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Self-rated health and health damaging behaviour among young women in Hungary in connection with family background

Submitted: 30 October 2003
Accepted: 7 March 2005

Summary

Objectives: To describe the relationship of subjective health and harmful lifestyle with familial risk factors, such as low parental educational level, parental psychiatric disorder reported by their offspring, alcohol use, and divorce.

Methods: 3615 hungarian women aged 15–24 in 1998. The questionnaire addressed socio-economic factors, physical and mental health, and health damaging behaviours.

Results: Low self-rated health (OR: 2.32; CI: 1.54–3.47; $p < 0.001$) or at least five health complaints (OR: 2.09; CI: 1.68–2.60; $p < 0.001$) were significantly more common among women with reported parental psychiatric disorder. Drug use (OR: 2.35; CI: 1.86–2.98; $p < 0.001$) and regular or excessive alcohol consumption (OR: 1.86; CI: 1.46–2.37) was in strongest association with parental high education.

Conclusions: Family related social problems, especially reported parental psychiatric disorders, regular alcohol consumption, and educational level, are important factors to be taken into account when planning specific interventions for young women.

Keywords: Young women – Family background – Health damaging behaviour – Self-rated health.

While the life expectancy rates of women are increasing in North America and Western Europe (European Commission 1997), the health condition of the Central-Eastern European female population is decreasing even though the political and economic system has improved through the past decade (Kopp et al. 2004). The high incidence of cardiovascular disease, lung and breast cancer, alcoholism, suicide, induced abortion, (Statistics Hungary 2002) and violence against women are the most important women's health issues that need to be addressed in this region.

The primary causes of preventable premature death among Hungarian women are cardiovascular disease, lung cancer, and breast cancer (Statistics Hungary 2002). Unfortunately, despite major health promotion campaigns, the prevalence of health damaging behaviours, such as smoking, drug use, and alcohol consumption, is increasing among the young female population. Early prevention of health damaging behaviour is especially important in this region, for the estimated number of female alcoholics in Hungary is over 200 000 (Statistics Hungary 2002). Also, the prevalence of smoking has increased among young women in Hungary in recent years, in fact the rate of increase has surpassed that of young men (Józan 1999). Drug use is becoming increasingly widespread in Hungary (Elekes 1999), an estimated 23.5 % of high school women have used drugs, but its magnitude remains uncertain because of underreporting.

One possible causative factor of ill health and health damaging behaviour is family background (Rahkonen et al. 1997). There are two possible ways adverse childhood conditions can affect adult health: increased vulnerability to disease, or consequential social disadvantages, such as educational and job opportunities and general life chances resulting in health damaging behaviour (Lundberg 1997). Parental mental illness and substance use has been shown to disrupt family environment, which in turn has detrimental effects on children of the ill (Farahati et al. 2003).

Lifestyle, such as cigarette use and alcohol consumption, develops by exposure to attitudes and behaviours of the environment such as the family or peer groups (Blaxter 1990). Parental health habits are considered to be an important factor of health damaging behaviour among youth (Hill et al. 2000). Adult children of alcoholic parents are at increased risk for psychiatric disorders, partly because of family

Soz Praventiv Med 51 (2006) 45–53
0303-8408/06/010045-09
DOI 10.1007/s00038-005-0006-8

disruption, increased violence, financial, occupational, and other consequences of alcoholism, and co-morbid psychiatric disorders of alcoholic parents (Johnson et al. 1991). Studies have shown that youth with parents consuming excessive amounts of alcohol are more likely to be at risk for alcohol problems themselves (Cotton 1979). The consequence may be early initiation of regular alcohol consumption, which in turn increases the likelihood of alcohol dependence in adulthood (Ghodsian & Power 1987). The initiation of smoking among young women is also in close association with social learning and social bonding within the family, school, and peer groups (Conrad et al. 1992). Also, results of Ellickson and Morton's study (1999) found parental low education to increase the possibility of hard drug use among white students and decrease the risk in ethnic groups.

There is evidence in the literature that family contexts are important for the socialisation of health behaviours in adolescence and that, for example, divorce-related difficulties experienced by girls usually emerge in adolescence (Kalter et al. 1985). Some suggest that children of divorced parents may have higher levels of drug use than children of non-divorced families (Flewing & Bauman 1990), therefore family disruption can be viewed as a likely risk factor for health damaging behaviour among young women.

The aim of the study was to gain epidemiological data on the health status of young women today and to analyse the relationship of familial characteristics, health, and health damaging behaviour in this young population. The hypothesis of the current study was that young women who live in adverse familial conditions have worse physical health and an increased prevalence of health damaging behaviour compared to those who do not. This, to our knowledge, is the first nationally representative study regarding young women's health exclusively in the Central-Eastern European region, and serves important data for preventive interventions for this special population.

Methods

The data presented are from a national representative study conducted in 1998 in Hungary (Csoboth et al. 2003). The organization and conduction of the survey was managed by the Végeken Foundation and the Institute of Behavioural Sciences at Semmelweis University, in Budapest, Hungary. The study was approved by the Research Ethics Committee of the Semmelweis University and the National Minorities Ombudsman.

Sample

The sample constructed for the Better Health for Women survey consisted of 3615 women aged 15–24, of which 2016 were students and 1599 were not students (working either outside or inside the home, or unemployed). A multi-stage stratified sampling method was applied.

The student sample was first stratified by the proportion of the population in each of the six Hungarian regions. In the second step, students were selected according to age and type of school. In the third step, 10 students from each grade were selected randomly from the student register. Questionnaires were filled out simultaneously by the selected students while a trained reviewer supervised the completion of the questionnaires. The non-student (employed, unemployed, on maternity leave, homemakers) sample was representative by region, settlement size, age, and occupation. The group of non-student women filled out the questionnaires by means of a door-to-door survey. The surveyors looked for one non-student individual meeting the pre-defined sampling-criteria at a pre-determined address. The sampling procedure was based on population data of the Hungarian Central Statistical Office. Within the six regions of the country settlements were selected randomly representing the distribution of settlement size (population below 20000, between 20000 and 50000, and above 50000). In the selected settlement, interviewees were identified by age, employment, and occupational status (manager, non-manager white-collar, skilled worker, unskilled worker, unemployed, working at home, maternity leave).

The refusal rate of the whole sample was 6%. Refusal rate was under 2% in the student group and 11% in the non-student group. Interviewers were instructed to substitute the sample in case of refusal, in the student sample another student was randomly selected from the same grade or when a non-student refused, the surveyor selected another woman who met the same requirements, namely region, settlement size, age, and occupational status.

Questionnaires and measures

Two versions of the questionnaire were devised, one for students and one for those who had already completed their studies (the difference was due to questions regarding employment). Both versions were self-administered and anonymous. The questionnaire contained questions about socio-economic background, school or workplace environment, health status, health behaviour, eating behaviour and habits, physical and sexual abuse, sexual behaviour, and mental health. The questionnaire was finalised after a pilot study on a sample of 120 young women.

The following measures were used in our data analysis:

Parental characteristics

Parental education: The educational level of parents was used in the social background analysis. We defined three cat-

egories: high education, if at least one parent has the college or university degree; middle, if at least one parent has a high school diploma; low, if neither parent has a high school diploma. When analysing for parental education the given measure was always compared to the least common education group.

Parental psychiatric disorder: The following questions were asked regarding existing mental disorders among parents: according to your knowledge is your birth mother/father suffering or has he or she suffered from depression or any other psychiatric disorders? The combined indicator of parental psychiatric disorder implies that at least one of the parents has been or is currently ill because of depression or other psychiatric disturbance.

Parental regular, excessive alcohol consumption: The following questions were asked: "Many families experience the following. Please mark if your mother/father drinks large amounts of alcohol regularly. If you don't live with your birth parents, then the questions refer to your step-parents/foster parents." The combined indicator of regular, excessive parental alcohol consumption implies that at least one of the parents consumes a large amount of alcohol regularly.

Health status

Self-rated health: According to previous studies, self-ratings of health and illness reliably reflect the health status of the individual (Idler & Benyamini 1997). To measure the subjective health status of Hungarian young women, respondents rated own health on a 5-point scale (very bad, bad, average, good, excellent). We combined the answers "very bad" and "bad" into one measure, which we named low self-rated health, to be able to compare young women reporting low self-rated health with the rest of the sample.

Health complaints: Women were asked to mark the presence of health problems from the list of the following 10 complaints: fatigue, frequent headache, frequent colds, loss of appetite, severe menstrual cramps, pain in extremities, abdominal complaints, constipation, joint pain, frequent diarrhoea. The category of "many health complaints" was defined as those who marked five or more complaints on this list.

Health damaging behaviour

Regular or excessive alcohol consumption: The following questions were asked concerning alcohol use: "Which statement applies to you most with regard to alcohol consumption?" ("I rarely drink alcohol, and when I do just very little"; "I regularly drink alcohol, but very little each time"; "I rarely drink alcohol, but when I do, I drink a large amount"; "I regularly drink a large amount of alcohol; I never drink alcohol"). The measure, "regular or excessive alcohol consumption" was taken as corresponding to the answers: "I rarely drink alcohol, but when I do, I drink a large amount"; "I regularly drink alcohol, but little each time" or "I regularly drink a large amount of alcohol".

Drug use: Questions regarding drug use were the following: "How many times have you used the following drugs during your life?" (Frequency: Never, I only tried, Less than 10 times, 10–20 times, Regularly.) The following drugs were listed: cannabis, poppy seed tea or opium, inhalants (glue or solvent), sedatives or sleeping pills, sedatives combined with alcohol, amphetamines, Speed, LSD or other hallucinogens, crack, cocaine, heroin, Ecstasy (MDMA). With the exception of regular cannabis use, other regular drug use was rare in the sample, therefore data was grouped into two groups, namely never used or tried/used the specific drug.

Smoking. The following question was asked: "Do you smoke?" (Yes/No).

Data analysis

The SPSS for Windows 7.0 statistical software was used for data analysis (SPSS 1997). Prevalence rates were calculated and presented as descriptive statistics.

Logistic regression analysis was used to compute the odds ratios (OR) of low self-rated health, multiple somatic complaints, and health damaging behaviour. The regression model included age and student-non-student status besides family characteristics. ORs were calculated with their Confidence Intervals of 95 % (95 % CI).

All measures used in the data analysis were dichotomized, except for the educational level of parents, where we used three groups (low, middle, and high educational level). The effect of parental educational level was analyzed in each case by using the group with the lowest prevalence of the studied measures (health measures, health risk behaviour) as the reference group. Age was grouped into 15–17 years, 18–21 years, and 22–24 years. The OR was always given compared to the reference group. The reference group was considered to have a risk of one in the tables.

Results

Sample characteristics are summarised in Table 1.

Family background

The majority of women had parents with low educational level. One fifth of women came from divorced families. Young women reported psychiatric disorders or depression to be present in 5 % of fathers and 11.2 % of mothers. Altogether 14.4 % of young women had at least one parent with a psychiatric disorder. 12.9 % of fathers and 2.1 % of mothers regularly consumed excessive amounts of alcohol. Altogether

Table 1 Description of sample characteristics (N = 3615, women, 15–24 yr, Hungary, 1998)

Measures	Frequency %)
Description of the family background:	
Parental educational level	
low	39.0
middle	36.6
high	24.4
Divorce, yes	20.6
Parental psychiatric disorder, yes	14.4
Parental regular, excessive alcohol consumption, *yes*	14.1
Self-rated health:	
excellent	12.4
good	56.4
average	26.9
bad	3.6
very bad	0.5
Frequency of health complaints:	
fatigue	63.8
frequent headache	46.6
frequent colds	37.1
severe menstrual cramps	34.5
pain in extremities	27.1
abdominal complaints	26.9
joint pain	25.8
constipation	19.6
frequent diarrhoea	5.8
loss of appetite	18.0
Health risk behaviour:	
smoking, yes	31.9
alcohol use:	
total abstinence	18.0
little amount occasionally	65.2
little amounts regularly	3.2
large amounts occasionally	13.3
large amounts regularly	0.3
drug use, yes	19.6

14.1 % of young women reported at least one parent consuming excessive amounts of alcohol regularly.

Physical health

When asked about their health, 12.4 % of young women rated their health excellent and 4.1 % of the respondents rated their health low. The most frequent health complaints of young women were fatigue (63.8 %) and frequent headache (46.6 %). Of the listed problems, five or more health complaints were reported by 22.9 % of young women. 32.7 % reported three or four complaints, and only 44.4 % marked less than three.

Health damaging behaviour

Smoking was highly prevalent in this sample, 31.9 % of women smoked cigarettes. When asked about alcohol consumption, only 18 % reported total abstinence. The prevalence of drug use among young women was analysed. 19.6 % of women have used at least one type of the drugs mentioned above. Cannabis was used most frequently (13 %), followed by sedatives-sleeping pills (8 %), amphetamines (4.2 %), sedatives with alcohol (3.9 %), Ecstasy (3.1 %), LSD (1.9 %), and inhalants (1.1 %). The frequency of cocaine, heroine, crack, and poppy seed tea or opium use was under 1 % each.

Family characteristics in relationship with young women's subjective health

The association between parental characteristics and bad subjective health or more than five health complaints was analysed (see Tab. 2). Reported parental psychiatric disorder was a significant predictor of low subjective health and more than five health problems. Parental regular, excessive alcohol consumption was also a significant predictor of multiple health problems, but we did not find any relationship with low subjective health. We found no association between divorce and health measures. The frequency of low self-rated health and a large number of complaints decreased with the increase of parental educational level. Daughters of parents with low educational level rated their health low and reported five or more health complaints significantly more than those with highly educated parents. There was a significant increase in risk for more than five health complaints among students, but no difference in subjective health was found between the two groups.

Family characteristics in relation to health risk behaviour

Health risk behaviour, namely smoking, regular or excessive alcohol consumption, and drug use, were significantly more frequent among (see Tab. 3) women who reported parental psychiatric disorder, regular, excessive alcohol consumption, or divorce. Parental educational level was a significant predictor of health damaging behaviour: daughters of parents with middle or high education were significantly more likely to use drugs or alcohol than daughters of parents with low education. Use of cigarettes was more frequent among women with parental high and low educational level. Being a student proved to be a significant risk factor for drug and alcohol use, but served as a protective factor in regard to smoking. Women between the ages of 18 and 21 also showed an increased risk for alcohol and drug use.

Conclusions and discussion

Our results reflect the importance of familial adverse conditions affecting the health of young women. Low subjective health and multiple health complaints were more prevalent

Table 2 Association of low self-rated health and more than five health complaints with family characteristics (N = 3615, women, 15–24 yr, Hungary, 1998)

	Low self-rated health** N=147			At least 5 health complaints N=776		
Variables	**N**	**% (of each variable within Low self-rated health)**	**OR (95 % CI)**	**N**	**% (of each variable within At least 5 health complaints)**	**OR (95 % CI)**
Parental psychiatric disorder						
present	41	7.9	**2.32** (1.54–3.47)	178	36.2	**2.09** (1.68–2.60)
none*	106	3.4	1	598	20.7	1
Parental regular, excessive alcohol consumption						
present	26	5.1	**0.98** (0.6–1.58)	153	31.7	**1.46** (1.16–1.81)
none*	121	3.9	1	623	21.5	1
Divorce						
yes	28	3.8	**0.81** (0.52–1.27)	175	25.5	**1.09** (0.88–1.34)
no*	119	4.2	1	601	22.3	1
Parental educational level						
low	67	4.8	**1.92** (1.16–3.02)	337	26.1	**1.55** (1.23–1.96)
middle	52	4.0	**1.55** (0.92–2.59)	264	21.6	**1.15** (0.91–1.44)
high*	24	2.8	1	160	19.6	1
Age groups (years)						
15–17*	37	3.4	1	240	23.1	1
18–21	53	4.0	**1.21** (0.75–1.95)	297	23.8	**1.07** (0.85–1.33)
22–24	49	5.2	**1.67** (0.93–2.99)	197	22	**1.07** (0.8–1.43)
Status						
student	74	3.7	**1.22** (0.77–1.94)	448	23.8	**1.29** (1.03–1.63)
non-student*	73	4.6	1	328	21.9	1

▲ OR= Odds Ratio (from logistic regression not adjusted for other variables), CI = Confidence Interval
* reference category
** a joint measure consisting of women who reported "very bad" and "bad" self-rated health

among women with adverse familial characteristics, namely reported parental psychiatric disorder or regular, excessive alcohol consumption. This coincides with other studies, such as the HBSC survey in Belgium, which found that adolescent health is influenced by inequalities in social position (Vereecken et al. 2004) and that adult health-state is influenced by childhood family conditions (Rahkonen et al. 1997; Lundberg 1997). A parental socio-economic gradient in connection with subjective health and multiple health complaints was also found among young Hungarian women, similar to Slovak adolescents (Geckova et al. 2004). Call & Nonnemaker's (1999) study supports these findings, in which they found that adolescents with parents with low educational level rated their health worse than those with highly educated parents.

We found a high prevalence of health damaging behaviour among young Hungarian women, coinciding with data from the Hungarian ESPAD study (Elekes 1999), which also found a 16.4 % frequency of drunkenness in the past month and a 23.5 % frequency of drug use among female high school students. Young female students in our sample were at an increased risk for alcohol and drug use, compared to the non-student group. Our measure of alcohol use included all women who drank alcohol (except for those who drank rarely and only little), because the regular use of alcohol, even in small amounts, in a young female population has been shown to increase the risk of future health damaging behaviour . Numerous studies (e. g. Ghodsian & Power 1987) have shown that early initiation of regular alcohol consumption increases the likelihood of alcohol dependence in adulthood. While individuals younger that 14 years have a 40 % likelihood, individuals drinking regularly only after the age of 20 have a 10 % chance of dependence (Grant & Dawson 1997). This is especially important in Hungary, where the number of alcohol dependent women in the population is high.

Table 3 Logistic regression analysis for the risk of health damaging behaviour in connection with family background (N = 3615, women, 15–24 yr, Hungary, 1998)

	Drug use N = 667			Regular or excessive alcohol consumption** N = 595			Smoking N = 1133		
Variables	**N**	**% (of each variable within Drug use)**	**OR (95 % CI)**	**N**	**% (of each variable Regular or excessive alcohol consumption)**	**OR (95 % CI)**	**N**	**% (of each variable within Smoking)**	**OR (95 % CI)**
Parental psychiatric disorder									
present	152	30.7	**1.68** (1.33–2.11)	126	24.5	**1.47** (1.16–1.88)	203	39.3	**1.37** (1.11–1.67)
none*	515	17.7	1	469	15.5	1	930	30.6	1
Parental regular, excessive alcohol consumption									
present	127	26.0	**1.41** (1.11–1.79)	109	21.6	**1.39** (1.08–1.8)	205	40.5	**1.36** (1.1–1.67)
none*	540	18.6	1	486	16.0	1	928	30.4	1
Divorce									
yes	195	27.9	**1.61** (1.31–1.98)	153	21.0	**1.39** (1.14–1.73)	292	40.0	**1.51** (1.26–1.8)
no*	472	17.5	1	442	15.7	1	841	29.8	1
Parental educational level									
low	195	15	1*	181	13.3	1*	482	35.3	**1.32** (1.11–1.57)
middle	232	19	**1.35** (1.08–1.68)	196	15.5	**1.14** (0.91–1.44)	354	27.7	1*
high	231	28.1	**2.35** (1.86–2.98)	208	24.3	**1.86** (1.46–2.37)	274	32	**1.3** (1.72–1.59)
Age groups (years)									
15–17*	153	14.6	1	193	17.7	1	316	29	1
18–21	297	23.9	**2.05** (1.61–2.61)	258	19.8	**1.66** (1.31–2.09)	496	37.8	**1.26** (1.03–1.53)
22–24	188	21	**1.94** (1.43–2.63)	115	12.4	**1.35** (0.98–1.86)	260	27.8	**0.7** (0.54–0.91)
Status									
student	371	19.4	**1.21** (0.97–1.54)	420	21.2	**2.36** (1.83–3.04)	591	29.8	**0.74** (0.6–09)
non-student*	296	19.9	1	175	11.3	1	542	34.5	1

▲ OPR= Odds Ratio (from logistic regression not adjusted for other variables), CI = Confidence Interval
* reference category
** a joint measure consisting of women drinking large amounts occasionally, or small or large amounts regularly

Analysing for determinants of health damaging behaviour, our results show that young women with reported parental psychiatric disorder, substance use, or divorce were more at risk for the presence of health damaging behaviour. Other studies have also found that unhealthy lifestyles were more prevalent among adolescents who were not family-oriented, due to disruption or other disorders present in the family (Gendinning et al. 1995). Increased substance use may be due to modelling their parents (Bhatt 1998) and also because of inadequate relationship with parents, pro-drug social influences, and pro-drug perceptions which may increase the risk of substance use (Hawkins et al. 1992). Parental depression and other psychiatric disorders have been shown to increase the risk for emotional and behavioural problems in their offsprings (Pike & Plomin 1996) and a close connection was also found between maternal affective problems and cannabis use frequency (Von Sydow et al. 2002).

Interestingly, the prevalence of health damaging behaviour was influenced significantly by parental educational level but not in the way expected: higher educational level was found to be a greater risk factor for drug use and excessive alcohol consumption. The same pattern was found in a previous Hungarian national representative study, where drug use was most frequent among youth with affluent parents or with parents with high educational level (Csoboth et al. 1997). One reason for this Hungarian phenomenon is that drugs and large amounts of alcohol are an expensive way of "having fun" for young women, therefore only those who live in a high socio-economic situation are able to afford such luxuries.

The data presented in this study can be expected to have certain limitations. Firstly, the measures were obtained from a self-administered questionnaire. Family data are subjective, and therefore raise the possibility of reporting bias. Nevertheless, subjective appraisal of parental disorders has been used as a format of gaining information about childhood conditions as published in international literature (Rahkonen et al. 1997; Farahati et al. 2003). Self-administration had another limitation: unlike the interview method, it could not obtain further details on family background. Certain mediating measures, such as physical activity or diet were not included in the present analysis due to the focus on the effect of family characteristics on women's health complaints and health damaging behaviour, but these will be included in future studies. Nevertheless, the significant relationship found between family background, health state, and health damaging behaviour adds important data for medical and public health interventions.

The health status of Hungarian women as reflected morbidity and mortality statistics (Statistics Hungary 2002) is lagging behind their peers living in Western European countries. Therefore specific health promotion and disease prevention programmes dealing with young women's health need to be implemented to prevent the further increase of chronic diseases in the Hungarian female population and because of the different needs and psychosocial problems that arise in this sub-group of the population. Parental educational level and socio-economic status are also factors that need to be included in interventions for young women, because different social norms and conditions give rise to different types of health damaging behaviour which have significant effects on health in the long run (Nation et al. 2003). High levels of alcohol consumption and irregular or binge drinking in Central-Eastern Europe have been shown to be a risk factor for developing cardiovascular disease (McKee & Britton 1998) and therefore must be regarded as an important preventive issue among adolescent women. Specific prevention programmes for young women whose parents are divorced (Wolchik et al. 2002), alcoholics, or have psychiatric disorders (Kumpfer & Alvarado 2003), may result in significantly less substance use, increasing the prospects for good mental and physical health in the future. In order to effectively improve the health behaviour of young women, action is needed to change attitudes and raise knowledge of health and related risk factors, and this action must take into account socio-economic factors such as level of education and family background.

Acknowledgments

The Better Health for Women Study was supported by a grant awarded to the Végeken Foundation in 1998 by the Bristol-Myers Squibb Foundation. We wish to thank: Professor Mária S. Kopp, M.D., Ph.D. for her constant support and Dr. János Réthelyi for his helpful comments on the paper.

Zusammenfassung

Selbst-berichtete Gesundheit und gesundheitsschädigendes Verhalten von jungen Frauen in Ungarn: der Einfluss der Familie

Fragestellung: Der Zusammenhang zwischen niedriger elterlicher Bildung, elterlicher psychischer Störung, Alkoholkonsum und Scheidung, und selbst-berichtete Gesundheit und gesundheitsschädigendes Verhalten wird beschrieben.

Methoden: 3615 ungarische junge Frauen im Alter von 15–24 wurden 1998 mittels Fragebogen befragt. Der Fragebogen enthält Fragen über sozioökonomische Faktoren, physische und psychologische Gesundheit und gesundheitsschädigendes Verhalten.

Ergebnisse: Niedrige selbst-berichtete Gesundheit (OR: 2,32; CI: 1,54–3,47; $p < 0,001$) und fünf oder mehr Gesundheitsbeschwerden (OR: 2,09; CI: 1,68–2,60; $p < 0,001$) waren signifikant häufiger bei Frauen mit elterlicher psychischer Störung. Drogenmissbrauch (OR: 2,35; CI: 1,86–2,98; $p < 0,001$) und ständiger oder exzessiver Alkoholkonsum (OR: 1,86; CI: 1,46–2,37) hängen am stärksten mit elterlicher Bildung zusammen.

Schlussfolgerungen: Familiäre soziale Probleme, hauptsächlich psychische Störungen der Eltern, ständiger Alkoholkonsum und die Bildung der Eltern sind wichtige Faktoren, die berücksichtigt werden müssen, vor allem wenn Interventionen für junge Frauen speziell geplant werden.

Résumé

État de santé et comportements dommageables pour la santé chez les jeunes femmes en Hongrie: effets des caractéristiques parentales

Objectifs: Décrire les associations entre la santé subjective, les modes de vie négatifs et des facteurs de risques familiaux (bas niveau d'éducation, maladies psychiatriques, consommation abusive d'alcool, divorce).

Méthodes: 3615 jeunes femmes hongroises (15–24 ans) en 1998. Le questionnaire comportait des questions concernant les aspects socio-économiques, la santé physique et mentale, et les comportements dommageables à la santé.

Résultats: Les femmes ayant un parent atteint de trouble psychiatrique ont rapporté une santé significativement moins bonne (OR: 2,32; CI: 1,54–3,47; p < 0,001) ou au moins cinq plaintes concernant leur santé (OR: 2,09; CI: 1,68–2,60; p < 0,001). La consommation de drogue (OR: 2,35; CI: 1,86–2,98; p < 0,001) et la consommation normale ou excessive d'alcool (OR: 1,86; CI: 1,46–2,37) sont très étroitement associées avec un niveau d'éducation parental élevé.

Conclusions: Lors de la planification d'interventions spécifiquement destinées aux jeunes femmes, il importe de tenir compte des problèmes sociaux des parents: troubles psychiatriques, consommation d'alcool régulière, niveau d'éducation.

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