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The effect of family structure on decision making, parenting styles and healthy lifestyle behaviour of adolescents in rural South Africa

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Abstract

The aim of the study was to compare perceived parenting styles, decision making styles and healthy lifestyle behaviours of adolescents from single and two-parent families within a rural setting in South Africa. The study employed a quantitative methodology with a cross-sectional comparative group design. The sample consisted of 457 Grade 9 learners from four randomly selected secondary schools in the Overberg Education District, Western Cape, South Africa. The data was collected using the Parental Style and Dimension Questionnaire, Melbourne Decision Making Questionnaire and the Health-Promoting Lifestyle Profile II as well as a short biographical questionnaire. The data was analysed using both descriptive and inferential statistics (MANOVA). The results suggest that maternal and paternal authoritative parenting, vigilant decision making and often engagement in healthy lifestyle behaviours were prevalent for adolescents in rural South Africa. The results furthermore suggest that there were no significant main effects of family structure on perceived parenting styles, decision making styles and healthy lifestyle behaviours. The findings also serve as a recommendation for future research to do an urban-rural comparison, as the applicability of urban findings are often questioned in rural studies.

Keywords: Decision making styles, parenting styles, healthy lifestyle behaviour, family structure, adolescent.

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Introduction

Globally the environment in which individuals find themselves in determines whether individuals are deemed healthy or not (Pelser, 2012). In an attempt to determine threats to health and well-being, as well as looking at the abilities to improve health, it becomes important to identify and understand the environments in which individuals find themselves in (Pelser, 2012). According

to the World Health Organisation (WHO), when considering the environments in which individuals find themselves, some of the poorer social settings can be considered as being responsible for 25 percent of preventable health risk factors (United Nations Environment Project, 2002). The social environment as well as the health status of a community plays a pivotal role in improving the quality of life, from a South African perspective the Reconstruction and Development Programme aimed at improving the quality of life of individuals particularly that of the poor (African National Congress, 1994).

When considering the environment and its role in health and well-being, research has focussed largely on the processes in urban communities, very little is known about the processes that take place within rural communities (De Marco & De Marco, 2010). In a review of literature examining rural communities and its outcomes, it suggests that few studies have assessed the effects and outcomes of rural communities over the past 50 years (De Marco & De Marco, 2010). Of the few studies that have examined community outcomes on individuals from an urban-rural perspective, it has been found that it impacts on a number of aspects related to health and well-being of individuals (De Marco & De Marco, 2010; Mujahid et al., 2007). Research has paid great attention to developmental outcomes and effects on the health of individuals in urban areas, an understanding of the outcomes in rural areas remain limited. However, even after considering the limited literature available on rural communities in relation to health and health engagement, it becomes important for researchers to be cognisant of the familial environment and social-relations (De Marco & De Marco, 2010) present within family homes as this environment too plays an important role.

The family is considered the foundation for socialising children into well-adjusted adults (Amoateng & Heaton 2007). Research focusing on the effect of family structure on human development has become of particular interest (Magnuson & Berger, 2009). Family structure often refers to the marital status of a family (Manning & Lamb, 2003) or the type of family in which a child is raised (Strohschein et al., 2009). Family structure is generally indicated as single and two parent households with the focus often being on single parent households (Davids & Roman, 2013).

Single parents are more likely to be socially isolated, work longer hours, and provide lower emotional and parental support than families having married parents (Jackson, Brooks-Gunn, Huang & Glassman, 2000). Single parents have to juggle the responsibilities of being a caregiver and provider to their children (Magnuson & Berger, 2009). Children raised in single parent households have less parental attention and supervision than children who are reared in households with married parents (Barrett & Turner, 2006; Davids & Roman, 2013). Single parent households more often have to battle with unemployment,

poverty and a lack of resources (Roman, 2011). In comparison to single parent households, married parent's households seem to have a higher socioeconomic status (Rosenfeld, 2010). Married parent's households are seen as being more 'attractive', because each parent brings his/her own resources that are used collectively, and a division of labour (responsibilities) exists within the household (Stoleru, Radu, Antal & Szigeti, 2011). Furthermore, children from married parent's households tend to be more emotionally and psychologically well-adjusted than children from other family structures (Goodman & Greaves, 2010). Family structure, however, has also been found to play a pivotal role in deciding the children's accessibility to health care (Gorman & Braverman, 2008). Children from single parent families are more likely to have limited or scarce access to preventative health and medical care than those from two parent families (Heck & Parker, 2002).

According to the World Health Organisation (2004) 60% of an individual's quality of life, health and well-being are dependent on his/her behaviours and lifestyle choices. Although adolescence is considered a relatively healthy phase of life, there are health needs due to the biological, social and psychological factors faced by adolescents which impact on health in later life (Lee & Loke, 2011; Patton et al., 2012). During adolescence an individual engages in health-risk behaviours which include smoking, having unprotected sex as well as adopting a sedentary lifestyle. This includes poor eating habits and low physical activity (Wang et al., 2009). These life changes and involvement in health-risk behaviours often leads to a rise in mortality rates and the development of risks. This leads to non-communicable diseases and ill-health in later life (Patton et al., 2012; Wang et al., 2009). The healthy lifestyle behaviours of an individual are often defined as being the activities or behaviours that form an important part of an individual's lifestyle and the determinants of the individual's health status (Lee & Loke, 2011). According to Umeh (2009), healthy lifestyle behaviours are dependent on a decision made to adopt a healthy lifestyle.

Often adolescents find themselves faced with situations in which they need to make decisions which are important to assist in their daily activities and life. These situations can include health related situations which are centred on individual health and well-being. Crucial to adolescent risk behaviour is the decision making that is engaged in when situations are faced that have detrimental consequences on the health behaviours of the adolescent (Steinberg, 2004). When individuals need to make decisions, there are particular approaches to making a decision. These decision making styles differ in the individual's convictions of optimism in solving the conflicting situation to no optimism where the decision is put off for a later stage or where the responsibility is passed onto another individual (Burnett, 1991). Decision making during adolescence is important as it assists with the many challenges that is common to this developmental phase. There is often an assumption that independent decision

making styles develop during adolescence, but Öztürk, Kutlu and Atli (2011) believe that it starts during pre-adolescence, due to the prevailing familial environment experienced. In addition, the way in which adolescents make decisions is often developed based on the decision making strategy used by their parents (Öztürk, Kutlu & Atli, 2011). Wolff and Crockett (2011) state that decision making often occurs within a social context where parents are present. Parents shape decisions that discourage behaviour that will be detrimental to ill health (Wolff & Crockett, 2011).

Parents play a crucial role in socialising and shaping adolescents values and belief systems (Spera, 2005). This socialisation process occurs within the parent-child relationship and via the parenting style of the parents (Akinsola, 2011). The commonly accepted parenting styles are authoritarian, authoritative and permissive parenting, and have been associated with different outcomes for children. An authoritarian parent is low on acceptance and high on control, while an authoritative parent is high on both control and acceptance, and a permissive parent is high on acceptance and low on control (Swartz et al., 2008). Parenting styles and practices have been specifically linked to the development of autonomous behaviour in adolescence (Pérez & Cumsille, 2012). Adolescent autonomy plays a crucial role in decision making, therefore, it can be suggested that parenting plays an important role in decision making of adolescents. Furthermore, the health and well-being of adolescents have been found to be related to parental support, as well as to the parent-child relationship (Manning & Lamb, 2003).

Research over the past few decades has focused largely on the role of family structure in light of marital status (Manning & Lamb, 2003). The notion of seeing family structure solely on the basis of marital status is no longer adequate, especially considering the growing number of children and adolescents who are reared in homes where cohabiting occurs (Manning & Lamb, 2003). This study therefore aims to address the following: (i) to describe the prevalence of perceived parenting styles, decision making styles and healthy lifestyle behaviours for adolescents in rural South Africa, as well as (ii) to compare perceived parenting styles, decision making styles and healthy lifestyle behaviours in one and two parent families. The aims of the current study are in line with what scholars are currently examining when considering healthy lifestyle behaviours, which attempt to establish the conduits towards healthy lifestyle behaviours by examining family structure (single and two-parent families), and context (perceive maternal and paternal parenting in the home environment) and striving towards health (decision making styles and healthy lifestyle behaviours) (Carr & Springer, 2010).

Methodology

A cross-sectional comparative group design was used to establish the decision making styles, parenting styles and healthy lifestyle behaviours of adolescents in rural South Africa, and to compare the aforementioned based upon family structure, i.e., single and two-parent families.

Participants

To obtain a heterogeneous group of participants, schools in the Overberg Education District (a rural area) which forms part of the Western Cape Education Department were stratified on the basis of socioeconomic status. Four schools were then randomly selected in the education district based on socioeconomic status of the school (using school fees as an indicator of socioeconomic status).

Data collection procedure

The data was collected using a self-report questionnaire that took approximately 25 minutes to complete at an agreed upon time in the school timetable that did not disrupt the normal running of the school day. The Grade 9 learners were invited to participate based on providing informed assent, and their parents providing informed consent. Participants were also given the opportunity not to participate or to withdraw from the study at any time without any negative consequences.

Ethical considerations

To maintain a high level of ethics throughout the research study, the following ethical considerations were put in place: The research project was registered with the University of the Western Cape for ethical clearance. After ethical clearance from the University, permission was sought from the Western Cape Education Department to gain access to the various schools, after which permission was sought and granted by the principals and teachers at the various schools. Parents of participants were informed about the study and had to provide written informed consent if they agreed for their child to partake in the study, additionally learners were also given assent forms if they too agreed. Confidentiality and anonymity was maintained throughout the study and participation was voluntary.

The final sample consisted of 457 participants 209 (46.2%) male and 243 (53.8%) female (Table 1).

Table 1: Demographic details of participants

		Total Sample	Single	Two Parent
Gender	Male	209 (46.2%)	57 (43.5%)	140 (46.8%)
	Female	243 (53.8%)	74 (56.5%)	159 (53.2%)
Age	Mean Age	16.31 (*SD*= 1.45)	16.13 (*SD*= 1.29)	16.31 (*SD*= 1.54)
Family structure		-	133 (30.6%)	301 (69.4%)

The participants who lived in two-parent families constituted 301 (69.4%) of the sample, while 133 (30.6%) lived in single-parent families. The mean age for participants was 16.31 (*SD* = 1.45) years.

Measuring instrument

A self-reported questionnaire was used to collect data from the participants. The questionnaire consisted of four sections, namely, (i) demographical characteristics (age, gender, home language, and family structure), (ii) the Parental Style and Dimension Questionnaire (PSDQ) (Robinson, Mandleco, Frost Oslen & Hart, 2001), (iii) Health-Promoting Lifestyle Profile II Questionnaire (Walker & Hill-Polerecky, 1996), and (iv) the Melbourne Decision Making Questionnaire (Mann, Burnett, Radford & Ford, 1997). The Parental Style and Dimension Questionnaire was a 32 item self-report questionnaire based on the three parenting styles as outline by Baumrind (Robinson, Mandleco, Frost Oslen & Hart, 2001). The parenting styles outlined in the questionnaire were both for mothers and fathers, and participants responded on a 4 point Likert scale ranging from 1 (not at all like him / her) to 4 (a lot like him / her). The Health-Promoting Lifestyle Profile II was a 52-item questionnaire using a 4 point Likert scale, where the composite score was used to assess self-reported frequencies in healthy lifestyle behaviours (1= never and 4= always) (Walker & Hill-Polerecky, 1996). The Melbourne Decision Making Questionnaire was a 22-item questionnaire which was based on the foundations of Janis and Mann's conflict model of decision making. The questionnaire assessed the four decision making styles, namely, vigilance, hypervigilance, buck-passing and procrastination and was assessed on a 3 point Likert scale ranging from 0 (not true for me) to 2 (true for me) (Mann, Burnett, Radford & Ford, 1997). The Cronbach alpha scores for the (i) Parental Style and Dimension Questionnaire was .85, (ii) the Health-Promoting Lifestyle Profile II was .86 and (iii) the Melbourne Decision Making Questionnaire was .60.

Data analysis

Groups of single and two-parent families were created, based on recoding the variables. The descriptive statistics for the sub-scales of *parenting styles, decision making styles* and *healthy lifestyle behaviours* were analysed. Multivariate analysis of variance (MANOVA) was conducted to compare the

different groups, as it allowed for more than one dependent variable to be measured. Since no significant multivariate differences were found, no univariate analysis of variance (ANOVA) was conducted (Field, 2009). The group differences were based on the adolescents' perspectives.

Results

The descriptive statistics for parenting styles, decision making styles and healthy lifestyle behaviours for single and two parent families are presented in Table 2. The results suggest that the highest mean score obtained for maternal parenting styles was for authoritative parenting (*M*= 3.09, *SD*= .50), this was similar for single (*M*= 3.10, *SD*=.54) and two-parent families (*M*= 3.09, *SD*=.49). The authoritative paternal parenting style was the most prevalent (*M*= 2.84, *SD*= .61). Authoritative parenting was also prevalent in single (*M*= 2.76, *SD*= .61) and two-parent families (*M*= 2.87, *SD*= .61). Vigilant decision making (*M*=1.43, *SD*=.35) was the most prevalent decision making style for the total sample, for both single (*M*= 1.43, *SD*= .36) and two-parent families (*M*= 1.43, *SD*= .34). The composite score for healthy lifestyle behaviours for the total sample (*M*= 2.74, *SD*= .39) was similar for single (*M*= 2.73, *SD*= .42) and two-parent families (*M*= 2.74, *SD*= .38).

Table 2: Descriptive statistics for parenting styles, decision making styles and healthy lifestyle behaviours for single and two parent families

	Total Sample		Single Parent Families		Two Parent Families		
Scales / Sub-Scales	Mean	*SD*	Mean	*SD*	Mean	*SD*	*F*
Perceived Parenting Styles[1]							
Maternal Authoritative Parenting	3.09	.50	3.10	.54	3.09	.49	.42
Maternal Authoritarian Parenting	2.42	.56	2.36	.60	2.45	.53	3.13
Maternal Permissive Parenting	2.46	.56	2.44	.58	2.47	.56	.04
Paternal Authoritative Parenting	2.84	.61	2.76	.61	2.87	.61	.30
Paternal Authoritarian Parenting	2.35	.60	2.26	.64	2.39	.59	1.68
Paternal Permissive Parenting	2.43	.55	2.37	.55	2.45	.55	.03
Decision Making Styles[2]							
Vigilant Decision Making	1.43	.35	1.43	.36	1.43	.34	.23
Hypervigilant Decision Making	1.16	.34	1.19	.37	1.14	.33	2.09
Procrastination	.96	.38	.97	.37	.94	.38	.39
Buck-Passing	.78	.41	.79	.41	.76	.40	.31
Healthy Lifestyle Behaviours[3]							
Healthy Lifestyle Behaviours	2.74	.39	2.73	.42	2.74	.38	1.31

[1] Participants responded on a 4 point Likert scale, 1= not at all like him / her and 4= a lot like him / her
[2] Participants responded on a 3 point Likert scale: 0= not true for me and 2= true for me
[3] Participants responded on a 4 point Likert scale, 1= never and 4= always

The results for multivariate analysis (MANOVA) (Table 2) which was used for comparing parenting styles, decision making styles and healthy lifestyle behaviour for adolescents in single and two-parent families, using Hotelling's trace statistic, suggests that there were no significant main effects for family structure on perceptions of parenting styles, decision making styles and healthy lifestyle behaviours for adolescents, $T = .05$, $F(11,285) = 1.31$, $p > .05$.

Discussion

The aim of the study was to (i) establish the prevalence of perceived parenting styles, decision making styles and engagement in healthy lifestyle behaviour of adolescents in rural South Africa and (ii) to compare this on the basis of family structure.

Engaging in healthy lifestyle behaviours, become important, particularly with the increase in contemporary health risks which often is associated with the environment in which individuals find themselves (Pelser, 2012). Research has suggested over the years that there has been a great inclination for studies to focus primarily on urban area, with rural communities often left under researched (De Marco & De Marco, 2010; De Marco & De Marco, 2009; Mujahid et al., 2007). The study adds to the current debates regarding the role that a rural community plays within the context of parenting styles, decision making styles and engagement in healthy lifestyle behaviours from the perspective of family structure as it is one of the first studies on the African continent to examine this.

The effects of family structure on the perceived parenting styles and decision making styles of adolescents on the engagement in healthy lifestyle behaviours within a rural community is important as it assess the psychosocial as well as environmental effects on engagement in healthy lifestyle behaviours. Rural communities are often synonymous with ill health, which have detrimental effects on the health status of individuals and the health determinants of the community (such as limited access to community health centres, increased sedentary lifestyles and limited to no access to primary health care) (Mitura & Bollman, 2003; Mitura & Bollman, 2004; Pampalon, Martinez & Hamel, 2006). Rural communities are often faced with poverty. These communities from a parenting perspective often have parents that display low parental warmth (Pinderhughes et al., 2001).

Parenting styles and the role it plays in child and adolescent emotional and behavioural development is an important component of parent-child relationships (Suzuki & Kitamura, 2011). The three parenting styles proposed by Baumrind differ in terms of parental control and acceptance as well as warmth and interactions displayed by the parent (Fuemmeler et al., 2012; Davids & Roman, 2014). The results of the current study suggest that authoritative

parenting has been the most prevalent perceived maternal and paternal parenting style perceived in both single and two-parent families. There is considerable research that associates authoritative parenting with favourable child and adolescent developmental outcomes, both nationally (Davids & Roman, 2014; Kritzas & Grobler, 2005; Latouf & Dunn, 2010) and internationally (Pearson et al., 2009; Kitamura et al., 2014). Pinderhughes et al. (2001) propose that parents in rural areas often display low parental warmth; however this study found that parents displayed warmth and parental control by displaying authoritative parenting.

The role parenting plays in adolescent decision making is an important one to consider since, during this transitional phase there is a great need for autonomy which means more adolescent yearning for independent decision making (Halpern-Felsher & Cauffman, 2001). Parenting has also been associated with adolescent decision making regarding health behaviour (Morton et al., 2010). Decision making among adolescents is always considered to involve risky decision making, because adolescence is a period of experimentation (Reyna & Farley, 2006). Adolescence is furthermore a period in which health behaviours are adopted which have implications for health in later life as it can either promote health or hinder this process (Morton et al., 2010). The results of the present study, however, found vigilance to be the most prevalent decision making style. Vigilance is a decision making style in which a number of steps are followed leading to the most desirable outcome. Ultimately, the individual feels competent and optimistic about the decision making process and behavioural outcome (Brown, Abdallah & Ng, 2011).

Individuals in rural communities often have to travel far distances to access health care facilities (De Marco & De Marco, 2010). These communities often have limited access to (i) clean drinking water, (ii) decent housing and safe recreational areas, (iii) close and available access to health care and health services (Macintyre, Ellaway & Cummins, 2002) which hinders the promotion of health and well-being within a rural community. Therefore, it is interesting to note that adolescents in the rural community made use of vigilant decision making, which would assist them in decision making which would aid in pro-social behaviour and engagement in more healthy alternatives. Furthermore, it is interesting to note, especially since adolescent decision making is often associated with risk-taking and frequent negative outcomes. However, vigilant decision making has often been associated with positive outcomes (Deniz, 2006), as well as with satisfaction in life. This promotes health and well-being of the adolescent (Bacanli, 2000), instead of health risk behaviours.

Health risk behaviours are prevalent during adolescence, and often there seems to be an increase in engaging in behaviours which are detrimental to their health and overall well-being (Lohaus, Vierhaus & Ball, 2009). Reitz, Deković, Meijer

and Engels (2006) account for the decrease in healthy lifestyle behaviours as being due to the role of authoritative parents, because during childhood authoritative parents exercise control and suggestions that encourage participation in healthy lifestyle behaviours. The findings in this study, however, are different to the results showing adolescents engaging less in healthy lifestyle behaviours (Levin, Kirby & Currie, 2012; Viner et al., 2012). Adolescents in the current study often engaged in healthy lifestyle behaviours. This leads one to question whether parents still play an important role in controlling and monitoring involvement in health behaviours.

Authoritative parenting, vigilant decision making and frequent engagement in healthy lifestyle behaviours were the most prevalent family structure characterises among adolescents in rural South Africa. No significant differences were found on the basis of family structure. These findings are consistent with previous studies conducted in South Africa that compared single and two-parent families and found no significant differences (Roman, 2011; Myburg, Poggenpoel & Du Plessis, 2011). However, in a more recent study comparing the goals and aspirations of adolescents from single and two-parent families, there were significant differences found (Davids & Roman, 2013). Research internationally has examined the associations between single and two-parent families and found differences in the outcomes on children and adolescents which can be detrimental to their health, well-being and development (Brown, 2010). However, when considering the contradictory findings of the role of family structure in relation to parenting, decision making and engagement in healthy lifestyle behaviours in current literature and the findings in this study, it leaves one to question the applicability once more of urban research findings to rural areas which are often diverse and differ to urban cities (Burke, O'Campo & Peak, 2006; De Marco & De Marco, 2010; De Marco & De Marco, 2009; Mujahid et al., 2007).

The aim of this study was to examine the prevalence of perceived parenting styles, decision making styles and engagement in healthy lifestyle behaviours of adolescents in rural South Africa, however it is recommended that future research examine a comparison between urban and rural adolescents to determine whether the proposed view of applicability of urban research is indeed similar or different to rural research findings. The findings of this study could, however, provide insight and guidance for youth development programmes and policies aimed at improving engagement in healthy lifestyle behaviours to improve health and well-being, as often policies and programmes neglect paying attention to (i) enhancing decision making skills or styles, which is important in the decision making process as well as (ii) the role that these decision making styles play in enhancing participation in healthy lifestyle behaviours of young persons.

Conclusion

The study found authoritative parenting, vigilant decision making and frequent engagement in healthy lifestyle behaviours were the most prevalent family structure characteristics among adolescents in rural South Africa, and no statistically significant differences were found on the basis of family structure. An important contribution was made by examining the prevalence of perceived parenting styles, decision making styles and engagement in healthy lifestyle behaviours of adolescents in rural South Africa. Most notably, it is one of the first studies to examine and compare parenting styles, decision making styles and healthy lifestyle behaviours on the basis of single and two-parent families in Africa.

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