaged in no sexual risk, low sexual risk or high sexual risk behaviors on scores on the

Generalized Trust Subscale of the Trust Inventory. There were no significant differences

across students reporting behavior in the three sexual behavior risk levels and scores on

the Generalized Trust subscale, $F (2,162) = .395$, $p=674$, indicating that there was no

difference in generalized trust between students who engaged in no, low, or high sexual

risk behaviors.

Table 6

Means, Standard Deviation and t-tests for Independent Samples of the Trust Inventory

Generalized Trust Subscale Scores and Engagement in Risky Health Behaviors

		N	Mean	Standard Deviation	t Test	Sig (2-tailed)
Alcohol	HED	76	3.68	0.52	0.75	0.45 (n.s.)
	Non-HED	89	3.62	0.43	_____	_____
Tobacco	Use 30 Day	16	3.56	0.36	0.77	0.44 (n.s.)
	Non-Use	149	3.66	0.49	_____	_____
Marijuana	Use 30 Day	18	3.53	0.33	1.09	0.28 (n.s.)
	Non-Use	147	3.66	0.45	_____	_____

*HED=Heavy Episodic Drinking

Risk Behaviors and Perceived Social Support. I further conducted t-tests for independent groups to determine if there were differences in scores on the Multidimensional Scale of Perceived Social Support (MSPSS) Family Subscale scores, Friend Subscale scores, or Significant Other subscale scores between students engaging in the high risk drinking of alcohol, use of tobacco or the use of marijuana. As displayed in Table 7, no significant differences were found for perceived support from family for those with high versus low risk behaviors. Similarly, as displayed in Table 8, no significant differences were found for perceived support from friends for those with high versus low risk behaviors. Also, no significant differences were found for perceived support from significant others for those with high versus low risk behaviors.

I conducted three one-way ANOVAs to test for differences between students who engaged in no sexual risk, low sexual risk or high sexual risk behaviors on scores on the MSPSS Family Subscale scores, Friend Subscale scores, and Significant Other subscale scores. There were no significant differences across students reporting behavior in the three sexual behavior risk levels and scores on the MSPSS Family Subscale Scores , $F(2,168) = .288$, p=766, indicating that there was no difference in perceived social support from family between students who engaged in no, low, or high sexual risk behaviors. There were also no significant differences across students reporting behavior in the three sexual behavior risk levels and scores on the MSPSS Friend subscale scores, $F(2, 169)=.247$, p=.781, or the MSPSS Significant Other subscale scores, $F(2, 168)=.292$, p= .747.

Table 7

Means, Standard Deviation and t Test for Independent Samples of the Multidimensional

Scale of Perceived Social Support Family Subscale Scores and Engagement in Risky

Health Behaviors

		N	Mean	Standard Deviation	t Test	Sig (2-tailed)
Alcohol	HED	77	6.13	1.25	-1.30	.195
	Non-HED	94	5.88	1.22	_____	_____
Tobacco	Use 30 Day	18	5.81	1.44	.651	.516
	Non-Use	153	6.02	1.21	_____	_____
Marijuana	Use 30 Day	19	5.86	1.24	.583	.592
	Non-Use	152	6.01	1.24	_____	_____

*HED= Heavy Episodic Drinking

Table 8

Means, Standard Deviation and t Test for Independent Samples of the Multidimensional

Scale of Perceived Social Support Friend Subscale Scores and Engagement in Risky

Health Behaviors

		N	Mean	Standard Deviation	t Test	Sig (2-tailed)
Alcohol	HED	78	6.04	1.14	-1.43	.154
	Non-HED	94	5.78	1.24	_____	_____
Tobacco	Use 30 Day	18	5.88	1.44	.087	.931
	Non-Use	154	5.90	1.17	_____	_____
Marijuana	Use 30 Day	19	6.08	0.88	-.694	-.203
	Non-Use	153	5.88	1.23	_____	_____

*HED= Heavy Episodic Drinking

Table 9

Means, Standard Deviation and t Test for Independent Samples of the Multidimensional Scale of Perceived Social Support Significant Other Subscale Scores and Engagement in Risky Health Behaviors

		N	Mean	Standard Deviation	t Test	Sig (2-tailed)
Alcohol	HED	77	6.08	1.13	-.671	.503
	Non-HED	94	5.97	1.11	_____	_____
Tobacco	Use 30 Day	18	5.72	1.45	1.183	.238
	Non-Use	153	6.05	1.07	_____	_____
Marijuana	Use 30 Day	19	5.86	.98	.668	.505
	Non-Use	15	6.04	1.14	_____	_____

*HED=Heavy Episodic Drinking

Analyses for Undergraduate Students

Almost one-third of the participants in the sample were graduate or professional students (Table 2), which was not the primary group in whom I was interested, nor the group I expected to engage in high health risk behaviors. Therefore I looked only at undergraduate students in my sample, calculated Pearson two-tailed correlations and analyzed differences with independent group t-tests between those who engaged in high risk behaviors in heavy episodic drinking, and marijuana and drug use compared to those who did not in the scores on the Trust Inventory (Table 10) and the Multidimensional Scale of Perceived Social Support (MSPSS) Family, Friends, and Significant Other Subscale Scores (Table 11). I further conducted one-way ANOVAs to see if there were

differences on both scales between in terms of engagement in the three levels of risk in

sexual behaviors (none, low, high).

Table 10

Means, Standard Deviation and t Test for Independent Groups for Undergraduate

Sample on the Trust Inventory and Engagement in Risky Health Behaviors

		N	Mean	Standard Deviation	t Test	Sig (2-tailed)
Alcohol	HED	63	3.61	0.45	.717	.475(n.s.)
	Non-HED	48	3.55	0.49	____	____
Tobacco	Use 30 Day	12	3.52	0.36	-.530	.597(n.s.)
	Non-Use	99	3.59	0.48	____	____
Marijuana	Use 30 Day	15	3.50	0.33	-.815	.417(n.s.)
	Non-Use	96	3.60	0.48	____	____

*HED=Heavy Episodic Drinking

For the undergraduate sample, there were no significant correlations between the

Total Trust scores and any of the risk behaviors, alcohol (r=-.067, p= .484), marijuana

(r=-.045, p= .642), tobacco (r=.036, p=.705), except sexual risk behavior (r=-.193,

p=.042). As displayed in Table 10, in the undergraduate only sample no significant

differences were found for in Total Trust for those with high versus low risk behavior

regarding heavy episodic drinking, marijuana or tobacco use. I also conducted a one-way

ANOVA to test for differences between undergraduate students who engaged in no

sexual risk, low sexual risk or high sexual risk behaviors on total scores on the Trust

Inventory. There were no significant differences across undergraduate students reporting

behavior in the three sexual behavior risk levels and scores on the Total Trust score, F

(2,108) = 1.263, p=.274, indicating that there was no difference in trust towards others between students who engaged in no, low, or high sexual risk behaviors.

I conducted Pearson two-tail correlations to test to relationships between risk behaviors and the MSPSS subscales in the undergraduate sample. There were no relationships between any of the MSPSS subscales and tobacco, marijuana, or sexual risk behaviors, nor between the MSPSS Significant Other subscale. However, there were significant relationships between the MSPSS Family subscale and the risk behavior of heavy episodic drinking (r=.224. p=.016) and between the MSPSS Friend subscale and heavy episodic drinking (r=.188, p=.043). I also conducted t-tests for independent groups to determine if there were differences in scores on the MSPSS Family Subscale scores, Friend Subscale scores, or Significant Other subscale scores between undergraduate students engaging in the high risk drinking of alcohol, use of tobacco or the use of marijuana. As displayed in Table 11, no significant differences were found for perceived support from family, friends, or significant others for those with high versus low risk behavior in the use of marijuana or tobacco. However, there were significant differences in those who engage in heavy episodic drinking and scores on all the MSPSS subscales.

I also conducted three one-way ANOVAs to test for differences between undergraduate students who engaged in no sexual risk, low sexual risk or high sexual risk behaviors on scores on the MSPSS Family Subscale scores, Friend Subscale scores, and Significant Other subscale scores. There were no significant differences across students reporting behavior in the three sexual behavior risk levels and scores on the MSPSS Family Subscale Scores, F (2,112) = .150, p=.861, indicating that there was no difference in perceived social support from family between students who engaged in no, low, or

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high sexual risk behaviors. There were also no significant differences across students reporting behavior in the three sexual behavior risk levels and scores on the MPSS Friend subscale scores, $F_{(2, 113)}=.105$, $p=0.90$, or the MPSS Significant Other subscale scores, $F_{(2, 112)}=.218$, $p= .804$.

Table 11

Means, Standard Deviation and t Test for Independent Samples of the Multidimensional Scale of Perceived Social Support Family, Friends, and Significant Others Subscales Scores and Engagement in Risky Health Behaviors for the Undergraduate Students in the Sample

Family Subscale		N	Mean	Standard Deviation	t Test	Sig (2-tailed)
Alcohol	HED	64	6.22	1.18	2.04	0.04*
	Non-HED	51	5.74	1.35	____	____
Tobacco	Use 30 Day	13	6.13	.93	.376	0.71(n.s.)
	Non-Use	102	5.99	1.31	____	____
Marijuana	Use 30 Day	16	5.88	1.27	-.450	0.65(n.s.)
	Non-Use	99	6.03	1.28	____	____
Friend Subscale		N	Mean	Standard Deviation	t Test	Sig (2-tailed)
Alcohol	HED	65	6.12	1.04	2.31	.029*
	Non-HED	51	5.59	1.43	____	____
Tobacco	Use 30 Day	13	6.19	0.82	.936	0.35(n.s.)
	Non-Use	103	5.85	1.29	____	____
Marijuana	Use 30 Day	16	6.06	0.92	.606	0.55(n.s.)

Sig Other Subscale		N	Mean	Standard Deviation	t Test	Sig (2-tailed)
	Non-Use	100	5.86	1.30	____	____
Alcohol	HED	64	6.14	1.02	2.082	.040*
	Non-HED	51	5.69	1.30	____	____
Tobacco	Use 30 Day	13	5.96	0.96	.066	0.95(n.s.)
	Non-Use	102	5.94	1.19	____	____
Marijuana	Use 30 Day	16	5.83	1.03	-.417	0.68(n.s.)
	Non-Use	99	5.96	1.19	____	____

- *P<0.05

- *HED=Heavy Episodic Drinking

CHAPTER V

DISCUSSION AND FUTURE RESEARCH

Social support from family and friends has been considered important sources of psychological well-being. I looked at the relationship between two measures of trust and perceived adequacy of social support (i.e., hypothesis 1 and 2). With regards to hypothesis 1, in this particular college student sample, there is a positive relationship between a tendency to trust and perceived support from family. Although I cannot make a direct link that this means trust of family and what family has to say or what the students have been taught by family because this was not directly asked in the measures I used, it is suggestive of this link. This finding could be because connections with the families are strong in this region of the United States and at this university where most students are rural, White, and conservative Christians.

My hypothesis that there would not be a relationship between trust and perceived adequacy of social support from family was made in opposition to what I found in the literature because, based on my own experience, I believed that once the students were in college they would begin to question the things they have been taught as they develop their own identity. A possible explanation for this difference in my experience and expectation based on knowledge of student development and the literature reviewed is

that family relationships are obligatory. In family relationships, people have different

roles to play according to social norms. Therefore the exchange of support in family ties

is compulsory to some extent and may not always be reciprocal (Li, Fok, & Fung, 2011).

I also speculate that the literature I reviewed was supported in this sample because

parents have begun to establish trusting relationship and my hypothesis was misinformed

because parents are staying connected with their children after they leave for college and

are more aware of what their children are doing (Chen & Thompson, 2007).

With hypothesis 2 there was a significant positive relationship between trust and

the adequacy of perceived support received from friends. Li, Fok, and Fung (2011)

report that friendships are voluntary and perceived as more reciprocal than family

relationships. Some individuals may regard their friends as family members and trust

them more because of the support they have received based on past experiences where

trust may have been earned, making that relationship of particular importance. The

literature demonstrates clearly that young people's access to a wide range of social

support resources (parents, peers, and other family members) helps reduce levels of

potentially harmful-risk taking behaviors, compared to those who relied upon peer-group

friends solely (Abbott-Chapman, Denholm, & Wyld, 2008). There are many cultural

groups that may define their peers as family or have adopted themselves into social

groups and organizations and refer to them as family. For example, it takes a village to

raise a child; there are a host of people who take on the role of "family". This previous

concept is worth considering because most individuals report living with someone other

than a relative, though they have immediate family members who are in college and may

or may not be students of the same university. This does imply that they would most

likely trust their peers as much as they would a family member. I did not hypothesize about the relationship of trust to the perceived support of significant other as indicated in Table 5 in the result section. But, in fact there was a significant relationship between MSPSS Total and subscales and Trust Total and subscales. As expected in the literature, the reliability of the scales was very high.

In reference to hypothesis 3, none of the sub hypothesis were upheld because there was not a positive relationship between how much people trust and their engagement in high risk health behaviors associate with heavy episodic drinking, tobacco and marijuana use, and sexual risk behaviors. This may be because the particular students in this sample are simply not engaging in high risk health behaviors.

Hypothesis 4 was upheld, there was not a relationship between perceived support from family members and engagement in high health risk behaviors. This may be because, "family is regarded as the primary and fundamental social system for nurturing youth and development and socializing adolescents to become healthy adults (Chen & Thompson, 2007, p. 119)"; though I defined family as "a psychosocial group constituted by at least one adult member and one or more others who work as a group toward mutual need fulfillment, nurturance, and development (p. 193)." Participants in the study may have found that their parents model appropriate behavior in relationship to high risk health behaviors. Though parents may be disapproving of the lifestyle their children use, they may still accept them and encourage them to do or behave better.

Hypothesis 5 or 6, there was no relationship found between adequacy of perceived support and engagement in high risk health behaviors because the different types of support from the two sources--family and friends--may have different meanings

for people of different ages. For the purpose of this study, I defined peer relationships in terms of psychosocial functions where peers are able to provide confirmation to each other through sharing perceptions, values, beliefs, and can provide friendship (Kram & Isabella, 1985). Participants may also view significant others as peers, up until the point of marriage. It may have been hard for married people to answer questions about family because they may have defined family as the something they were born into or married into, which was not explicitly defined in the survey and was left up to personal interpretation.

Cultural norms and seeking support may influence how people seek support and whom they trust (i.e., shame and pride). According to Mortenson (2009) "seeking social support from friends and family often involves risks and relational consequences that may discourage people from seeking that help (p. 33)." The manner in which people perceive the support may be based on the trust that they have in that group or individual. For example, it may be more likely that an individual wants the support of their family for long-term purposes but seeks instant gratification of their peers thought they may not entirely trust them.

The hypotheses that were rejected may have been because of the lack of variance in the sample population engagement in high risk health behaviors. When writing my hypotheses, I assumed most of the participants would be undergraduates, but almost a third of my sample were graduate or professional students. I believe a larger sample of undergraduate students would have shown more engagement in high risk health behaviors because graduate and professional students have a tendency to be focused more on school. Most likely, graduate and professional students have completed cognitive

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development and are making wiser choices. Among undergraduate students in the sample, there was a significant difference found between those who reported engaging in heavy episodic drinking and those who did not and the adequacy of perceived support from family, friends and significant others. There were no differences on scores of Total Trust or the MSPSS and engaging in other health risks behaviors for undergraduate students. There may be an expectation for undergraduate students to drink alcohol and frequently it turns into heavy episodic drinking when they have the support of their friends or significant others. There is also the possibility that family (i.e., parents) expect high levels of alcohol to be consumed during undergraduate years, especially during the first year. The antecedent for heavy episodic drinking may include family, friends, and significant others because it is what society expects to happen. What can be further analyzed is the difference in undergraduate heavy episodic drinking for different genders and how cultural norms influence alcohol consumption. College students typically don't engage in heavy episodic drinking alone so friend and significant other trust and support, then because similar to what individuals find in family members because you typically assume that if you consume large amounts of alcohol that your friends or significant other will take care of you.

I found no previous research on the perceived adequacy of support from significant others and engagement in high risk health behaviors and this may be so because significant others may be considered peers. The results of the study fit the resource model because it proposes that health behaviors have multiple dimensions and that different types of health behavior may have different correlations or causes which is shown in the results of my hypotheses. The results of the study are irrelevant to the

Health Belief Model because I did not consider the health status and perceptions of health influence on behavior and there is no way to determine a person's implicit or explicit definition of health. Future analysis or consideration may look at health resources in conjunction with social resources and health behaviors.

In the future, I would like to explore emotional dimensions (self-disclosure), communal nature (supporting or participating in mutually shared activities), and social ability and compatibility. I would like to look further into self-indulgence to determine if that is a common response to stress and if it relates to risky behavior. I would like to further study the peer influences on substance use and help people get a better understand themselves, their motives, and coping strategies. I would like to explore the perceptions of how the media bombards people with risky and irresponsible sexual behavior and how it appears to reluctantly depict contraception use. This relates to my study because I want to explore the prevalence of HIV and sexually transmitted infections/disease and explore if the availability of medication and treatment influence the behaviors and decisions of people. I would like to look into the recommendation for positive reinforcement for responsible sexual behavior and determine if it is something that must be influenced by parents or peers. I analyzed the data in a spring semester so it may possible that those engaging in high risk behaviors may have already dropped out of school. Further analysis of this sample, looking only at freshman students, may show a relationship in engaging in risky health behaviors because a large amount of the sample from this study was freshman students. I am also interested in studying whether or not trust in others is more highly related to students engaging in health risk behaviors than perception of support from peers or family members.

I conducted this study for the purpose of informing communities of the high risk health behaviors that college students are engaging in and to aid individuals with making healthier choices. Healthier choices can be made when individuals have adequate support systems that they can trust. I wanted to know whom college students trusted when making important decisions and felt adequately supported. Who college students' trust may also be related to the behaviors that individual students learn and engage in. There is also a possibility that when participants read the title of the study they answered differently because they do not believe that there is risk associated with the things that they find pleasurable or enjoy. I hope from this research to promote positive health behaviors.

REFERENCES

Abbott-Chapman, J., Denholm, C., & Wyld, C. (2008). Social support as a factor
     inhibiting teenage risk-taking: Views of students, parents and professionals.
     Journal of Youth Studies, *11*(6), 611-627. doi:10.1080/13676260802191938

Brown, J. L., & Vanable, P. A. (2007). Alcohol use, partner type, and risky sexual
     behavior among college students: Findings from an event-level study. *Addictive
     Behaviors*, 32(12), 2940-2952. doi:10.1016/j.addbeh.2007.06.011

Butler, J. R. (1999). Trust expectations, information sharing, climate of trust, and
     negotiation effectiveness and efficacy. *Group & Organization Management*,
     24(2), 217-238. doi:10.1177/1059601199242005

Canty-Mitchell, J., & Zimet, G. D. (2000). Psychometric properties of the
     Multidimensional Scale of Perceived Social Support in urban adolescents.
     American Journal Of Community Psychology, 28(3), 391-400.
     doi:10.1023/A:1005109522457

Chen, A., & Thompson, E. (2007). Preventing Adolescent Risky Sexual Behavior:
     Parents Matter!. *Journal for Specialists in Pediatric Nursing*, 12(2), 119-122.
     doi:10.1111/j.1744-6155.2007.00101.x

Chen, A., Thompson, E., & Morrison-Beedy, D. (2010). Multi-system influences on

    adolescent risky sexual behavior. *Research in Nursing & Health*, 33(6), 512-527.

    doi:10.1002/nur.20409

Coleman, L. M., & Cater, S. M. (2005). A Qualitative Study of the Relationship Between

    Alcohol Consumption and Risky Sex in Adolescents. *Archives of Sexual*

    Behavior, 34(6), 649-661. doi:10.1007/s10508-005-7917-6\

Cook, K. S., Yamagishi, T., Cheshire, C., Cooper, R., Matsuda, M., & Mashima, R.

    (2005). Trust Building via Risk Taking: A Cross-Societal Experiment. *Social*

    Psychology Quarterly, 68(2), 121-142. doi:10.1177/019027250506800202

Couch, L. L., Adams, J. M., & Jones, W. H. (1996). The assessment of trust orientation.

    Journal of Personality Assessment, *67*(2), 305-323.

    doi:10.1207/s15327752jpa6702_7

Couch, L. L., & Jones, W. H. (1997). Measuring levels of trust. *Journal of Research in*

    Personality, *31*(3), 319-336. doi:10.1006/jrpe.1997.2186

Currall, S. C., & Judge, T. A. (1995). Measuring trust between organizational boundary

    role persons. *Organizational Behavior and Human Decision Processes*, *64*(2),

    151-170. doi:10.1006/obhd.1995.1097

Desiderato, L. L., & Crawford, H. J. (1995). Risky sexual behavior in college students:

    Relationships between number of sexual partners, disclosure of previous risky

    behavior, and alcohol use. *Journal of Youth and Adolescence*, 24(1), 55-68.

    doi:10.1007/BF01537560

Edwards, A. P., & Graham, E. E. (2009). The relationship between individuals' definitions of family and implicit personal theories of communication. *Journal of Family Communication*, *9*(4), 191-208. doi:10.1080/15267430903070147

Fulton, J. J., Marcus, D. K., & Payne, K. T. (2010). Psychopathic personality traits and risky sexual behavior in college students. *Personality and Individual Differences*, 49(1), 29-33. doi:10.1016/j.paid.2010.02.035

Gay, L. R., Mills, G. E., & Airasian, P. W. (2009). *Educational research, competencies for analysis and applications*. (9 ed.). Upper Saddle River: Prentice Hall.

Gil, S. (2005). Personality Traits and Coping Styles as Mediators in Risky Sexual Behavior: A Comparison of Male and Female Undergraduate Students. *Social Behavior and Personality*, 33(2), 149-158. doi:10.2224/sbp.2005.33.2.149

Gottlieb, B. H., & Bergen, A. E. (2010). Social support concepts and measures. *Journal of Psychosomatic Research*, 69(5), 511-520. doi:10.1016/j.jpsychores.2009.10.001

Graham, M.L., Ward, B., Munro, G., Snow, P., and Ellis, J., 2006. Rural parents, teenagers and alcohol. What are parents thinking? *Rural and remote health: The electronic journal of rural and remote health research, practice and policy* [online] 1 (6), article, 383.

Guilamo-Ramos, V., Jaccard, J., Dittus, P., & Bouris, A. M. (2006). Parental Expertise, Trustworthiness, and Accessibility: Parent-Adolescent Communication and

Adolescent Risk Behavior. *Journal of Marriage and Family*, 68(5), 1229-1246. doi:10.1111/j.1741-3737.2006.00325.x

Haglund, K. A., & Fehring, R. J. (2010). The association of religiosity, sexual education, and parental factors with risky sexual behaviors among adolescents and young adults. *Journal of Religion and Health*, 49(4), 460-472. doi:10.1007/s10943-009-9267-5

Hair, E. C., Park, M., Ling, T. J., & Moore, K. A. (2009). Risky behaviors in late adolescence: Co-occurrence, predictors, and consequences. *Journal of Adolescent Health*, 45(3), 253-261. doi:10.1016/j.jadohealth.2009.02.009

Harber, K. D., Yeung, D., & Iacovelli, A. (2011). Psychosocial resources, threat, and the perception of distance and height: Support for the resources and perception model. *Emotion*, *11*(5), 1080-1090. doi:10.1037/a0023995

Hayes, L., Smart, D., Toumbourou, J.W., and Sanson, A., 2004. Parenting influences on adolescent alcohol use. Melbourne: Australian Institute of Family Studies, Commonwealth of Australia.

Jackson, D. N., Hourany, L., & Vidmar, N. J. (1972). A four-dimensional interpretation of risk taking. *Journal of Personality*, *40*(3), 483-501. doi:10.1111/j.1467-6494.1972.tb00075.x

Kram, K. E., & Isabella, L. A. (1985). Mentoring alternatives: The role of peer

    relationships in career development. *Academy Of Management Journal*, *28*(1),

    110-132. doi:10.2307/256064

Leech, T. J. (2010). Everything's better in moderation: Young women's gender role

    attitudes and risky sexual behavior. *Journal of Adolescent Health*, 46(5), 437-443.

    doi:10.1016/j.jadohealth.2009.10.012

Lewis, M. A., Lee, C. M., Patrick, M. E., & Fossos, N. (2007). Gender-specific

    normative misperceptions of risky sexual behavior and alcohol-related risky

    sexual behavior. *Sex Roles*, 57(1-2), 81-90. doi:10.1007/s11199-007-9218-0

Li, T., Fok, H., & Fung, H. H. (2011). Is reciprocity always beneficial? Age differences

    in the association between support balance and life satisfaction. Aging & Mental

    Health, 15(5), 541-547. doi:10.1080/13607863.2010.551340

Mayer, R. C., Davis, J. H., & Schoorman, F. (1995). An integrative model of

    organizational trust. *Academy Of Management Review*, *20*(3), 709-734.

    doi:10.2307/258792

McAllister, D. J. (1995). Affect- and cognition-based trust as foundations for

    interpersonal cooperation in organizations. *Academy Of Management Journal*,

    38(1), 24-59. doi:10.2307/256727

McAllister, D. J. (1997). The second face of trust: Reflections on the dark side of

    interpersonal trust in organizations. In R. J. Lewicki, R. J. Bies, B. H. Sheppard,

R. J. Lewicki, R. J. Bies, B. H. Sheppard (Eds.) , *Research on negotiation in organizations, Vol. 6* (pp. 87-111). US: Elsevier Science/JAI Press.

McWhirter, J.J., McWhirter, B.T., McWhirter, E.H., & McWhirter, R.J. (2007). *At Risk Youth: A Comprehensive Response for Counselors, Teachers, Psychologists, and Human Service Professionals*. Belmont, CA: Thomas Higher Education

Miller, J. D., Lynam, D., Zimmerman, R. S., Logan, T. K., Leukefeld, C., & Clayton, R. (2004). The utility of the Five Factor Model in understanding risky sexual behavior. *Personality and Individual Differences*, 36(7), 1611-1626. doi:10.1016/j.paid.2003.06.009

Mortenson, S. T. (2009). Interpersonal trust and social skill in seeking social support among Chinese and Americans. Communication Research, 36(1), 32-53. doi:10.1177/0093650208326460

Nanda, S., & Konnur, N. (2006). Adolescent drug and alcohol use in the 21st century. *Psychiatric Annuals*, 36(10), 706-712. Retrieved from EBSCOhost.

Patel, V. L., Yoskowitz, N. A., & Kaufman, D. R. (2007). Comprehension of sexual situations and its relationship to risky decisions by young adults. *AIDS Care*, 19(7), 916-922. doi:10.1080/09540120701203303

Potard, C. C., Courtois, R. R., & Rusch, E. E. (2008). The influence of peers on risky sexual behaviour during adolescence. *The European Journal of Contraception and Reproductive Health Care*, 13(3), 264-270. doi:10.1080/13625180802273530

Poulson, R. L., Eppler, M. A., Satterwhite, T. N., Wuensch, K. L., & Bass, L. A. (1998). Alcohol consumption, strength of religious beliefs and risky sexual behavior in college students. *Journal Of American College Health*, *46*(5), 227-232. doi:10.1080/07448489809600227

Quinn, P. D., & Fromme, K. (2010). Self-regulation as a protective factor against risky drinking and sexual behavior. *Psychology of Addictive Behaviors*, 24(3), 376-385. doi:10.1037/a0018547

Reimuller, A., Shadur, J., & Hussong, A. M. (2011). Parental social support as a moderator of self-medication in adolescents. *Addictive Behaviors*, 36(3), 203-208. doi:10.1016/j.addbeh.2010.10.006

Rousseau, D.M., Sitkin, S.B., Burt, R.S., & Camerer, C. (1998). *Not so different after all: A cross-discipline view of trust.* Academy of Management Review, 23 (3), 393-404.

Sharma, M. (2011). Health belief model: Need for more utilization in alcohol and drug education. *Journal of Alcohol and Drug Education*, *55*(1), 3-6.

Sheeran, P., & Abraham, C. (1996). The health belief model. In M. Conner, P. Norman (Eds.) , *Predicting health behaviour: Research and practice with social cognition models* (pp. 23-61). Maidenhead, BRK England: Open University Press.

Slovic, P. Assessment of risk-taking behavior. Psychological Bulletin, 1964, 61, 220-233.

Springer, A., Kelder, S., Orpinas, P., & Baumler, E. (2007). A Cross-National Comparison of Youth Risk Behaviors in Latino Secondary School Students Living in El Salvador and the USA. *Ethnicity & Health*, *12*(1), 69-88. doi:10.1080/13557850601002155

Tanner, J. R., Carlson, L. A., Raymond, M., & Hopkins, C. D. (2008). Reaching parents to prevent adolescent risky behavior: Examining the effects of threat portrayal and parenting orientation on parental participation perceptions. *Journal of Public Policy & Marketing*, 27(2), 149-155. doi:10.1509/jppm.27.2.149

Venegas, J., Cooper, T. V., Naylor, N., Hanson, B. S., & Blow, J. A. (2012). Potential cultural predictors of heavy episodic drinking in Hispanic college students. *The American Journal on Addictions*, *21*(2), 145-149. doi:10.1111/j.1521-0391.2011.00206.x

Webster-Stratton, C. (1997). From parent training to community building. *Families In Society*, *78*(2), 156-171.

Weiten, W., Lloyd, M. A., Dunn, D. S., & Hammer, E. Y. (2008). *Psychology applied to modern life, adjustment in the 21st century*. (9th ed.). Belmont, California: Wadsworth Pub Co.

Wilson, H. W., & Donenberg, G. (2004). Quality of parent communication about sex and its relationship to risky sexual behavior among youth in psychiatric care: a pilot study. *Journal of Child Psychology and Psychiatry*, 45(2), 387-395. doi:10.1111/j.1469-7610.2004.00229.x

Zapolski, T. B., Cyders, M. A., & Smith, G. T. (2009). Positive urgency predicts illegal

    drug use and risky sexual behavior. *Psychology of Addictive Behaviors*, 23(2),

    348-354. doi:10.1037/a0014684

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The

    Multidimensional Scale of Perceived Social Support. *Journal of Personality*

    Assessment, *52*(1), 30-41. doi:10.1207/s15327752jpa5201_2

Zimet, G. D., Powell, S. S., Farley, G. K., & Werkman, S. (1990). Psychometric

    characteristics of the Multidimensional Scale of Perceived Social Support.

    Journal of Personality Assessment, *55*(3-4), 610-617.

    doi:10.1207/s15327752jpa5503&4_17

Zwane, I. T., Mngadi, P. T., & Nxumalo, M. P. (2004). Adolescents' views on decision-

    making regarding risky sexual behaviour. *International Nursing Review*, 51(1),

    15-22. doi:10.1111/j.1466-7657.2003.00214.x

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you Very Strongly Disagree

Circle the "2" if you Strongly Disagree

Circle the "3" if you Mildly Disagree

Circle the "4" if you are Neutral

Circle the "5" if you Mildly Agree

Circle the "6" if you Strongly Agree

Circle the "7" if you Very Strongly Agree

1. There is a special person who is around when I am in need. SO

2. There is a special person with whom I can share my joys and sorrows. SO

3. My family really tries to help me. Fam

4. I get the emotional health and support I need from my family. Fam

5. I have a special person who is a real source of comfort to me. SO

My friends really try to help me. Fri

6. I can count on my friends when things go wrong. Fri

7. I can talk about my problems with my family. Fam

8. I have friends with whom I can share my joys and sorrows. Fri

9. There is a special person in my life who cares about my feelings. SO

10. My family is willing to help me make decisions. Fam

11. I can talk about my problems with my friends. Fri

The items tended to divide into factor groups relating to the source of the social support, namely family (Fam), friends (Fri) or significant other (SO).

Trust Inventory (Couch, Adams, & Jones, 1996).

Please rate how strongly you agree or disagree with each of the following statements:

1	2	3	4	5
Strongly Disagree	Disagree	Neither Disagree nor Agree	Agree	Strongly Agree

1. My partner makes me feel safe.

2. I tend to be accepting of others.

3. My partner sometimes makes me uncomfortable.

4. My relationships with others are characterized by trust and acceptance.

5. I do not worry that my partner will leave me.

6. Basically I am a trusting person.

7. It is better to trust people until they prove otherwise than to be suspicious of others until they prove otherwise.

8. I accept others at "face value"

9. I am skeptical that relationships ever work out.

10. Most people are trust worthy.

11. I believe in my partner.

12. In relationships, I tend to be alert for the possibility of rejection or betrayal.

13. It is better to be suspicious of people you have just met, until you know them better.

14. I make friends easily.

15. I am sure about how my partner feels about me.

16. Only a fool would trust most people.

17. I am doubtful that my partner will always be there for me if I need him/her.

18. I tell my partner that I trust him/her completely.

19. I find it better to accept others for what they say and what they appear to be.

20. I would admit to being more than a little paranoid about people I meet.

21. Relationships will only lead to heartache.

22. I have few difficulties trusting people.

23. I am rarely ever suspicious of people with whom I have a relationship.

24. Basically, I tend to be distrustful of others.

25. I am afraid my partner will hurt me emotionally.

26. I am afraid my partner will betray me.

27. Experience has taught me to be doubtful of others until I know they can be trusted.

28. I generally believe what my partner tells me.

29. I never believe my partner when he/she tells me how he/she feels about me.

30. I have a lot of faith in the people I know.

31. Even during the "bad times," I tend to think that things will work out in the end.

32. I feel that I can be myself in the presence of my partner.

33. I am uncertain about how my partner feels about me.

34. I tend to take others at their word.

35. When it comes to people I know, I am believing and accepting.

36. It is dangerous to "let your guard down" with your partner.

37. I feel I can depend on most people I know.

38. I am sometimes doubtful of my partner's intentions.

39. When my partner is with others, I worry that he/she will not be faithful.

40. I almost always believe what people tell me.

The Youth Risk Behavior Surveillance Survey (Center for Disease Control)

The following questions are about health behavior. Please answer the questions based on what you really do.

The first questions ask about tobacco use.

1. Have you ever tried cigarette smoking, even one or two puffs?

    A. Yes

    B. No

2. 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 or 10 years old

    D. 11 or 12 years old

    E. 13 or 14 years old

    F. 15 or 16 years old

    G. 17 years old or older

3. 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

4. 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

5. 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 bought them from a vending machine

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

6. During the past 30 days, on how many days did you smoke cigarettes on OSU property?

    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

7. Have you ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days?

    A. Yes

    B. No

8. During the past 12 months, did you ever try to quit smoking cigarettes?

    A. I did not smoke during the past 12 months

    B. Yes

    C. No

9. 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

10. During the past 30 days, on how many days did you use chewing tobacco, snuff, or dip on OSU property?

    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

11. 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 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.

12. During your life, on how many days have you had at least one drink of alcohol?

A. 0 days

B. 1 or 2 days

C. 3 to 9 days

D. 10 to 19 days

E. 20 to 39 days

F. 40 to 99 days

G. 100 or more days

13. 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 or 10 years old

D. 11 or 12 years old

E. 13 or 14 years old

F. 15 or 16 years old

G. 17 years old or older

14. During the past 30 days, on how many days did you have at least one drink of alcohol?

    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

15. During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours? (FOR MALES)

    A. 0 days

    B. 1 day

    C. 2 days

    D. 3 to 5 days

    E. 6 to 9 days

    F. 10 to 19 days

    G. 20 or more days

16. During the past 30 days, on how many days did you have 4 or more drinks of alcohol in a row, that is, within a couple of hours? (FOR FEMALES)

    A. 0 days

    B. 1 day

C. 2 days

D. 3 to 5 days

E. 6 to 9 days

F. 10 to 19 days

G. 20 or more days

17. During the past 30 days, how did you usually get the alcohol you drank?

A. I did not drink alcohol during the past 30 days

B. I bought it in a store such as a liquor store, convenience store,

supermarket, discount store, or gas station

C. I bought it at a restaurant, bar, or club

D. I bought it at a public event such as a concert or sporting event

E. I gave someone else money to buy it for me

F. Someone gave it to me

G. I took it from a store or family member

H. I got it some other way

18. During the past 30 days, on how many days did you have at least one drink of

alcohol on OSU property?

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

19. During your life, how many times have you used marijuana?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 to 99 times

G. 100 or more times

20. 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 or 10 years old

D. 11 or 12 years old

E. 13 or 14 years old

F. 15 or 16 years old

G. 17 years old or older

21. During the past 30 days, how many times did you use marijuana?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

22. During the past 30 days, how many times did you use marijuana on OSU property?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

The next questions ask about other drugs.

23. During your life, how many times have you used any form of cocaine, including

powder, crack, or freebase?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

24. During the past 30 days, how many times did you use any form of cocaine,

including powder, crack, or freebase?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

25. During your life, how many times have you sniffed glue, breathed the contents of

aerosol spray cans, or inhaled any paints or sprays to get high?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

26. During your life, how many times have you used heroin (also called smack, junk,

or China White)?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

27. During your life, how many times have you used methamphetamines (also called

speed, crystal, crank, or ice)?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

28. During your life, how many times have you used ecstasy (also called MDMA)?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

29. During your life, how many times have you used hallucinogenic drugs, such as LSD, acid, PCP, angel dust, mescaline, or mushrooms?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

30. During your life, how many times have you taken steroid pills or shots without a doctor's prescription?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

31. During your life, how many times have you taken a prescription drug (such as Oxycontin, Percocet, Vicodin, Codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription?

A. 0 times

B. 1 or 2 times

C. 3 to 9 times

D. 10 to 19 times

E. 20 to 39 times

F. 40 or more times

32. During your life, how many times have you used a needle to inject any illegal drug into your body?

A. 0 times

B. 1 time

C. 2 or more times

33. During the past 12 months, has anyone offered, sold, or given you an illegal drug on OSU property?

A. Yes

B. No

The next questions ask about sexual behavior.

34. Have you ever had sexual intercourse?

   A. Yes

   B. No

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

   A. I have never had sexual intercourse

   B. 11 years old or younger

   C. 12 years old

   D. 13 years old

   E. 14 years old

   F. 15 years old

   G. 16 years old

   H. 17 years old or older

36. During your life, with how many people have you 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

37. During the past 3 months, with how many people did you have sexual intercourse?

   A. I have never had sexual intercourse

   B. I have had sexual intercourse, but not during the past 3 months

C. 1 person

D. 2 people

E. 3 people

F. 4 people

G. 5 people

H. 6 or more people

38. Did you drink alcohol or use drugs before you had sexual intercourse the last time?

A. I have never had sexual intercourse

B. Yes

C. No

39. 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

40. The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy? (Select only one response)

A. I have never had sexual intercourse

B. No method was used to prevent pregnancy

C. Birth control pills

D. Condoms

E. Depo-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), Implanon (or any implant), or any IUD

F. Withdrawal

G. Some other method

H. Not sure

41. During your life how many people have you had sex with whose HIV status was

unknown to you?

A. Never

B. 1 person

C. 2 people

D. 3 people

E. 4 people

F. 5 people

G. 6 or more people

42. The last time you had oral sex did you use protective barriers?

A. Never had oral sex

B. Yes

C. No

Oklahoma State University Institutional Review Board

Date: Monday, March 05, 2012

IRB Application No   ED1248

Proposal Title: The Relationship of Trust, Parental and Peer Support Relationships, and
                                Health Risk Behaviors in College Students

Reviewed and   Exempt
Processed as:

Status Recommended by Reviewer(s): Approved   Protocol Expires: 3/4/2013

Principal
Investigator(s):

LaMeshia S. Reese-Taylor   Sue Jacobs
1822 N. Perkins Rd. Apt. 111   431 Willard
Stillwater, OK 74075   Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the
rights and welfare of individuals who may be asked to participate in this study will be respected, and that
the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45
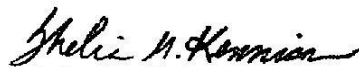CFR 46.

☒ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval
   stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol
   must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar
   year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are
   unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the
authority to inspect research records associated with this protocol at any time. If you have questions
about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219
Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,

Shelia M. Kennison

Shelia Kennison, Chair
Institutional Review Board

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VITA

LaMeshia Sheri Reese-Taylor

Candidate for the Degree of

Master of Science

Thesis: THE RELATIONSHIP OF TRUST, PARENTAL AND PEER SUPPORT
RELATIONSHIPS, AND HEALTH RISK BEHAVIORS IN COLLEGE
STUDENTS

Major Field: Counseling (Community option)

Biographical:

Education:

Completed the requirements for the Master of Science in Counseling
(Community option) at Oklahoma State University, Stillwater, Oklahoma in
July, 2012.

Completed the requirements for the Bachelor of Science in Applied
Developmental Psychology and Bachelor of Arts in Children's Studies at
Eastern Washington University, Cheney, Washington in 2010.

Experience:

Thesis: Preventative Measures of Child Sexual Abuse and Associated High Risk
Behavior
Eastern Washington University
Cheney, Washington

Work Experience:

Counseling Intern   6/2011-5/2012
Domestic Violence Intervention Services Inc./ Call Rape
Tulsa, Oklahoma

Field Study Intern   1/2010-8/2010
Lutheran Community Services Northwest
Spokane, Washington

Name: LaMeshia S. Reese-Taylor   Date of Degree: July, 2012

Institution: Oklahoma State University   Location: Stillwater, Oklahoma

Title of Study: THE RELATIONSHIP OF TRUST, PARENTAL AND PEER SUPPORT
        RELATIONSHIPS, AND HEALTH RISK BEHAVIORS IN COLLEGE
        STUDENTS

Pages in Study: 78   Candidate for the Degree of Master of Science

Major Field: Counseling (Community option)

Scope and Method of Study: The scope of this study was limited to students at
        Oklahoma State University who chose to participate. The purpose was to
        examine the relationship of trust, parental and peer support relationships, and
        health risk behaviors. Participants answered questions about 4 areas of high risk
        health behaviors, trust, and support. A sample of 172 students (one-third graduate
        students) volunteered to participate. Pearson correlations were used to examine
        the associations among trust, the perceived adequacy of support received from
        parents and peers, and engagement in high risk health behaviors. In additional
        analyses, Independent sample t-tests and ANOVAs were used to examine
        differences in trust and perceived support between those who engaged in high risk
        behaviors and those who did not for the total sample and undergraduates only.

Findings and Conclusions: There was a positive relationship between trust and the
        adequacy of perceived support received from family and friends. There was not a
        relationship between engagement in high risk health behaviors and trust or
        adequacy of perceived support. However, for undergraduate students, there was a
        significant difference between those who engaged in heavy episodic drinking and
        those who did not and perceived support from family and friends.

ADVISER'S APPROVAL: Dr. Sue C. Jacobs