

It's My Body and None of Your Business: Developmental Changes in Adolescents' Perceptions of Rights Concerning Health

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We examined developmental changes in adolescents' perceptions of an individual's right to engage in risky behaviors that could pose harm to health. The views of 563 early, 506 middle, and 467 late adolescents concerning the degree to which individuals have a right to engage in smoking, drinking, and drug use (private health beliefs) or whether the government has a right to impose constraints on individuals (public health beliefs) were surveyed over 3 years. Endorsements of individual rights increased between early and middle adolescence and remained stable into late adolescence. Endorsements of public health beliefs showed a curvilinear trend with middle adolescents less likely than early or late adolescents to endorse the government's right to constrain individual choices. Regardless of age, endorsements of public health were positively and individual rights were negatively related to an adolescent's belief that s/he had a right to intervene in a friend's risky choices.

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Health risk behaviors are one of the major foci of research in the field of adolescent behavior. The dominant paradigm is a rational choice model, that is, if provided with the facts about the potential harm of experimentation with alcohol, tobacco, or other substances, an adolescent will make decisions that are in his or her own best interest. The underlying assumption is that health and risk are choices that individuals make with the potential harm of such choices a burden they bear (Guttman & Ressler, 2001; Leichter, 2003; Minkler, 1999).

This paradigm leaves underexplored two important questions relevant to adolescents and health. The first is how adolescents conceive of the rights and responsibilities associated with health and risk. The second is whether they think the risky health choices of others (family members, friends, etc.) are matters that should concern them or whether these are private matters and that individuals have no right to interfere in the choices that others make. Our article takes up these two questions by looking at developmental patterns in early-, middle-, and late-adolescents' conceptions of rights associated with health risks and their beliefs about whether individuals have a "right" to intervene in a friend's risk taking.

The social representation (Moscovici, 1988) of health as a private choice may be a peculiarly American one. In contrast to the United States, in many countries health is viewed as a public good. There also is a shared understanding that health is a fundamental human right and thus all individuals can make legitimate claims on the state to provide for their health care needs (Haigh, 2002). An example is provided in Article 24 of the United Nations Convention on the Rights of the Child (CRC) that holds that the state has a responsibility to insure the provision of children's rights to health care (providing access and informing their and their parents' choices).

Developmental research on children's and adolescents' conceptions of rights has drawn from the CRC's framing of child rights and thus has included both self-determination and care and protection from harm in the definition of child rights (Cherney & Shing, this issue; Peterson-Badali & Ruck, this issue; Peterson-Badali, Ruck, & Ridley, 2003). This framing of rights implies relationships between parties (parents/caretakers and children or states and citizens) and the expectations and mutual obligations that bind them. In our program of work, we have employed the metaphor of a "social contract" and the concept of "social responsibility" to elucidate the "ties that bind" persons and polities. The concept of a "social contract" draws from political theory and posits that individuals choose to give up certain rights to the government in an exchange for both social order and the guarantee of their liberties.

In this article, we examine how adolescents of different ages conceive of the rights of individuals to experiment with substances (alcohol, tobacco, or other drugs [ATOD]) and how they conceive of the government's right, in the interests of the broader public good, to make and enforce laws that constrain individual

rights. Adolescents are the age group most likely to experiment and take health risks. Yet we know almost nothing about how they conceive of the rights and responsibilities associated with risks to health. Should individuals have the right to take risks that could pose harm? If so, do adolescents defend that right based on the belief that it is only the individual who is harmed by the act? Or does society have a right to constrain individuals from taking risks?

The literature on adolescents' conceptions of rights concerning health risks is rather slim. However, there is relevant work on adolescents' social judgments, some of which focuses on their perspectives on personal rights and laws concerning drug use. In their study of 9th to 12th graders, Nucci, Guerra, and Lee (1991) found that age-related changes in sociomoral reasoning and perspective taking had no bearing on adolescents' beliefs that an individual's drug use was a moral matter that could affect others. Adolescents in this study went so far as to say that an individual could ignore laws regulating substance use if s/he were the only one harmed by such use. Finally, Nucci et al. (1991) found that youth who used drugs considered this choice a personal matter and discounted any harm either to the self or to others. Others have pointed to the relationship between the perceived harmfulness of a substance and the defense of an individual's "right" to use it. For example, adolescents consider caffeine and nicotine use as personal choices but cocaine and crack use as moral matters that transcend an individual's personal choice (Killen, Leviton, & Cahill, 1991). Logically, if a youth perceived a substance as harmful, she or he should be more likely to endorse the state's role in restricting its use in the interests of protecting the public good.

The lack of age differences in the Nucci et al. study is rather puzzling in light of the large literature on the increase in sociocognitive competencies during the adolescent years. Based on that literature, one would expect that older adolescents should be more capable of appreciating the implications to others and to society of an individual's decisions and behaviors (Eisenberg & Sheffield Morris, 2004). According to domain theory, when we make judgments, we distinguish moral matters of human welfare from social conventions (Turiel, 1983) and further distinguish conventional from personal and private matters (Nucci, 1996). Between early and middle adolescence there is an increasing awareness of social conventions as constituent elements that regulate the social system (Horn, 2005; Nucci, 2006). Coincident with this developmental shift are basic changes in the ways in which adolescents draw distinctions between convention and personal/private prerogatives, matters that become sites of conflict with their parents and also bases for asserting their own autonomy (Smetana, 2002).

Between early and late adolescence, issues of self-determination and the rights of individuals to decide on matters that concern them increases (Smetana, 2002). Self-determination and privacy are rights that adolescents seek for themselves but also ones they defend for people in general. Older adolescents appear to be more

willing than their younger peers to endorse individual rights even when the exercise of those rights implies exclusion or unfair treatment of people (Helwig, 1995). However, it is in middle adolescence when the personal prerogative to exclude others is most strongly endorsed (Horn, 2003) as a legitimate form of social regulation, a necessary convention for maintaining the social system. Perhaps it is because middle adolescents are wrangling with the conventions of the system and trying to make sense of social norms, that endorsements of personal prerogatives and the rights of individuals peak at this time (Horn, 2005). Compared to children and early adolescents (Killen, Lee-Kim, McGlothlin, & Strangor, 2002) and to late adolescents (Horn, 2003), middle adolescents are more likely to defend an individual's prerogative to exclude others based on their lack of conformity to social norms or how well they would fit in with a group.

Research on children's and adolescents' concepts of rights also points to an increase in commitments to self-determination between early and middle adolescence. Ruck and his colleagues found that children and early adolescents endorsed children's right to care and nurturance and adults' responsibility to provide it. Middle adolescents endorsed the right to care but were more likely than their younger peers to also endorse a child's right to self-determination (Ruck, Abramovitch, & Keating, 1998). Compared to early adolescents as well as to their own mothers, those in the middle adolescent years are more likely to insist on an individual's right to self-determination (Ruck et al., 1998; Ruck, Peterson-Badali, & Day, 2002). Finally, with respect to risky behavior, the commitment to an individual's "right" to choose to harm himself or herself appears to peak in middle adolescence (Berkowitz, Guerra, & Nucci, 1991; Killen et al., 1991).

Whereas endorsements of individual rights peak at middle adolescence, perceptions of the harm associated with risky activities declines at this age. Cauffman, Steinberg, and Woolard (2002) asked 11- to 24-year-olds to evaluate the danger and potential harmfulness of a range of risky activities such as riding with a drunk driver or having unprotected sex. While 11- to 13-year-olds rated these activities as risky, scary, dangerous, and more harmful than beneficial, 14- to 24-year-olds were less likely to say they were harmful or dangerous. In our own research on whether adolescents would intervene to discourage their friends' use of alcohol, tobacco, or other drugs, we found declines between early and middle adolescence in intentions to intervene and increases in deciding to ignore the friend's behavior (Flanagan, Galloway, & Elek, 2005). In summary, compared to early adolescents, middle adolescents are more committed to the rights of individuals to self-determination and privacy yet are less likely to perceive risky behaviors as harmful and less willing to discourage friends' ATOD use.

But what about endorsements of public responsibility for others? Would we expect developmental changes in beliefs about society's or the government's right to constrain individuals from choices that might pose harm to themselves or to others? Sociocentric understanding, differentiation of the social world, and

the capacity to conceive of abstract categories increases between early and late adolescence (Eisenberg & Sheffield Morris, 2004; Keating, 2004). Thus, older adolescents should have a more sophisticated understanding of the purpose of laws and social institutions such as the government in protecting the public. Similarly, by late adolescence, there should be an increased awareness of the secondary harm to others of individual acts such as passive smoking and the costs to society of an individual's health risk choices. Late adolescents are more capable than younger adolescents of differentiating personal experience from abstract categories (e.g., laws, government) (Dalbert & Sally, 2004; Flanagan & Stout, 2008), and they are less likely to rely on stereotypes or social conventions as the bases for their judgments (Horn, 2003, 2005).

In light of these age-related changes, we expect that early adolescents will conceive of individual rights to decide about health (privacy beliefs) as the opposing pole to the society or government's rights to constrain individual behaviors (public health beliefs). In contrast, we expect that, as adolescents get older, these two sets of beliefs will be differentiated, orthogonal to one another: endorsing one will not be inversely related to endorsing the other. We contend that endorsing the rights of individuals to make their own health behavior choices and the right of society to constrain individuals from engaging in health related risks are *not* two ends of the same continuum. By late adolescence, youth have developed a coordinated understanding of the conventions of their social system (Nucci, 2006). Thus, by this time there should be an appreciation *both* of an individual's right to privacy and self-determination *and* of the responsibility of the state to make laws that protect the welfare of the public.

Gender and Perceptions of Rights and Responsibilities

There is a large literature documenting gender differences in social relationships and the manifestation of social responsibility. Females tend to feel more responsible for peers and guilty about neglecting those responsibilities (Eisenberg & Sheffield Morris, 2004; Williams & Bybee, 1994). Gender differences also have been found in early adolescents' responses to hypothetical dilemmas of friendship. In response to interpersonal conflicts, females are more likely to say they would accommodate whereas males are more likely to choose to stand up for their rights. If a hypothetical friend had a problem, females are more likely to say they would offer support whereas males say they would avoid or blame the friend (Rose & Asher, 1999). With respect to social exclusion, there is consistent evidence that, during both childhood and adolescence, females are more averse to excluding others than are their male peers (Killen et al., 2002; Killen & Stangor, 2001). Although there is mixed evidence for gender differences in perceptions of rights (for a review, see Peterson-Badali & Ruck, this issue), Day, Peterson-Badali, and Ruck (2006) found that females, especially 10th graders, are more likely than

their male peers to endorse nurturance rights. And in our own studies of adolescents' intentions to intervene in friends' risk taking, adolescent girls are more likely to endorse various strategies to help their friends avoid harm whereas boys are more inclined to say they would ignore their friends' behaviors (Flanagan et al., 2005).

Hypotheses

In light of the relevant body of work, we formulated the following hypotheses. First, we expected to find an increase between early and late adolescence in endorsements of individual rights concerning health decisions. Given the preponderance of evidence of an increase in endorsements of self-determination rights between early and middle adolescence, we expected that the steepest increase would occur between these ages. Second, with respect to endorsements of public responsibility for health, we hypothesized a curvilinear relationship with middle adolescents less likely than early and late adolescents to endorse this belief. Third, we expected that, regardless of age, females would be more likely than their male peers to endorse public responsibility for health and males would be more likely to endorse an individual's right to take risks. Finally, we expected that young people's attitudes about individual rights and public responsibility for health would be related to their feeling that they have a right to intervene in the health risk behaviors of their friends. Endorsements of public responsibility should be positively related to the perception that one has a right to intervene whereas endorsements of individual rights should be inversely related to the perception of this right.

Methods

Sample

This analysis utilized data from the Social Responsibility and Prevention Project, a 3-year, longitudinal study designed specifically to assess those factors that influence the willingness of young people to intervene to dissuade peers from risky behaviors. We surveyed students from 5th through 12th grades in seven rural, suburban, and small-urban school districts in the northeastern United States. Surveys were conducted each spring from 2002 to 2004.

Active parental consent was obtained for all the participants and resulted in a participation rate of 51%. Demographically, participating youth reflected the school districts from which we recruited with approximately 80% from European-American backgrounds, 10% from African-American, and 7% from Latino-American backgrounds. Based on parents' reports, 20% of participating families had incomes below \$30,000, 25% between \$30,001 and \$50,000, 45% between \$50,001 and \$100,000, and 10% had incomes above \$100,000. Fifty-four

percent of the participants were females. Students also were categorized into three age groups: early (12–13), middle (14–15), and late (16 and older) adolescents, based on their age in Wave 2 of the study.

Procedures

Surveys were administered during the second semester of each school year with approximately 1 year between waves. We surveyed 2,768 students during the first year, with 1,411 (5th, 8th, and 10th graders) eligible for the panel study. In Wave 2 we refreshed the sample with additional 6th through 12th graders from the participating schools. No new 5th graders entered the study after the first year and no additional participants were added during the third year. This resulted in 2,644 students surveyed in the second and 1,933 in the third year of the study with 839 participants at all three waves. Cross-sectional analyses take advantage of the full sample available each year and SEM analyses are based on the longitudinal sample.

Measures

All measures are based on a set of Likert-type items (1 = *strongly disagree* to 5 = *strongly agree* or 1 = *not at all important* to 5 = *very important*). A complete set of scales, items, and factor loadings is presented in Table 1.

Health rights. Six items tapped beliefs about rights concerning health. Both exploratory and confirmatory factor analyses were performed on these items that resulted in two factors. Three items formed the “Health as an Individual Right” scale (It’s my body, I can do what I want with it; If I want to smoke or drink, it’s my choice; and People have a right to smoke, they are only hurting themselves) and three items formed the “Public Health” belief scale (If something is bad for your health, the government should tell you to avoid it; The government should make laws to protect society against drunk driving; and Smokers need to be responsible, not smoke when little kids are around). Both scales had adequate measures of internal consistency: Cronbach’s alpha of .78 for “individual right” and .71 for “public health.”¹

No right to intervene. Adolescents’ assessment of their right to intervene in the risk behaviors of friends was measured with items developed for the Social Responsibility and Prevention project. The main dependent variable in this study is adolescents’ belief that intervening in a friend’s risky behaviors is “none of my

¹Note that the public health items were added at Waves 2 and 3 and the individual rights items were included at all three waves.

Table 1. Descriptive Statistics of Variables for Full Sample and Three Adolescent Groups

Variables (Factor Loadings)	Full Sample (<i>N</i> = 1,365)		Early Adolescent (<i>n</i> = 474)		Middle Adolescent (<i>n</i> = 457)		Late Adolescent (<i>n</i> = 434)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
No right to intervene (time 2)								
Drunkness—none of my business (.84)	2.02	1.06	1.99	1.06	2.05	1.09	2.03	1.02
Smoking—none of my business (.79)	2.53	1.21	2.31	1.21	2.58	1.24	2.73	1.13
Drugs—none of my business (.90)	2.07	1.09	1.98	1.09	2.12	1.11	2.12	1.07
Party—none of my business (.83)	2.19	1.04	2.13	1.09	2.24	1.06	2.20	.97
Public health (time 1)								
Not smoke when kids around (.56)	4.27	1.02	4.36	1.05	4.24	1.03	3.52	1.07
Bad for health government intervene (.80)	3.54	1.17	3.51	1.27	3.60	1.14	4.21	.97
Drunk driving government intervene (.60)	4.17	1.00	4.39	.94	4.12	1.00	3.97	1.00
Individual Right (time 1)								
My body I can do what I want with it (.79)	3.16	1.32	2.88	1.41	3.28	1.28	3.26	1.25
Smoking or drinking is my choice (.60)	3.12	1.40	2.60	1.34	3.28	1.39	3.57	1.27
People have a right to smoke (.59)	3.24	1.32	3.20	1.39	3.25	1.30	3.36	1.12

business,” that is, an individual has no right to intervene in his or her friend’s tobacco, alcohol, or drug use. It was based on responses to four vignettes in which a hypothetical friend would either be smoking cigarettes, drinking alcohol, using drugs, or where a group of friends were planning to go to a drinking party. Respondents were asked to rate how likely it was that they would ignore the behavior or say nothing because it was none of their business.

Data Analysis Plan

To understand developmental patterns, we took advantage of both the cross-sectional and longitudinal data. First, we tested for age and gender differences in health beliefs. Next, we used repeated measures analysis of variance over the three (or two, for the Public Health questions) waves of the study to compare trends for the three age groups. Finally, we used structural equation models (SEM) to test the relationships over time between prior health beliefs (at Wave 2) and subsequent endorsements that individuals have no right to intervene in the risky behavior of friends (at Wave 3). We tested measurement and structural invariance in the models for the three groups as well as mean-level differences between groups.

Results

Health Rights Beliefs

Figure 1 displays the percentage of adolescents at each age who agreed or strongly agreed with the individual rights or public health scales.² Several trends are noteworthy. First, endorsements of individual rights were higher for older compared to younger adolescents, $F(7, 2,459) = 24.4, p < .001$: Thirteen percent of 11-year versus 38% of 18-year-olds endorsed such rights. Second, we found marginal support for our hypothesis of a curvilinear relationship between age and endorsement of public health beliefs $F(7, 2,505) = 3.26, p = .002$. Sixty-three percent of 11-year-olds, 51% of 14- to 15-year-olds, and 60% of 17- to 18-year-olds endorsed this belief. Notably, at every age, adolescents were more likely to endorse public health than individual rights beliefs.

As predicted, there were significant gender differences with boys more likely than girls to endorse health rights beliefs, $F(1, 2,443) = 11.9, p = .001$ at Wave 1 and $F(1, 2,535) = 5.59, p = .018$ at Wave 2. At Wave 3 there were no gender differences $F(1, 1,857) = .432, p = .515$. As predicted, for the public health beliefs, the opposite pattern was found: girls were more likely than boys

²For consistency, respondents’ ages in this figure are based on ages reported at Wave 1.

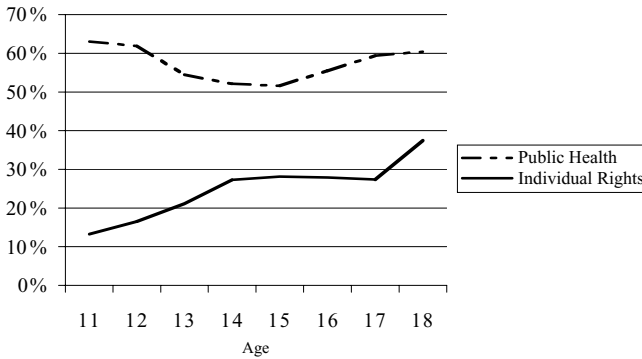


Fig. 1. Health beliefs by age: public health and individual rights.

to endorse these beliefs, $F(1, 2,532) = 49.6, p < .001$, $F(1, 1,857) = 31.1, p < .001$ at Waves 2 and 3, respectively.

Developmental Trends

To test for developmental trends, we split the sample into early-, middle-, and late-adolescent groups and ran repeated measures analysis of variance with health beliefs as the repeated measure and gender and parental education entered as covariates.

Figure 2 displays patterns for the three age groups for “Individual Rights” beliefs. Early adolescents have the lowest means at each wave whereas middle adolescents are more likely to endorse individual rights at each wave. Only at Wave 1 were late adolescents more likely than middle adolescents to endorse individual rights.

There were no interactions of time with age group on adolescents’ endorsements of health as a private right. However, there was a significant between-group effect for age group, $F(2,726) = 14.92, p < .0001$. *Post hoc* tests revealed that early adolescents ($M = 2.84$) were less likely than middle ($M = 3.14$) and late adolescents ($M = 3.16$) to endorse these beliefs.

There was a significant difference between groups $F(2,749) = 9.38, p < .0001$ and an interaction of age group with time ($p < .05$) on adolescents’ endorsement of public health beliefs. Consistent with our hypotheses and illustrated in Figure 3, middle adolescents ($M = 3.73$) were the least likely to endorse public health beliefs with late adolescents ($M = 3.92$) as likely as early adolescents ($M = 3.93$) to endorse such beliefs. In addition, whereas the public health beliefs of middle and late adolescents were stable over the last two waves of the study, early adolescents’ endorsements of these beliefs declined between Waves 2 and 3.

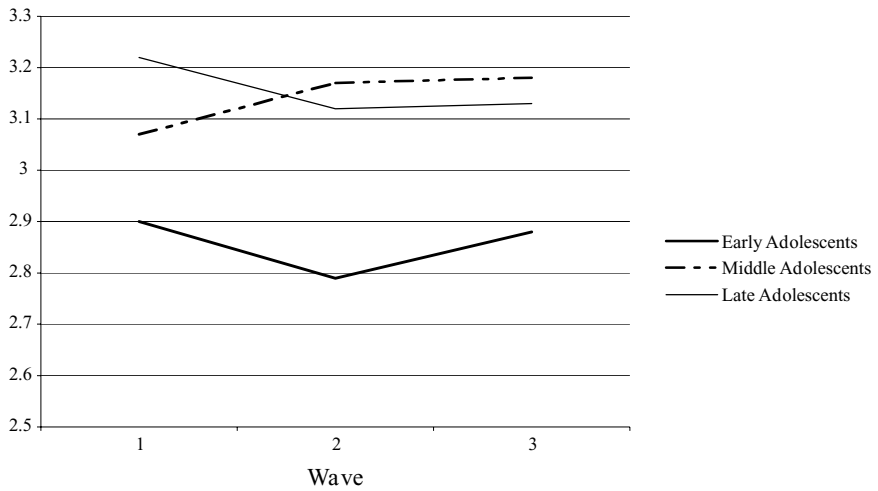


Fig. 2. Belief in health as an individual right by wave.

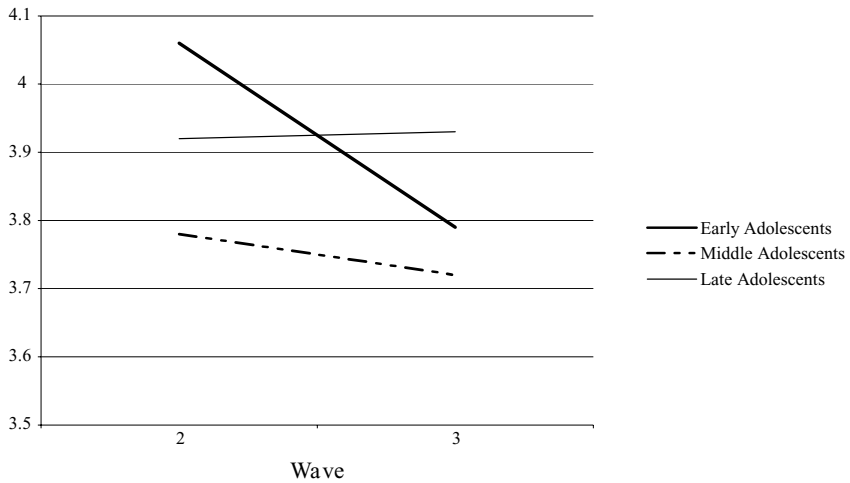


Fig. 3. Belief in health as a public responsibility by wave.

No Right to Intervene

Our conceptual model hypothesizes that adolescents' beliefs about health rights affect their assumptions about the right to intervene if friends are using drugs, drinking alcohol, or smoking: negatively related to individual rights and

positively related to public health beliefs. We also expected that girls would be more likely than boys to feel they had a right to intervene. To determine whether there were developmental differences in how these processes operate, we utilized a multiple group modeling approach with early ($n = 562$), middle ($n = 506$), and late adolescents ($n = 467$) as the groups. For the construct items, the percentage of cases classified as missing ranged from 1.1% to 5.1%. Rather than deleting cases with missing data, we analyzed the data using full information maximum likelihood estimation (Eliason, 1993).

Analytic Strategy

The data analyses involved several steps. First, we used confirmatory factor analyses to show that our measurement models were an appropriate fit for the overall sample. Second, we divided the sample into three age groups and estimated a multiple group measurement model that had latent variable factor loadings constrained to be equal. Third, we estimated multiple group SEM where gender, public health beliefs at Time 1, and individual rights beliefs at Time 1 were regressed on endorsement of the right to intervene at Time 2. Our final model was a multiple-group SEM with factor loadings constrained to be equal and the parameter estimates of the path coefficients estimated freely across groups.

Measurement Model

Figure 4 shows the multiple group measurement model for the latent variables: right to intervene (t2), public health beliefs (t1), and individual rights beliefs (t1). We assessed model fit using the comparative fit index (CFI) and the root mean square error of approximation (RMSEA). Based on these measures, our multigroup measurement model fit the data well (CFI = .98, RMSEA = .04) (Bentler, 1990; Browne & Cudeck, 1993). For this model, we also conducted χ^2 difference tests and determined that there was factorial invariance for the item loadings across groups. The results suggested that a model with all factor loadings constrained to be equal across groups adequately fit the data ($\chi^2 = 187.325$, $df = 106$). The χ^2 difference ($\chi^2 = 24.21$, $df = 12$) between our unconstrained and constrained models was not significant, indicating that the model with constrained factor loadings was a good fit for the data.

Table 2 reports the correlations of the latent variables for the overall sample ($\chi^2 = 80.161$, $df = 32$, CFI = .987, RMSEA = .031) and for the three adolescent groups with correlations marked to correspond with Figure 4. For the overall sample, individual rights beliefs and no right to intervene had a moderate, positive correlation. Public health beliefs and no right to intervene were negatively related. Overall, public health and individual rights beliefs had a weak, negative correlation. All correlations, except for public health beliefs with individual rights beliefs

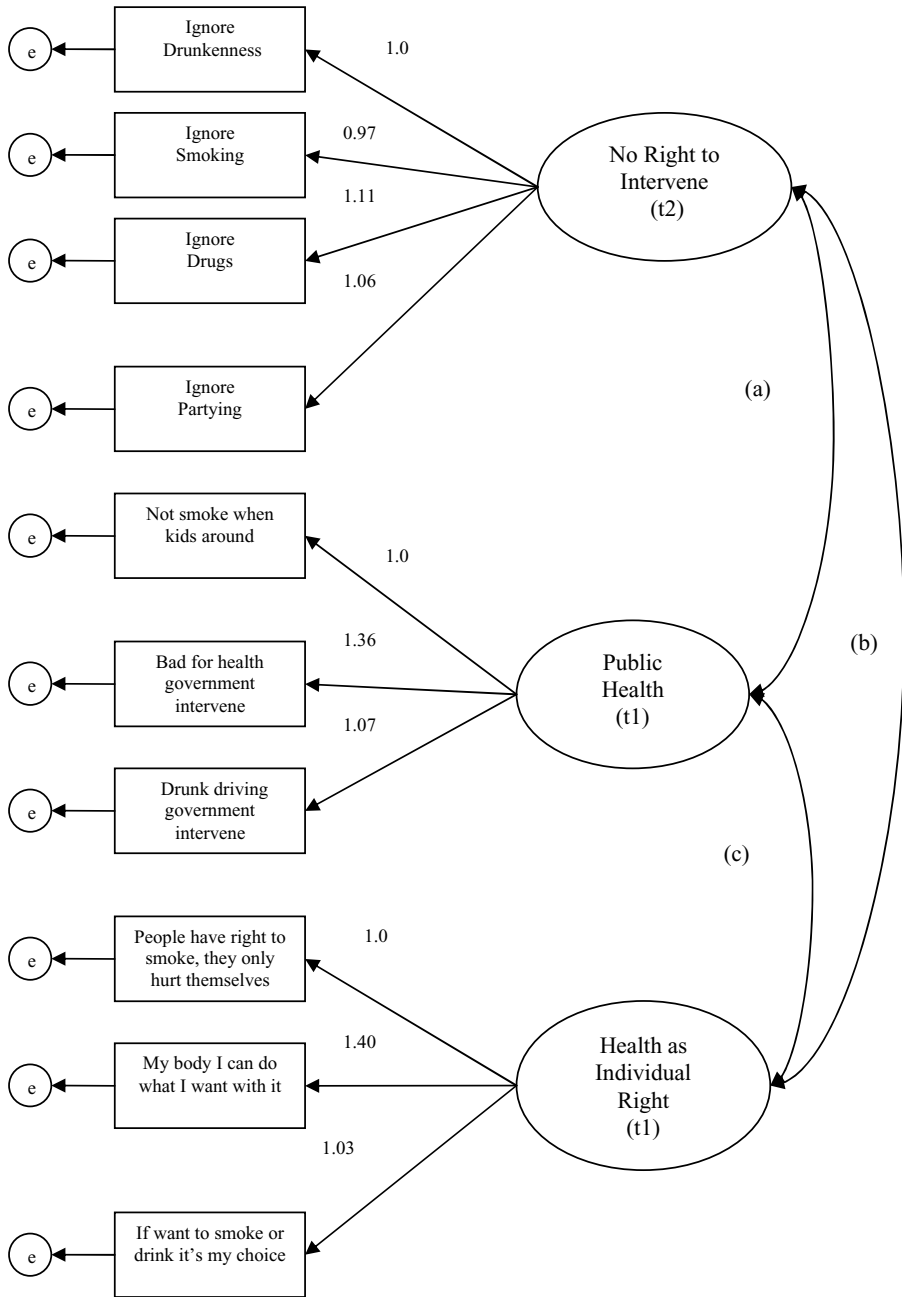


Fig. 4. Multiple group measurement model with equality constraints on factor loadings.

Table 2. Correlations of Latent Variables for Full Sample and Three Adolescent Groups

Correlation	Full Sample (<i>N</i> = 1,534)	Early Adolescent (<i>n</i> = 561)	Middle Adolescent (<i>n</i> = 506)	Late Adolescent (<i>n</i> = 467)
(a) Ignore: None of my business (t2) with public health (t1)	-.29***	-.25***	-.35***	-.22**
(b) Ignore: None of my business (t2) with individual right (t1)	.24***	.18**	.27***	.23***
(c) Public health (t1) with individual right (t1)	-.09*	-.25***	.02	.07

Note. * $p < .05$; ** $p < .01$; *** $p < .001$.

for the middle- and late-adolescent groups, were in the expected directions, and were statistically significant.

The bivariate associations show several interesting age patterns. For instance, for middle adolescents there are stronger associations between both the individual right and public health constructs and endorsing “no right to intervene” when compared to the results for the early or late adolescents. This suggests that, for middle adolescents, there is a stronger relationship between beliefs about health rights and behavioral norms concerning the right to intervene in friends’ behavior and supports contentions that, at this age, they are trying to fit in and to make sense of social conventions (Horn, 2003; Nucci, 2006). Among early adolescents, there is a negative relationship between individual rights and public health beliefs but among middle and late adolescents, these beliefs are uncorrelated. This suggests that, for early adolescents, beliefs in individual rights and public health are polar opposites whereas for middle and late adolescents they are not. The fact that endorsements of individual rights and public health beliefs are not polar opposites for the middle and late adolescents points to the increasing sophistication of their social representation of health.

Structural Equation Model

Table 3 displays the results of the structural equation models for the overall and multiple group samples. In these models public health beliefs, individual rights beliefs, and gender are each regressed on right to intervene. Table 3 presents the unstandardized and standardized path coefficients for the overall and multiple group SEMs. Unstandardized coefficients reflect differences across age groups, while standardized coefficients report the magnitude of effects within groups.

Table 3. Path Coefficients for SEMs of Adolescent Intervention Rights Beliefs

	No Right to Intervene in a Friend's ATOD Use											
	Full Sample (<i>N</i> = 1,533)			Early Adolescent (<i>N</i> = 560)			Middle Adolescent (<i>N</i> = 506)			Late Adolescent (<i>N</i> = 467)		
	Coefficient	Standardized Coefficient		Coefficient	Standardized Coefficient		Coefficient	Standardized Coefficient		Coefficient	Standardized Coefficient	
Public health	-.342***	-.254		-.309***	-.209		-.437***	-.335		-.308***	-.221	
(t1)	(.050)			(.097)			(.080)			(.092)		
Individual right	.067***	.209		.096	.093		.292***	.279		.249***	.240	
(t1)	(.029)			(.065)			(.057)			(.060)		
Female	-.173***	-.217		-.118	-.141		.000	.000		-.211**	-.289	
	(.045)			(.079)			(.019)			(.073)		
<i>R</i> ²		.138			.069			.216			.123	

Note. Model fit for the overall sample SEM: $\chi^2 = 80.161$; *df* = 32; CFI = .987; RMSEA = .031.

Model fit for the multiple-group SEM: $\chi^2 = 227.455$; *df* = 130; CFI = .975; RMSEA = .038.

Standard errors in parentheses. ATOD = alcohol, tobacco, and drug. * *p* < .05, ** *p* < .01, *** *p* < .001.

The *unstandardized coefficients* in Table 3 reveal several differences across adolescent age groups. First, the coefficient for individual rights beliefs increases between early and middle adolescence and then declines slightly for late adolescents. Whereas for early adolescents, beliefs in individual rights have little impact on intentions to intervene, for middle and late adolescents, beliefs that health risks are an individual's decision are significantly associated with their perceptions that they have no right to intervene in their friends' risk taking. We can infer that, to the extent that they endorse an individual's right to take risks, they would be unlikely to act if a friend were taking risks. Second, the coefficient for public health beliefs is higher for middle adolescents than for early or late adolescents. This suggests that endorsements of public health are more strongly associated with the belief in a right to intervene in friends' risk taking in middle than in early or late adolescence. Table 3 also shows that gender was related to late adolescents' concepts of their right to intervene with females more likely than males to endorse this right. However, there were no gender differences in early or middle adolescents' convictions of their right to intervene in friends' risky behaviors.

The *standardized* path coefficients reported in Table 3 provide information on the magnitude of the effects of adolescent public health beliefs, individual rights beliefs, and gender on their convictions regarding the right to intervene. For early adolescents, only the coefficient for public health beliefs is a significant predictor of perceptions of the right to intervene. Neither belief in health as an individual right nor gender have a significant impact on early adolescents' convictions that they have a right to intervene in the behavior of others.

Among middle adolescents, both individual rights and public health beliefs are significant predictors of the conviction that one has a right to intervene in friends' risk taking. The direct effects of the exogenous variables indicate that public health beliefs are a stronger predictor than are beliefs in individuals' rights. For late adolescents, the differences in the magnitude of the effects of the independent variables on the conviction that one has a right to intervene are small. All three of the independent variables (gender, public health, and individual rights) are equally important for understanding late adolescents' convictions regarding their right to intervene. Furthermore, as the discussion of bivariate relationships pointed out, older adolescents no longer hold public health and individual rights beliefs as polar opposites, pointing to a maturational pattern, that is, both beliefs can exist within the same individual.

Our model explains 7% of the variance in early adolescents' convictions about their right to intervene, 22% of middle adolescents' convictions, and 12% of late adolescents' convictions. In each case, public health beliefs are the most significant predictor of adolescents' convictions that they have a right to intervene in the risk behaviors of friends. In short, young people who endorse society's right to curb individuals from risky choices that could impact others' health and

well-being also believe they have a right (or obligation) to intervene in the risky behaviors of their friends.

Discussion

In this study, we revealed developmental differences in adolescents' representation of health and the rights associated with risky behaviors that might compromise health. Between early and late adolescence, there is an increase in the defense of an individual's right to engage in risks that might compromise health. At the same time, there appears to be a curvilinear relationship between age and an appreciation of the implications to the public's health of an individual's risky choices: Early and late adolescents are more likely than are middle adolescents to endorse the right of society to curb or penalize individuals for making risky choices. Taken together, these results point to developmental changes in the social representation of health and the rights associated with risky choices. By late adolescence there is a sophisticated conceptualization of health: A commitment to an individual's right to experiment with substances is tempered by a recognition of the need for laws enacted by government that constrain individuals' rights in the interest of a larger public good. The results are consistent with age trends in social judgments, social exclusion, and endorsements of individual rights: What we might refer to as an ardent commitment to personal rights as a basis for making decisions and regulating social interactions appears to peak in middle adolescence (Horn, 2003; Killen et al., 2002; Ruck et al., 1998).

Besides age, there were gender differences in beliefs about rights associated with health risks. Females were less likely than males to endorse individual rights and more likely to endorse public health, although these gender differences disappeared as adolescents grew older. This is consistent with literature on friendship in which females are more likely to offer support to a friend in need (Rose & Asher, 1999). It also supports gender differences in adolescents' perceptions of rights with females more likely than their male peers to endorse nurturance rights (Day et al., 2006; Peterson-Badali & Ruck, this issue). Finally, this result is consistent with the fact that female adolescents are more likely than their male peers to consider social exclusion a moral matter rather than a social convention (Horn, 2003).

The results also show that health beliefs have an impact on adolescents' conviction that they do or do not have a right to intervene in a friend's risk taking. For middle adolescents in particular, both public and private health beliefs accounted for a significant percentage of the variance in youths' convictions. Our models did not explain as large a proportion of the variance in early and late adolescents' convictions about intervening in friends' risky choices. Future research should consider other factors that may affect youths' convictions about dissuading friends from ATOD use.

We want to draw attention to the relatively high level of espousal of public health beliefs and comparatively low level of adherence to individual rights. Although this gap in attitudes is smaller among older respondents, it is noteworthy that, in a society where the dominant social representation of health is that it is a private rather than a public good, adolescents do appreciate the state's role in constraining individual choices in the interests of public health. These results are consistent with other work showing that both young people and their mothers are more likely to endorse nurturance than self-determination rights (Day et al., 2006; Ruck et al., 2002). The fact that we measured public health beliefs in a relatively narrow way is a limitation of our study. Additional items tapping youths' beliefs about the responsibilities of the state to its children and of health as a human right would have provided a more detailed picture of how adolescents conceive of health and the rights and responsibilities associated with it.

The results of this program of work are relevant for health promotion and risk prevention efforts with young people. Individual responsibility and informed decision making are the standards of most prevention programs but the emphasis is typically on individuals making those decisions on their own. Based on the results of this study, interventions could emphasize: (a) that there are both private and public dimensions of health, (b) that individual behaviors including risky choices have implications for others' well-being, and (c) that dissuading friends from behaviors that might compromise their health is a responsibility friends owe one another.

References

- Bentler, P. M. (1990). Comparative fit indices in structural models. *Psychological Bulletin*, *107*(2), 238–246.
- Berkowitz, M. W., Guerra, N., & Nucci, L. (1991). Sociomoral development and drug and alcohol abuse. In W. M. Kurtines & J. L. Gewirtz (Eds.), *Handbook of moral behavior and development, Vol. 3: Application* (pp. 35–53). Hillsdale, NJ: Erlbaum.
- Browne, M. W., & Cudeck, R. (1993). Alternative ways of assessing model fit. In K. A. Bollen & J. S. Long (Eds.), *Testing structural equation models* (pp. 136–162). Newbury Park, CA: Sage.
- Day, D. M., Peterson-Badali, M., & Ruck, M. D. (2006). The relationship between maternal attitudes and young people's attitudes toward children's rights. *Journal of Adolescence*, *29*, 193–207.
- Eisenberg, N., & Sheffield-Morris, A. (2004). Moral cognition and pro social responding in adolescence. In R. M. Lerner & L. Steinberg (Eds.), *Handbook of adolescent psychology* (pp. 155–188). New York: Wiley.
- Eliason, S. R. (1993). *Maximum likelihood estimation: Logic and practice*. Newbury Park, CA: Sage.
- Flanagan, C., Galla, L., & Elek, E. (2004). Friends don't let friends . . . or do they? Developmental and gender differences in intervening in friends' ATOD use. *Journal of Drug Education*, *34*(4), 351–371.
- Flanagan, C. A., & Stout, M. (2008). *Developmental origins of social trust: Patterns over two years for early, middle, and late adolescents*. Manuscript under review.
- Guttman, N., & Ressler, W. H. (2001). On being responsible: Ethical issues in appeals to personal responsibility in health campaigns. *Journal of Health Communications*, *6*, 117–136.
- Haigh, F. (2002). Human rights approach to health. *Croatian Medical Journal*, *43*(2), 166–169.

- Helwig, C. C. (1995). Adolescents' and young adults' conceptions of civil liberties: Freedom of speech and religion. *Child Development, 66*, 152–166.
- Horn, S. (2003). Adolescents' reasoning about exclusion from social groups. *Developmental Psychology, 39*(1), 71–84.
- Horn, S. S. (2005). Adolescents' peer interactions: Conflict and coordination among personal expression, social norms, and moral reasoning. In L. Nucci (Ed.), *Conflict, contradiction, and contrarian elements in moral development and education* (pp. 113–128). Mahwah, NJ: Erlbaum.
- Keating, D. P. (2004). Cognitive and brain development. In R. M. Lerner & L. Steinberg (Eds.), *Handbook of adolescent psychology* (pp. 45–84). New York: Wiley.
- Killen, M., Lee-Kim, J., McGlothlin, H., & Stangor, C. (2002). How children and adolescents evaluate gender and racial exclusion. *Monographs for the Society for Research in Child Development*. Serial No. 271, Vol. 67, No. 4. Oxford, UK: Blackwell Publishers.
- Killen, M., Leviton, M., & Cahill, J. (1991). Adolescent reasoning about drug use. *Journal of Adolescent Research, 6*, 336–356.
- Killen, M., & Stangor, C. (2001). Social reasoning about inclusion and exclusion in gender and race peer group contexts. *Child Development, 72*, 174–186.
- Leichter, H. M. (2003). “Evil habits” and “personal choices”: Assigning responsibility for health in the 20th century. *Milbank Quarterly, 81*(4), 603–626.
- Minkler, M. (1999). Personal responsibility for health? A review of the arguments and the evidence at the century's end. *Health Education and Behavior, 26*(1), 121–140.
- Nucci, L. P. (1996). Morality and the personal sphere of action. In E. Reed, E. Turiel, & T. Brown (Eds.), *Values and knowledge* (pp. 41–60). Hillsdale, NJ: Erlbaum.
- Nucci, L. P. (2006). Education for moral development. In M. Killen & J. Smetana (Eds.), *Handbook of moral development* (pp. 657–681). Mahwah, NJ: Erlbaum.
- Nucci, L., Guerra, N., & Lee, J. (1991). Adolescent judgments of the personal, prudential, and normative aspects of drug usage. *Developmental Psychology, 27*, 841–848.
- Peterson-Badali, M., Ruck, M. D., & Ridley, E. (2003). College students' attitudes toward children's nurturance and self-determination rights. *Journal of Applied Social Psychology, 33*(4), 730–755.
- Rose, A. J., & Asher, S. R. (1999). Children's goals and strategies in response to conflicts within a friendship. *Developmental Psychology, 35*, 69–79.
- Ruck, M. D., Abramovitch, R., & Keating, D. P. (1998). Children's and adolescents' understanding of rights: Balancing nurturance and self-determination. *Child Development, 64*, 404–417.
- Ruck, M. D., Peterson-Badali, M., & Day, D. M. (2002). Adolescents' and parents' understanding of children's rights in the home. *Journal of Research on Adolescence, 12*, 373–398.
- Smetana, J. G. (2002). Culture, autonomy, and personal jurisdiction in adolescent-parent relationships. In H. Reese & R. Kail (Eds.), *Advances in child development and behavior* (Vol. 29, pp. 51–87). New York: Academic Press.
- Turiel, E. (1983). *The development of social knowledge: Morality and convention*. Cambridge: Cambridge University Press.
- Williams, C., & Bybee, J. (1994). What do children feel guilty about? Developmental and gender differences. *Developmental Psychology, 30*(5), 617–623.

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