



Social isolation, drunkenness, and cigarette use among adolescents



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HIGHLIGHTS

- We constructed a measure of social isolation that included distinct types of social isolation (socially avoidant, actively isolated, socially disinterested) and a group representing sociable youth.
- We examined the effect types of social isolation have on drunkenness and cigarette use when compared to sociable youth.
- Socially disinterested youth were more vulnerable to drunkenness and cigarette use when compared to sociable youth.
- Socially avoidant youth had lower odds of drunkenness and no significant differences in cigarette use compared to sociable youth.
- Actively isolated showed no differences in drunkenness and cigarette use.

ARTICLE INFO

Article history:

Received 20 April 2015

Received in revised form 18 August 2015

Accepted 3 October 2015

Available online xxxx

Keywords:

Alcohol

Cigarettes

Peer relationships

Social isolation

Adolescence

ABSTRACT

Introduction: This study compares isolated to sociable youth to investigate the relations between different network types of social isolation and alcohol and cigarette use.

Methods: Using data from the National Longitudinal Study of Adolescent to Adult Health we developed a network measure that includes various types of social isolation. Types of social isolation were operationalized as socially avoidant, actively isolated, and socially disinterested, with sociable youth as the reference category. Random effects ordinal logit models were fit to estimate the association between different types of social isolation and drunkenness and cigarette use.

Results: Different types of social isolation had varying effects on drunkenness and cigarette use. On the one hand, socially disinterested youth were at an increased risk for drunkenness and cigarette use. On the other hand, socially avoidant youth had lower odds of drunkenness and no significant differences in cigarette use when compared to sociable youth. Actively isolated youth showed no differences in drunkenness and cigarette use.

Conclusions: The role played by marginalized social positions in youth substance use is an important yet overlooked problem. This study can contribute to better targeted and more effective health behavior prevention efforts for vulnerable adolescents.

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1. Introduction

Youth alcohol and cigarette use have long been understood to be driven by peer influence. Studies consistently demonstrate that youth with substance-using peers are likely to engage in similar behaviors (Ali & Dwyer, 2009; Dishion & Owen, 2002; Hall & Valente, 2007; Fujimoto & Valente, 2015; McVicar, 2011; Lakon & Valente, 2012; Urberg, Luo, Pilgrim, & Degirmencioglu, 2003). As a result, scholars have been quick to discount the relevance of socially marginalized youth when exploring behavior thought to be thoroughly social in nature. While a small body of work has documented a link between social

isolation and youth substance use, most research in this area does not consider the possibility of multiple types of social isolation. Thus the present study examines the effects that various types of social isolation have on alcohol and cigarette use among youth.

Although most studies of youth alcohol and cigarette use focus on substance-using peers, a growing number of network studies focus on social position when examining youth alcohol and cigarette use. For instance, studies consistently find that social isolates are at increased risk for cigarette use. In a meta-analysis of eight studies investigating friendship, social positions and smoking, Choi and Smith (2013) find that isolated youth are approximately 1.5 times more likely to engage in smoking when compared to youth in other social positions. In a recent longitudinal study of 6th graders in Pennsylvania and Iowa, Osgood, Feinberg, Wallace, and Moody (2014) confirm these findings, demonstrating that social isolates are the most likely to smoke cigarettes

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when compared to youth in core groups. Marginalized youth are not the only youth at risk for substance use in the status hierarchy. Youth that are more popular have also been linked to both cigarette (Ennett & Bauman, 1994; Fang, Li, Stanton, & Dong, 2003) and alcohol use (Ennett et al., 2006; Osgood et al., 2014). In other words, the least and most visible youth appear to be at greatest risk of cigarette use, whereas alcohol use is a behavior that is initiated mostly in social settings. Though these studies have yielded important insights into the role of peers and social position, most overlook the considerable heterogeneity that exists among marginalized youth, and how various types of social isolation may be differentially associated with alcohol and cigarette use when compared to sociable youth.

Scholars find considerable differences in motivations and circumstances surrounding youth isolation. Some youth may be forced into a state of isolation as a result of peer rejection. These youth are often referred to as “active isolators” (Rubin, 1982; Rubin & Asendorpf, 1993). Others may be in a state of self-imposed isolation. Often referred to as instances of “social withdrawal,” these youth generally fall into two categories: “socially disinterested” and “socially avoidant.” Socially disinterested youth reject peer interaction because of a lack of motivation to engage in social relationships. These are youths who have the ability to engage in meaningful relationships but choose to remain in solitude (Coplan, Prakash, O’Neil, & Armer, 2004). Socially avoidant youth exhibit a combination of poor social skills and high avoidance motivations (Asendorpf & van Aken, 1999). They avoid contact with the broader peer network and prefer to remain isolated. That is, these youth avoid contact with their peers and prefer to remain in solitude.

Types of isolated youth also present differences in social and behavioral outcomes. For instance, socially avoidant youth exhibit the highest levels of social anxiety and depression when compared to other marginalized youth (Coplan et al., 2013). Similar studies also find that among college students, those with the highest level of shyness and lowest levels of sociability reported the greatest anxiety (Mounts, Valentiner, Anderson, & Boswell, 2006). In contrast, socially disinterested children spend more time in solitude but do not show significant differences in both social and cognitive abilities when compared to sociable children (Coplan et al., 2004). Studies also suggest that the stress associated with peer rejection may lead to antisocial behaviors such as aggression, which has been supported by a number of empirical studies (Dodge et al., 2003; London, Downey, Bonica, & Paltin, 2007; Prinstein & La Greca, 2004).

Among adults, studies demonstrate that various types of loneliness elicit different coping responses. Individuals in a chronic state of loneliness tend to engage in more avoidance coping mechanisms, such as alcohol use (Cacioppo et al., 2000; Hawkey & Cacioppo, 2010), whereas young adults with short bouts of loneliness engage in active coping strategies such as talking with family and friends and attending religious services (Heinrich & Gullone, 2006; Wilson & Moulton, 2010). Given the differences in motivations and experiences, as well as differences in social and behavioral outcomes among isolated youth, youths with different isolation types may perceive and cope with their marginalized positions differently, which may elicit varying responses to alcohol and cigarette use.

In this paper we sought to test the hypothesis that due to differences in motivations, experiences, and perceptions among isolated types, alcohol and cigarette use will vary across isolation sub-types. Nationally representative peer network data was used to develop a measure that includes three distinct types of isolation, along with a fourth group representing sociable (non-isolated) youth. We then examined how various types of isolation influenced drunkenness and cigarette use using two Waves from the National Longitudinal Study of Adolescent Health. By disaggregating social isolation into different network forms, findings from this study have implications for programs and policies that aim to reduce alcohol and cigarette use among adolescents.

2. Data and method

2.1. Data source and analysis sample

This study used data from Waves I and II of the National Longitudinal Study of Adolescent Health (“Add Health”), a nationally representative samples of adolescents in grades 7–12 in 1994–95. The Add Health data is a multistage cluster sample with high schools serving as the primary sampling unit. The sampling frame included 80 representative high schools, stratified by region, urbanicity, school type and size, and ethnicity. The largest feeder school for each high school was also included when available, which resulted in a final sample of 132 schools. In Wave I of the Add Health (1994–1995) an in-school survey was administered to every student who attended a given school. A total of 90,118 questionnaires were completed for the in-school survey. The in-school survey was followed by an in-home survey, completed by 20,745 adolescents selected at random from schools that participated in the in-school survey. In Wave II in 1996, 14,738, of the original Wave I respondents from the in-home survey were interviewed. The response rates were 79% for Wave I and 88.6% for Wave II.

In several respects the Add Health is an ideal data source for the current study. First, the Add Health is the only large nationally representative sample of school-aged youth with peer network data. The rich peer network data provided by the Add Health also allows for the identification and examination of unique friendship structures that are often inaccessible in smaller, regional samples. This allows us to create multiple measures of social isolation with adequate sample sizes for each type. The Add Health survey also contains an array of individual, school, family, and behavioral measures that allow us to include adequate control measures to fully isolate the effects of both adolescent drunkenness and cigarette use. For inclusion in the current analytic sample, respondents must have had valid responses for all measures included from Waves I and II and had sufficient school-level data. An important limitation of the Add Health data is its age. Clearly we would have preferred more recent data, and it is possible that changes in adolescents’ drinking and smoking habits (such as e-cigarettes), as well as new technologies for adolescent socializing (social media) in the intervening twenty years limit the generalizability of our findings. Still, because our theoretical argument concerns social network patterns that are fundamental and universal, we are convinced that patterns discovered in the current study are likely to be relevant to how adolescent drug and alcohol use are studied today.

2.2. Measures

2.2.1. Drunkenness and cigarette use

The measures for drunkenness and cigarette use were obtained from Wave II of the Add Health in-home survey. Drunkenness was derived from the question “Over the past 12 months, on how many days have you gotten drunk or “very, very high” on alcohol?” Response categories for drunkenness and ranged from 0 = never to 6 = everyday. To simplify and ease in the interpretation of the results, we used these categories to construct a 4-point ordinal measure for drunkenness: abstain from drunkenness (never), occasional drunkenness (1 to 2 days in the past 12 months), approaching weekly (2 to 3 days a month), and weekly or more (1 or 2 days week or almost every day). Smoking was similarly operationalized into a 4-point ordinal measure with youth who reported “never even trying a puff or two” of cigarettes as non-smokers. Experimental smokers reported trying cigarettes but deny smoking in the last 30 days. Intermittent smokers indicated smoking between 1 and 29 cigarettes in the past month, whereas daily smokers reported smoking on a daily basis. The final measure ranged from 0 = non-smokers to 3 = regular smoker.

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