



Social Correlates of Health Risk Taking Behavior among Adolescent

Dr. Naina Sharma¹

**Assistant Professor,
Department of Distance Education,
Punjabi University, Patiala**

Manmeet Kaur²

**Research Scholar,
Department of Psychology,
Punjabi University, Patiala**

Abstract:

Aim of this study was to assess the prevalence of Health risk taking behaviours. The sample for the present study comprised of 532 adolescents (Males=238 and Females=294) of +1 (Arts) and +2 (Arts) from (private and public schools) Patiala district in the age range of 15-18 years. This study conducted in two phases: PHASE I: Consent of the school, parents and youth were be taken, Filled questionnaires pertaining to Health risk-taking behavior, parental relationship, peer relationship and Taking the feedback report from the students. PHASE II: Identification of the students having very high health risk-taking behavior. Intervention program is being tailored on the basis of the identified psychosocial variables of the high health risk-taking behaviour adolescents. Post-test session will be conducted by filling questionnaire assessing health risk-taking behaviour. On the basis of the obtained results it is concluded that the parent relationship dimensions (rejection, chaos, coercion) positively correlated with health risk taking behaviours. It proved hypothesis that males are higher on health risk taking behaviours. The parent relationship dimensions (rejection, chaos, coercion) negatively correlated with health risk taking behaviours (Protective factors). Peer relationship (identified regulation and intrinsic motivation) would be negatively correlated with health risk-taking behaviours (risk factors), and peer relationship (identified regulation and intrinsic motivation) positively correlated with health risk taking behaviours (protective factors).

Keywords: Health Risk Taking Behavior, Parent Child Relationship, Peer Relationship.s

Introduction:

Adolescent period connote important transition from childhood to adulthood and youth go through major psychosocial problems. Youth experience more independence, build their own identity, and establish relationships, struggling with academic goals, more peer pressure and less parental supervision which results in engaging in unhealthy behaviors or health risk taking behaviors. Health risk taking behavior (HRTB) involves behaviors that are detrimental to health and wellbeing of adolescents.

Risk can be defined as “the appraised likelihood of a negative outcome for behaviour” (Zuckerman, 1994). Risk-taking behaviour is defined in the developmental literature as engagement in behaviours that are associated with some probability of undesirable results (Boyer, 2006), the implementation of goal directed options that could lead to negative consequences (Byrnes et al., 1999) and increase the likelihood of adverse physical, social or psychological consequences (Resnick, 1997). **Health risk-taking behaviour** can be defined as *engaging, often impulsively in behaviours that are high in subjective desirability or excitement but which carry the potential for injury or loss* (Geier et al., 2010). Health Risk-taking behaviours are those behaviours that involve some potential for danger while also providing an opportunity to obtain some form of reward, seem more appropriate (Leigh, 1999). They are those activities or *behaviours that are detrimental to the health and well-being of youth* (Lamb, 1992). It is generally accepted that problem behaviours are undesirable in society and cause negative outcomes that adolescent behaviour account for half of the illness experienced during these years (Kerr & Stallin, 2000). The term “Health risk-taking behaviour” has been used to associate with health damaging behaviours such as substance abuse, risky sexual behaviours, homicidal and suicidal behaviours, violence and delinquency etc.

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs that effects physical and psychological health, which can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. Substance use refers

excessive use of addictive substances, especially when such consumption or misuse of substance is not for therapeutic purpose but rather for the purpose of altering the normal functioning of the mind and body (Hewin & Enoch, 2009). Parasuraman et al. (2009) evaluated on house to house survey that 1,24,385 females and 74,369 Males aged 15-54 years in 29 states found that prevalence for major substances were alcohol (13% of men and 2% of women) (NFHS-4, 2015-16).).

High risk sexual behaviour has been defined as early initiation of sexual intercourse, vaginal, oral and anal sex (level of sexual activity) with a susceptible person or partner or multiple partners which can lead to Sexually transmitted diseases (STDs) and teen pregnancies. The National Family Health Survey (NFHS-4, 2015- 16) indicated that 4% of young women and 15% of young men had ever experienced sex before marriage and only 14.1% (14.7% urban vs 13.9% rural) of unmarried sexually active adolescent females used a contraceptive (IIPS, 2007).

Suicidal behaviour is major leading domain of health risk-taking behaviour among youth worldwide. Suicide is defined as an act of intentionally terminating one's own life. Sometimes they are referred to as "suicidality" while others term these as "suicide-related behaviours" or "suicidal behaviour". According to the WHO, Suicide worldwide was estimated to represent 1.8% of the total global burden of disease in 1998; in 2020, this figure is projected to be 2.4%. The WHO (2013) defines **Violence** as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development or deprivation”. The National Family Health survey (NFHS-4, 2015-16) revealed that 27% adolescent females experienced physical, sexual, or emotional violence in India. Williams et al. (2009) found that prevalence rate of violent and antisocial behaviour is highest at 15–19 years of age for girls and boys and also this group is most vulnerable and hospitalised each year due to injuries caused by violence (Australian Institute of Health and Welfare, 2007).

Researchers have endorsed parent/peer relationships to be an important variable in health risk-taking behaviour. **Parenting relationships or Parental monitoring:** Parent and peer relationships are believed to play a key role in adolescent health risk-taking behaviour. Parent relationship refers to behaviors and strategies used by parents to control and socialize their

Social Correlates of Health Risk Taking Behavior among Adolescent

children (Cole & Cole, 2009). Parent relationships are believed to play a key role in adolescent health risk-taking behaviour. Bowlby (1982) theory of attachment examined that the association between parent-child relationship and adolescent risk-taking tendencies. He found insecurely attached and preoccupied adolescents are more prone to extreme relational dysfunction, socially manifested anger, tend to have decreased social competence (resilience) and also are more likely to engage in risky behaviours. (Allen et. Al., 2002).

Parental care tends to strengthen adolescents' resilience and their ability to avoid risk-taking behaviour. Allen and colleagues (2002) have also found that insecurely-preoccupied adolescents are more likely to engage in risks, because their mothers use reasoned arguments in conflictual parent-teen interactions. (Marsh et. Al., 2003). Steinberg and colleagues (1994) found that authoritative and authoritarian parented adolescents are less likely to engage in risk-taking behaviours than indulgent or neglectful parented adolescents. (Lamborn et.al., 1991). Flannery and colleagues (1999) focused on adolescents that spent more after school time with friends, less parental monitoring are more likely to engage in risk-taking and delinquent behaviours. Parental factors are also consistent resources to help youth overcome risks for violent behaviour. Maternal support protected youth from the negative influences of peer violent behaviour (Zimmerman et.al, 1998). Parental monitoring and paternal support were found to compensate for peer violent behaviour (Howard & Boekeloo, 2003; Zimmerman et.al, 1998). Parental monitoring also compensated for the risk of living in a risky neighbourhood (Griffin et.al, 1999). Maternal and paternal support also compensated for and protected youth from the negative consequences of exposure to violence (Zimmerman et.al, 1998). Several research studies maintained an idea that parenting techniques and peer pressure influence risk-taking behaviours. While social influences are believed to play a significant role in adolescent's involvement in health risk-taking behaviour. Parent-peer relationships may provide a unique framework or understanding the social processes that underlie adolescent behaviour (Kobus, 2003). Lansford and colleagues (2003) found that interactive effects of parenting styles, peer affiliation and peer anti-social behaviours on the development of risk-taking tendencies.

Peer Influence is defined as the strong influence upon an individual of their peers seek to influence the individual's cognitions, affections and behavior (Torun, 2007). Adolescent develops very warm **relationship with peers** because they feel safe, secure and also gives sense

Social Correlates of Health Risk Taking Behavior among Adolescent

of belongingness. This power can influence adolescents toward greater or lesser risk-taking behaviour. Recognition and support by peers are an important factor in impacting upon an individual (Gizir, 2007). Peer groups provide an individual with independence, self-confidence, recognition, acceptance and support, all of which are highly important to adolescents. With increasing support by friends, an adolescent's individual may come under control of the peer group (Kiran-Esen, (2003) and hence this is in turn accompanied by peer pressure (Sari & Tekbiyik, 2012). Peer relationships are also play a key role in adolescent health risk-taking behaviour. Peer behaviours and attitudes may also cause a risk for violent behaviour that promotive factors may compensate for or protect against. Anger-control skills compensate for the effects of peer delinquent behaviour for predicting adolescent violent behaviour (Griffin et.al, 1999). Perceived social status was found to moderate (i.e., a protective factor) the relationship between peer delinquent behaviours and adolescent violent behaviour (Prinstein, Boergers & Spirito, 2001). Adolescents' religiosity also compensated for the risk of peer substance use (Howard & Boekeloo, 2003) and exposure to violence for violent behaviour (Barkin, Kreiter & Durant, 2001).

Several research studies found that adolescents that associate with peers are more likely to engage in risky behaviours. (Benthin et.al., 1993; Blanton et.al., 1997; Gerrard et.al., 1996). Laird and colleagues (2001) has researched that children who are rejected by peers, associated with antisocial peers in adolescence are more likely engage in risk-taking behaviours. (Dishon et.al., 1991; Petit and Battes, 2001; Miller-Johnson et.al., 1999). Davey (1999) proposed a typology of risks and examined specific adolescent risks to the well-being of young people and indicates males are more likely to be susceptible on Mental health and behaviour risks (Behavioural and conduct problems, suspension, mental health problems, substance dependence), Physical risks (Accidental injury and death, Intentional injury and homicide, Suicide), Unsafe sexual behaviours and lack of educational qualifications risks. Females are likely to be susceptible on Physical risks (Suicide, Family violence), Sexual risks (Abuse, STD, Early sexual experience) and Economic risks (unemployment and low income). Silva and Stanton (1996) found an association between smoking and delinquent behaviour, aged 15 yrs old, for both boys and girls. They found that likelihood of substance use was much higher for males (with a strong link between drinking and smoking) as compared to the females.

Jessor's model conceptualized the role of risk and protective factors in health risk-taking behaviour. It includes five major explanatory domains or sources of variance are biology, social environment, perceived environment, personality and behaviour, which constitute a general explanatory framework for risk behaviour (Jessor, 1991). Risk factors are characteristics within the individual or conditions that increase the likelihood someone will engage in unhealthy behaviour such as alcohol use, smoking, substance use etc. They are assumed to predispose an individual or group to some negative outcome and therefore to pose a threat to well-being. There are three kinds of risk factors namely, models risk, opportunity risk and vulnerability risk. Protective factors are characteristics within the individual or conditions that help someone cope successfully with life challenges. When people can successfully negotiate their problems and deal with pre-existing risk factors, they are less likely to engage in unhealthy behaviour. They are instrumental in healthy development and build resiliency, skills and connections. There are three kinds of protective factors namely, models protection (Health belief model, Subjective expected utility theory, Protection motivation theory, Theory of Reasoned action), control protection (Health enhancing behaviours and enhancement of indicators of health) and support protection (Strong sense of connectedness of relationships). Researchers examined risk factors and protective factors in one individual and four social key contexts – the family, the peer group, the school, and the neighbourhood. Jessor's theory emphasizes the great variety of factors influencing young people's risk behaviours and the interactions between them. Furthermore the model takes into consideration changes over time regarding individual maturity and social context as well as the fact that risk behaviour may influence risk factors or vice versa.

Need of the study

Researchers have endorsed adolescence to be the most vulnerable stage as involved in different health risk-taking behaviours. As maturation in adolescence is incomplete and often contributes to impulsivity, sensation-seeking, depression and inefficacious coping resulting into health risk taking behaviour. Several research studies have reported that ability to form relationship, to solve problems, to develop a sense of autonomy and to have a plan and hope in life are important aspects affecting physical, mental and social health. There has been very less work done in India related to the reasons associated with the rise in substance abuse, STD/STI, suicide and violence in this population. Statistics (NFHS-4, 2015-16) indicate that youth of India in the age group 15-

Social Correlates of Health Risk Taking Behavior among Adolescent

18 years having great knowledge of health risks, but many adolescents tend to be less informed that they often have a sense of having unlimited power, feelings of invulnerability and impulsiveness that can lead to reckless behaviour.

So, they may be trying to demonstrate differences by experimenting with substances and law breaking activities. Empirical evidence suggests that risk-taking behaviour as a conceptual entity comes from three sources: risk-taking behaviours generally display a developmental trajectory such as rates of sexual activity and substance use have been found to increase with increasing age during adolescence, often shares similar psychological, environmental and biological antecedents and also have been found in predictable ways such as sexually active teens are more likely to their non-sexually active teens to be using alcohol and substance use (Millstein et.al, 1992, Igra & Irwin, 1996).

Thus, Adolescents have some specific physical, socioeconomic, and emotional vulnerabilities that give reasons why they are so inclined to take risks. In the period of adolescence, they also tend to argue a lot with peers and with people in authority and they can also become very emotional during arguments. Gender roles, feelings about self-worth and relationships with family and peers are important psychological and behavioural concerns that enable individual to deal effectively with the challenges of everyday life. There are gaps in understanding, explaining and controlling health risk-taking behaviour in adolescents. It's vital to study the social correlates (parent and peer relationships) of health risk-taking behaviour related to specific culture.

Objectives

Keeping in view the need of the study following objectives were framed:

- To assess the prevalence of Health risk taking behaviors.
- To study the relationship between parent child relationship and health risk taking behaviors.
- To study the relationship between peer relationship and health risk taking behaviors.

Hypotheses

- It is expected that there would be greater percentage on Health risk taking behaviours in males.
- Parent relationship (warmth, structure, autonomy support) would be negatively correlated with health risk-taking behaviours (risk factors) and positively correlated with health risk taking behaviours (protective factors).
- Parent relationship (rejection, chaos, coercion) would be positively correlated with health risk-taking behaviours (risk factors) and negatively correlated with health risk taking behaviours (protective factors).
- Peer relationship (external regulation and introjected regulation) would be positively correlated with health risk-taking behaviours (risk factors) and negatively correlated with health risk taking behaviours (protective factors).
- Peer relationship (identified regulation and intrinsic motivation) would be negatively correlated with health risk-taking behaviours (risk factors) and positively correlated with health risk taking behaviours (protective factors).

Methodology

Sample: The sample for the present study comprised of 532 adolescents (Males=238 and Females=294) of +1 (Arts) and +2 (Arts) from (private and public schools) Patiala district in the age range of 15-18 years. The following psychological measures were used:

- I. Youth risk behaviour surveillance system (Centers for disease control and prevention, 2017): Risk Factors (Violence, Bullying, Suicide, Smoking, Alcohol, Drugs, Sexual behavior, Concussions) and Protective factors (Safety, Bodyweight, Breakfast, Physical activity, Health related behaviors)
- II. Parents as Social Context (Skinner, Johnson and Snyder, 2007): Warmth, Rejection, Structure, Chaos, Autonomy Support, Coercion
- III. Peer self regulation questionnaire (Ryan and Connell, 1989): External Regulation, Introjected Regulation, Identified Regulation, Intrinsic Motivation

Design and Procedure:

This study conducted in two phases:

PHASE I: Consent of the school, parents and youth were be taken, Filled questionnaires pertaining to Health risk-taking behavior, parental relationship, peer relationship and Taking the feedback report from the students.

PHASE II: Identification of the students having very high health risk-taking behavior. Intervention program is being tailored on the basis of the identified psychosocial variables of the high health risk-taking behaviour adolescents. Post-test session will be conducted by filling questionnaire assessing health risk-taking behaviour.

Results**Table 1 Prevalence of Health Risk-Taking Behaviors**

S.No	Domains		Low	Average	High
1	Violence	Total	57%	31%	12%
		Male	42%	36%	22%
		Female	69%	27%	3%
2	Bullying	Total	55%	33%	12%
		Male	54%	30%	16%
		Female	56%	35%	8%
3	Suicide	Total	70%	24%	6%
		Male	59%	30%	11%
		Female	78%	10%	12%
4	Cigarette Smoking	Total	92%	2%	6%
		Male	88%	3%	9%
		Female	96%	2%	2%
5	Drinking Alcohol	Total	78%	17%	5%
		Male	60%	31%	9%
		Female	93%	5%	2%
6	Drugs	Total	51%	35%	14%
		Male	39%	36%	25%
		Female	63%	19%	18%

Social Correlates of Health Risk Taking Behavior among Adolescent

7	Sexual beh.	Total	92%	4%	4%
		Male	84%	13%	3%
		Female	98%	1%	1%
8	Concussions	Total	65%	22%	13%
		Male	56%	29%	15%
		Female	72%	11%	17%
9	Health related behavior	Total	28%	61%	11%
		Male	16%	71%	13%
		Female	10%	82%	9%
10	Safety	Total	13%	67%	20%
		Male	15%	60%	25%
		Female	12%	64%	24%
11	Body Weight	Total	30%	56%	14%
		Male	40%	49%	11%
		Female	21%	63%	16%
12	Breakfast	Total	27%	36%	37%
		Male	26%	50%	24%
		Female	24%	24%	52%
13	Physical Activity	Total	12%	70%	18%
		Male	18%	62%	20%
		Female	16%	65%	18%

Table 1 : results revealed that males are higher on violence (22%), bullying (16%), cigarette smoking (9%), drinking alcohol (9%), drugs (25%), sexual behaviours (3%) than females whereas females are higher on suicide (12%) and concussions (17%) than males. On protective factors, males are higher on safety (25%), Physical activity (20%) and health related behaviours (13%) than females whereas females are higher on bodyweight (16%) and breakfast (52%) than males. It proved our hypothesis that males are higher on health risk taking behaviours.

Social Correlates of Health Risk Taking Behavior among Adolescent

Table No. 2 correlation of parental relationship (warmth, rejection, structure, chaos, autonomy support and Coercion) and Health risk taking behaviors (Risk Factors)

	<i>vio</i>	<i>Bull</i>	<i>Sui</i>	<i>smo</i>	<i>alco</i>	<i>drugs</i>	<i>Sex</i>	<i>concu</i>
Warmth	-0.120	0.018	-0.247	-0.168	-0.060	-0.122	-0.082	0.016
Structure	-0.238	0.077	-0.176	-0.358	-0.123	-0.132	-0.200	0.125
Autonomy support	-0.210	-0.019	-0.297	-0.279	-0.066	-0.149	-0.005	0.143
Rejection	0.053	0.115	0.055	0.031	0.019	0.057	0.076	-0.065
Chaos	0.167	0.177	0.154	-0.014	0.121	0.082	0.274	0.000
Coercion	0.030	0.062	0.133	0.096	0.076	0.148	0.173	0.035

p>.05= 0.088 p>.01= .115

A perusal of Table 2: revealed that there was significant negative correlation between warmth and violence (-0.120**); suicide (-0.247**); smoking (-0.168**); drugs (-0.122**). Structure was also found to be significant negative correlation with violence (-0.238**); suicide (-0.176*); smoking (-0.358**); alcohol (-0.123**); drugs (-0.132**); sexual behaviors (-0.200**). Similar trends were located for autonomy support and Health risk taking behaviors (risk factors). Negative correlations were obtained between autonomy support and violence (-0.210**); Suicide (-0.297**); smoking (-0.279**); drugs (-0.149**). It proved our hypothesis that parent relationship dimension (warmth, structure and autonomy support) negatively correlated with health risk taking behaviours. Rejection was found to be significantly positively correlated with bullying (0.115**). Positive significant correlations were obtained between chaos and violence (0.167**); bullying (0.177**); suicide (0.154**); alcohol (0.121**); and sexual behavior (0.274**). Positive significant correlation were found between coercion and suicide (0.133**); smoking (0.096*); drugs (0.148**); sexual behaviour (0.173**). It proved our hypothesis that parent relationship dimensions (rejection, chaos, coercion) positively correlated with health risk taking behaviours.

Social Correlates of Health Risk Taking Behavior among Adolescent

Table No. 3 correlation of parental relationship (warmth, rejection, structure, chaos, autonomy support and Coercion) and Health risk taking behaviors (Protective Factors)

	<i>Saf</i>	<i>body</i>	<i>Brea</i>	<i>Phyact</i>	<i>Hrbs</i>
Warmth	0.110	-0.058	0.082	0.038	0.115
Structure	0.087	0.163	0.149	0.096	-0.048
Autonomy support	0.060	-0.013	0.046	0.051	0.034
Rejection	-0.008	-0.035	0.087	-0.110	0.079
Chaos	-0.167	0.047	-0.010	0.046	-0.185
Coercion	-0.092	-0.124	-0.058	0.133	-0.100

p>.05= 0.088 p>.01= .115

A perusal of Table 3: revealed that there was significant positive correlation between warmth and Safety (0.110*); and health related behaviors (0.115**). Structure was also found to be significant positive correlation with bodyweight (0.163**); breakfast (0.149**) and physical activity (0.096*). It proved our hypothesis that parental relationship dimensions (warmth, structure, autonomy support) positively correlated with health risk taking behaviors (Protective factors). Rejection was found to be significantly negatively correlated with physical activity (-0.110*). Negative significant correlations were obtained between chaos and safety (-0.167**); and health related behaviors (-0.185**). Similar trends were located for coercion and Health risk taking behaviors (protective factors). Significant Negative correlations were obtained between coercion and Safety (-0.092*); bodyweight (-0.124**); health related behaviours (-0.100*) while it showed significant positive correlation with physical activity (0.133**). It proved our hypothesis that parent relationship dimensions (rejection, chaos, coercion) negatively correlated with health risk taking behaviours (Protective factors).

Social Correlates of Health Risk Taking Behavior among Adolescent

Table No. 4 correlation of Peer relationship (External regulation, Introjected regulation, Identified Regulation, Intrinsic motivation) and Health risk taking behaviors (Risk Factors)

	<i>vio</i>	<i>Bull</i>	<i>Sui</i>	<i>Smo</i>	<i>alco</i>	<i>drugs</i>	<i>sex</i>	<i>concu</i>
Ext. Reg.	-0.046	0.123	0.010	-0.070	-0.046	-0.022	0.119	0.282
Int. Reg.	0.028	0.042	-0.059	-0.073	0.011	-0.058	0.187	0.229
Idn. Reg.	-0.104	0.094	-0.084	-0.046	-0.043	-0.035	0.068	0.272
Int. Mot.	-0.120	0.128	-0.029	-0.094	-0.116	-0.033	0.038	0.300

p>.05= 0.088 p>.01= .115

Positive and significant correlation were found between External regulation and bullying (0.123**); sexual behaviour (0.119**); and concussions (0.282**). Introjected regulation was found to be significantly positively correlated with sexual behaviour (0.187**) and concussions (0.229**). It proved our hypothesis Peer relationship (external regulation and introjected regulation) would be positively correlated with health risk-taking behaviours (risk factors). Identified Regulation was also found to be significant positive correlation with bullying (0.094*); concussions (0.272**) while it also showed negative correlation with violence (-0.104*). Negative significant correlations were obtained between intrinsic motivation and violence (-0.120**); smoking (-0.094*); alcohol (-0.116**) while it also showed significant positive correlation with bullying (0.128**) and concussions (0.300**). It proved our hypothesis that peer relationship (identified regulation and intrinsic motivation) would be negatively correlated with health risk-taking behaviours (risk factors).

Table No. 5 correlation of Peer relationship (External regulation, Introjected regulation, Identified Regulation, Intrinsic motivation) and Health risk taking behaviors (Protective Factors)

	<i>Saf</i>	<i>Body</i>	<i>Brea</i>	<i>phyact</i>	<i>Hrbs</i>
Ext. Reg.	0.217	0.221	0.176	0.090	0.042
Int. Reg.	0.134	0.325	0.242	-0.029	0.047
Idn. Reg.	0.220	0.189	0.103	-0.048	0.086
Int. Mot.	0.239	0.206	0.080	-0.184	0.016

p>.05= 0.088 p>.01= .115

Social Correlates of Health Risk Taking Behavior among Adolescent

Positive and significant correlation were found between External regulation and Safety (0.217**); body weight (0.221**); breakfast (0.176**) and physical activity (0.090*). Introjected regulation was found to be significantly positively correlated with safety (0.134**); body weight (0.325**); breakfast (0.242**). It does not prove our hypothesis Peer relationship (external regulation and introjected regulation) negatively correlated with health risk taking behaviours (protective factors). Identified Regulation was also found to be significant positive correlation with safety (0.220**); bodyweight (0.189**); breakfast (0.103*). Positive significant correlations were obtained between intrinsic motivation and safety (0.239**); bodyweight (0.206**) while it showed significant negative correlation with physical activity (-0.184**). It proved our hypothesis that peer relationship (identified regulation and intrinsic motivation) positively correlated with health risk taking behaviours (protective factors).

Discussion

- A study by Guo, Hill, Hawkins Catalano, and Abbott (2002), found that family conflict, family bonding, and peer's antisocial behavior were independent predictors of adolescent substance abuse and suggested that family bonding may affect the child to associate with peers and engage in more positive behavior.
- A strong feeling of rejection which are characteristics of neglectful parenting are the factors associated with health risk behaviours among adolescents (Pant & Priyanka, 2006).
- Hoeve, Dubas, Eichelsheim, Van der Laan, Smeenk and Gerris (2009), reported that parent child relationship has its significant effect on the personality traits and risk behavior of a developing child.
- Skinner, Johnson and Snyder (2005), concluded that parent-child relationship are significant precursors to disruptive behavior, vulnerability and succumbing to substance use, alcohol, smoking and violence by children and adolescents.
- A study by Chassin, Presson, Rose, Sherman, Davis and Gonzalez (2005), found that adolescents who smoke and drink perceive their less parental warmth and care than adolescents who do not. The child's perception of the parents' demanding behavior, as associated with authoritative style parenting, was found to be a strong inverse predictor of the child's alcohol use.

Social Correlates of Health Risk Taking Behavior among Adolescent

- Various researchers reported that adolescents who rated their parents as having a parenting style with higher levels of intimacy and autonomy considered a “healthy” parenting style(s) were less likely to initiate smoking, or more likely to report intention to quit if they already initiated smoking(O’Byrne, Haddock & Poston, 2002). Findings from several studies also indicated that adolescents whose parents had neglectful/unengaged had an increased risk of engaging in substance abuse(O’Byrne et al., 2002).
- Steinberg and Mohanan (2007), stated that the strongest predictors of risky behavior in adolescents is affiliation with delinquent peers, an association that has been attributed in varying degrees to peer socialization and friendship choices, in which risk-taking adolescents normally gravitate toward each other.
- Negative peer influence among young adolescents may promote engaging in risky behavior like substance abuse(Berger, 2007).
- Peer groups encourage their members to engage in various incorrect behaviors like using drugs and smoking (Aktug, 2006). Kiran-Esen (2003) reported a positive relationship exists between peer pressure and risk-taking behavior. In addition, individuals with peers who perform delinquent behavior are more likely to perform such behaviors themselves.

Recommendations

- Psychosocial approaches to treatment of health risk taking behaviors in adolescents must begin with a comprehensive understanding of the problem.
- Skill training for problem solving, emotional regulation, social skills, and communication are an essential part of the treatment for health risk taking behaviors in adolescents.
- Motivational Enhancement Therapy (MET) help them in bolstering their resolve in seeking help and in making a plan for change. It has been shown to improve engagement in treatment and in reducing risky behavior.
- To provide teachers with workshops on how to deal with adolescents who influence others with bad behaviour and set strong measures on them and to let it known to adolescents what will become to them if they influence others and if they respond positively to peers pressure.

Social Correlates of Health Risk Taking Behavior among Adolescent

- Government should encourage non-governmental organizations (NGOs) to train parents about the proper parenting styles in which adolescents can be brought up. This may help parents to adopt parenting styles such as the authoritative parenting style that may improve adolescents' outcomes and prevent them to indulge in health risk taking behaviors.
- The media like newspapers and radio stations should be encouraged to publish information on dangers of bad peer influence and health risk taking behaviors among adolescents. This may expose adolescents to reality about the dangers of associating with such groups.

REFERENCES

- Alexander, M., Garda, L., Kanade, S., Jejeebhoy, S., & Ganatra, B. (2007). Correlates of premarital relationships among unmarried youth in Pune district, Maharashtra, India. *Int Fam Plan Perspect*, 33, 150-159.
- Allen, J.P., Marsh, P., McFarland, C., McElhaney, K.B., Land, D.J., Jodl, K.M., et al. (2002). Attachment and autonomy as predictors of the development of social skills and delinquency during mid adolescence. *Journal of Consulting and Clinical Psychology*, 70, 56–66.
- Bowlby, J. (1982). *Attachment*. New York, NY, US: Basic Books.
- Boyer, T.W. (2006). The development of risk-taking: A multi perspective review. *Developmental Review*, 26, 291-345.
- Byrnes, J.P., Miller, D.C., & Reynolds, M. (1999). Learning to make good decisions: a self-regulation perspective. *Child Development*, 70, 1121–1140.
- Byrnes, J.P., Miller, D.C., & Schafer, W.D. (1999). Gender differences in risk taking: a meta-analysis. *Psychological Bulletin*, 125, 367–383.
- Gajalakshmi, V., & Kanimozhi, C.V. (2010). A survey of 24,000 students aged 13-15 years in India: Global Youth Tobacco Survey 2006 and 2009. *Tob Use Insights*, 3, 23-31.

Social Correlates of Health Risk Taking Behavior among Adolescent

- Geier, C. F., Terwilliger, R., Teslovich, T., Velanova, K., & Luna, B. (2010). Immaturities in reward processing and its influence on inhibitory control in adolescence. *Cerebral Cortex*, 20, 1613–1629.
- Griffin, K.W., Scheier, L.M., Botvin, G.J., Diaz, T., & Miller, N. (1999). Interpersonal aggression in urban minority youth: mediators of perceived neighborhood, peer, and parental influences. *Journal of Community Psychology*, 27, 281–98.
- Howard, D., Qiu, Y., & Boekeloo, B. (2003). Personal and social contextual correlates of adolescent dating violence. *Journal of Adolescence Health*, 33, 9–17.
- Jessor, R. & Jessor, S. L. (1977). *Problem behaviour and psychosocial development: A longitudinal study of youth*. New York: Academic Press.
- Kerr, M., & Stattin, H. (2000). What parents know, how they know it, and several forms of adolescent adjustment: Further support for a reinterpretation of monitoring. *Developmental Psychology*, 36, 366 – 380.
- Kumar, G.A., Dandona, R., Kumar, S.G., & Dandona, L. (2011). Behavioral surveillance of premarital sex among never married young adults in a high HIV prevalence district in India. *AIDS Behav*, 15, 228-35.
- Lamb, J (1992). American Psychiatric Association task force on the homeless mentally ill: Treating the homeless mentally ill. Washington: American Psychiatric Association.
- Leigh, B. C. (1999). Peril, chance, and adventure: Concepts of risk, alcohol use and risky behaviour in young adults. *Addiction*, 94, 371–383.
- Marsh, P., McFarland, F. C., Allen, J. P., McElhaney, K. B., & Land, D. (2003). Attachment, autonomy, and multifinality in adolescent internalizing and risky behavioral symptoms. *Development and Psychopathology*, 15, 451–467.

Social Correlates of Health Risk Taking Behavior among Adolescent

- Martins, A., Ramalho, N., and Morin, E. (2010). A comprehensive meta-analysis of the relationship between emotional intelligence and health. *Personality and Individual Differences*, 49, 554–564.
- Mayer, J. D., & Salovey, P. (1997). What is emotional intelligence? In P. Salovey, & D. Sluyter (Eds.), *Emotional development and emotional intelligence: educational implications*. New York: Basic Books.
- Mayer, J. D., Caruso, D. R., & Salovey, P. (1999). Emotional intelligence meets traditional standards for an intelligence. *Intelligence*, 27, 267–298.
- National Safety Council. (2003). *Course material for Principles of Occupational Safety and Health*. Itasca, IL: National Safety Council.
- Resnick, M.D., Bearman, P.S., & Blum, R.W. (1997). Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *JAMA*, 27, 823-832.
- Santhya, K.G., Ram, U., Acharya, R., Mohanty, S., Jejeebhoy, S.J., Singh, A., *et al.* (2009). Pre-marital sexual relations among youth in India: findings from the youth in India, situations and needs study. *Proceedings of the xxvi International Union for the Scientific Study of Population Conference*. Marrakech, Morocco.
- Savithri, R., Mehra, S., Kole, S.K., & Sakhuja, A. (2002). Sexual behaviour among adolescents and young people in India : some emerging trends. Working Paper Series No. 3. New Delhi: MAMTA - Health Institute for Mother and Child.
- Steinberg, L., & Scott, E. S. (2003). Less guilty by reason of adolescence: developmental immaturity, diminished responsibility, and the juvenile death penalty. *American Psychologist*, 58, 1009–1018.
- Trinidad, D. R., & Johnson, C. A. (2001). The association between emotional intelligence and early adolescent tobacco and alcohol use. *Personality and Individual Differences*, 32, 95–105.

Social Correlates of Health Risk Taking Behavior among Adolescent

Tsaousis, I., and Nikolaou, I. (2005). Exploring the relationship of emotional intelligence with physical and psychological health functioning. *Stress Health*, 21, 77–86.

Zuckerman, M. (1994). *Behavioural expressions and biosocial bases of sensation seeking*. New York, NY: Cambridge University Press.