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Development of the Brief Social Capital for Youth Sexual and Reproductive Health Scale: Exploratory and Confirmatory Factor Analysis

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Abstract

Social capital plays an important role in sexual and reproductive health among youth, yet few measures to assess this concept have been developed and tested for this population. We developed and examined the factor structure of the Brief Social Capital for Youth Sexual and Reproductive Health Scale. Drawing on the empirical literature, we identified item content to assess an overall construct of social capital in relationship to youth's sexual and reproductive health, including condom self-efficacy, civic engagement, and adult and community support. We conducted exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) with a sample of 200 youth, predominately low-income and ethnic minority in Denver, Colorado. EFA with geomin rotation yielded a three-factor solution. CFA provided an adequate model fit with acceptable standardized factor loadings. This study provides a validated measure for future research to further examine social capital and youth sexual and reproductive health.

Keywords

youth social capital; social capital; adolescents; reproductive health; sexual health; instrument development

The promotion of sexual and reproductive health among youth remains a public health priority in the United States (Centers for Disease Control and Prevention, 2013; Kann et al., 2014). National surveillance data indicate that youth (defined here as adolescents between 13 and 24 years of age) disproportionately engage in sexual risk behaviors, including condomless sex, multiple sex partners, and using alcohol or drugs prior to sexual intercourse (Finer & Zolna, 2014; Kann et al., 2014; Santelli, Lindberg, Abma, McNeely, & Resnick,

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2000; Viner et al., 2012). Not surprisingly, youth are at increased risk of sexually transmitted infections (STIs), including HIV and unintended pregnancy as compared with other age groups (Córdova, Huang, Lally, Estrada, & Prado, 2014; Tello, Cervantes, Córdova, & Santos, 2010). A growing body of literature suggests that social determinants of health—defined as the contexts in which youth are born, live, attend school, and develop—play an essential role in sexual and reproductive health (World Health Organization, Commission on Social Determinants of Health, 2008). Within this framework, researchers have examined social capital as an important social determinant of health. The concept of social capital has emerged from multiple theoretical frameworks and remains complex, with no universal definition (Bourdieu, 1986; Murayama, Fujiwara, & Kawachi, 2012; Putnam, 2000). However, broadly defined, social capital can be understood by the ways in which individuals are embedded in social organizations that facilitate cooperation for mutual benefit, including civic or community engagement (Kritsotakis & Gamarnikow, 2004; Putnam, 1993). Because adolescents are embedded in social organizations that shape their sexual and reproductive health, it is important to consider the roles that condom self-efficacy and parent–adult support play in youth’s sexual behaviors (McCurdy & Daro, 2001; Wulfert & Wan, 1993). Compared with the adult population, research on the role of social capital in sexual and reproductive health among youth remains underdeveloped (Crosby, Holtgrave, DiClemente, Wingood, & Gayle, 2003; Murayama et al., 2012; Viner et al., 2012).

Although the evidence supports a positive relationship between social capital and health (Gilbert, Quinn, Goodman, Butler, & Wallace, 2013), there is less support for the relationship between social capital and the sexual and reproductive health among youth. Some findings suggest that social capital might play a protective role among economically disadvantaged youth who display low teen-pregnancy rates (Crosby & Holtgrave, 2006; Denner, Kirby, Coyle, & Brindis, 2001). A problem in the emergent literature is the lack of valid and reliable measurement of the construct of social capital as it relates to sexual and reproductive health among youth (Crosby et al., 2003; Murayama et al., 2012). Valid measures of social capital can provide consistency and lead to the development of intervention strategies to improve youth sexual and reproductive health behaviors. Therefore, the purpose of this study was to examine the feasibility of integrating indicators of social capital with other factors, including condom self-efficacy and parent/adult support, that are well documented to impact sexual health behavior into a single parsimonious latent variable. We first conducted an exploratory factor analysis (EFA) of a single latent variable with items including condom self-efficacy, civic engagement, and adult and community support. We then conducted a confirmatory factor analysis (CFA) to produce this single latent variable of social capital related to sexual and reproductive health.

Social Capital and Health

Higher levels of social capital have been linked to increased trust, expectations of reciprocity, and access to knowledge and resources (Smylie, Medaglia, & Maticka-Tyndale, 2006). Social capital may improve health through increasing knowledge and information, and also through the emotional benefits of support and respect (Kawachi & Berkman, 2000). Indeed, social capital is associated with improved health behaviors and health outcomes

among adults, including less smoking and binge drinking, lower STI rates, and reduced mortality (Carpiano, 2007; Holtgrave & Crosby, 2003; Murayama et al., 2012).

Youth Social Capital

Considerably less is known about how social capital affects health behaviors among youth (Crosby et al., 2003; Kawachi & Berkman, 2000; McPherson et al., 2013; Murayama et al., 2012). Social capital is likely relevant and critical because adolescence is an important time of cognitive and behavioral development that establishes patterns of health into emerging adulthood. This developmental period is heavily influenced by social determinants of health, and social capital is a potentially important positive social determinant that can promote youth health (McPherson et al., 2013; Viner et al., 2012). However, the concept of social capital as studied with adults may not be directly applicable to youth. Given that adolescence is an important time of cognitive development, condom self-efficacy should be considered as an influential factor among youth. That is, the cognitive appraisal of condom use likely mediates whether, and the extent to which, youth apply condom knowledge and skills to engage in protective sexual behaviors (Wilfert & Wan, 1993). Furthermore, parents and other adults may play a much larger role in the development and behavior of youth relative to older independent adults (Córdova et al., 2011; Dumont & Provost, 1999; Furstenberg & Hughes, 1995; McPherson et al., 2013). Thus, incorporating parent/adult support theory may be beneficial in developing a fuller understanding of how social capital shapes youth reproductive and sexual health. Broadly defined, parent/adult-child support includes the ways in which parents and adults who demonstrate interest in the well-being of the youth are emotionally and physically involved (McCurdy & Daro, 2001). A recent review of the literature identified two main domains of social capital among youth: (a) family social capital, including family structure, parental and other adult support; and (b) community social capital, including peer support, civic engagement, trust, and school and neighborhood quality (McPherson et al., 2013). Therefore, integrating aspects of condom self-efficacy and parent/adult support into a social capital model are likely to have great utility and to provide a robust framework for the present study.

Youth, Social Capital, and Health

The literature on the specific role of social capital on youth's health is unclear. Although a number of investigators have found that social capital is associated with favorable health outcomes among youth (Furstenberg & Hughes, 1995), others have found a negative relationship (McPherson et al., 2013). For example, Furstenberg and Hughes (1995) found that elements of social capital, such as parental support and attendance in religious services, among low-income youth were associated with improved academic success, later ages at first pregnancy, economic stability, and improved mental health in adulthood. Regarding sexual and reproductive health outcomes, state-level social capital has been negatively associated with population sexual risk behaviors (Holtgrave & Crosby, 2003), and both state- and community-level social capital that included adult support and civic engagement have been associated with lower adolescent pregnancy rates (Crosby & Holtgrave, 2006; Denner et al., 2001). In addition, having supportive parental relationships and a peer or adult mentor has been associated with a reduction in sexual risk behaviors among youth, such as early

sexual initiation and noncontraceptive use (McPherson et al., 2013). Contrary to these findings, close peer social networks and high levels of parental monitoring have been associated with a potential increase in substance use (McPherson et al., 2013).

Although parents are generally considered the most important adult influences on youth, a focus on parental support alone may overlook social capital that youth receive through other supportive adults in their lives. This is particularly important among low-income youth, who are more likely to experience family instability but may have greater access to nonparental adult support than higher income youth (Fomby, Mollborn, & Sennott, 2010). Moreover, consistent with research on social capital and adult health, social capital may be more beneficial for low-income youth because it may buffer structural disadvantage. Indeed, social capital has been identified as a key way that policy and programs can intervene to promote healthy behaviors in youth when structural-level factors are more difficult to improve (Crosby et al., 2003; Denner et al., 2001; Furstenberg & Hughes, 1995; Kawachi, 2006; Viner et al., 2012).

Measurement of Youth Social Capital

Scale development focused on social capital and sexual and reproductive health in youth remains limited (Grootaert, Narayan, Woolcock, & Nyhan-Jones, 2004; Harpham, Grant, & Thomas, 2002; Lochner, Kawachi, & Kennedy, 1999; Pronyk et al., 2008). For example, Grootaert and colleagues (2004) developed the Integrated Questionnaire for the Measurement of Social Capital (SC-IQ). The SC-IQ aims to measure six dimensions of social capital, including groups and networks, trust and solidarity, collective action and cooperation, information and communication, social cohesion and inclusion, and empowerment and political action (Grootaert et al., 2004). Although the SC-IQ seems promising in assessing the influence of social capital on sexual risk behaviors (e.g., Pronyk et al., 2008), the SC-IQ is limited such that the tool is not youth centered, does not focus on sexual and reproductive health, and was pilot tested with samples from Albania and Nigeria (Grootaert et al., 2004). Within the small but growing literature on the role of social capital on the sexual and reproductive health of youth, a more consistent measurement of social capital would improve the reliability and trustworthiness of findings (Crosby et al., 2003; Denner et al., 2001; McPherson et al., 2013). Yet, few researchers have examined the role of community social capital and civic engagement, on sexual and reproductive health, and even fewer investigators have examined a composite measure of social capital (McPherson et al., 2013).

We consider, however, that social capital may only be part of a critical constellation of factors that facilitate sexual and reproductive health for youth. Despite the strong association between self-efficacy and sexual and reproductive health behaviors (Buhi & Goodson, 2007; Malcolm et al., 2013; Voisin, Hotton, Tan, & DiClemente, 2013) and between family dynamics and self-efficacy (Malcolm et al., 2013), the investigation of social capital and sexual and reproductive health has generally overlooked self-efficacy. In addition, youth comfort with discussing sex and condom use with adults and peers as a form of social capital has also not been studied (McPherson et al., 2013). Thus, to harness the promotive power of social capital on the sexual and reproductive health of youth through interventions,

we need more valid and reliable measurements of social capital that include support from nonparent adults, community support, civic engagement, and self-efficacy. Extending current definitions informed by the empirical literature, we define social capital as condom self-efficacy, civic engagement, and adult and community support.

Method

Data for the present study were taken from a cross-sectional study of youth residing in the Denver Metropolitan area of Colorado, with predominantly impoverished neighborhoods with sizable ethnic minority residents. The conduct of the study with human participants was approved by the University of Colorado's Colorado Multiple Institutional Review Board and by the Research Review Committees of the partnering collaborators at Florence Crittenton Services, YTH (Youth, Tech, Health), and the National Latina Institute for Reproductive Health.

Procedure

A convenience sample of youth were recruited between February and March 2014 from community-based agencies and educational institutions identified by the study's Community Advisory Committee, former and current community-based research partners, research community liaisons, and project community contacts from each participating partner. In addition, enrolled participants were asked to refer to the study other individuals in their social networks to complete the survey. To be eligible for the study, participants had to be (a) between the ages of 14 and 21 years and (b) able to read and write in English.

Potential participants were either read aloud or shown a video describing the consent process. We obtained a waiver of parental consent based on Colorado law allowing those below 18 to seek information and services related to sexual and reproductive health. Participants who provided assent were then enrolled in the study. Participants completed the assessment in a reserved room either with paper and pencil or via computer-assisted self-interviewing (CASI). The assessment took approximately 20 to 30 minutes to complete. Participants received a US\$15 cash incentive for their time answering the survey.

Participants

The study's sample consisted of 200 youth. The majority of participants were female (57.2%), with a mean age of 17.4 years ($SD = 1.7$ years, range = 14–21 years). With respect to ethnicity/race, 98 (48.48%) participants identified as Hispanic/Latino, followed by 43 (21.72%) non-Hispanic White, 34 (17.17%) non-Hispanic Asian, 21 (10.61%) non-Hispanic Black, and four (2.02%) Other, respectively. Among the female participants, 63 were Hispanic, followed by 19 non-Hispanic White, 17 non-Hispanic Asian, 13 non-Hispanic Black, and one Other, respectively. No significant differences in the distribution of participants by gender across different racial/ethnic groups were found, $\chi^2(4) = 8.35$ ($p = .08$). The majority of youth reported being in 11th grade (58.5%), followed by some college (29.0%), 12th grade (4.0%), 8th grade (3.0%), and 10th grade (2.5%), respectively.

Identifying Items to Measure

Drawing from the empirical literature on how best to measure the constructs of social capital (Furstenberg & Hughes, 1995; Lochner et al., 1999) and self-efficacy as these relate to sexual and reproductive health (Pratte, Whitesell, McFarlane, & Bull, 2010), we developed a total of 18 potential items to assess the constructs of condom self-efficacy, civic engagement, adult support, and community support. Although adult support traditionally has not been a construct utilized in the measurement of social support among adult populations, investigators have demonstrated the important role of adult support in youth development (Dumont & Provost, 1999; Zimet, Dahlem, Zimet, & Farley, 1988). For example, a review of the influence of adult support on adolescent sexual and reproductive health indicates that higher levels of adult support are linked to a decreased risk in adolescent sexual risk behaviors, including condomless sex, number of sexual partners, and alcohol or drug use before last sexual intercourse (Grossman & Bulle, 2006).

Analytic Approach

Following the steps outlined in Cervantes, Fisher, Córdova, and Napper (2012), we used a three-step analytic approach. First, we examined item content relevance assumptions of normality. We excluded any items that only 5% of participants or less reported having experienced with the content and we examined the retained items for assumptions of normality. Second, we computed measurement models using EFA (Fabrigar & Wegener, 2011). We computed two-, three-, and four-factor solutions with geoma, promax, and varimax rotations. Model fit was evaluated utilizing the factor loadings, eigenvalues, and interpretability. Item loadings <0.32 and eigenvalues <1 (Kaiser Criterion) were removed (Tinsley & Tinsley, 1987). To confirm scale reliability, we computed Cronbach's alpha separately for each factor. Researchers have indicated that alpha values of $>.8$ are good, $>.7$ are acceptable, and $>.6$ are questionable (George & Mallery, 2003). It is important to note that Cronbach's alpha may underestimate the reliability because the underlying model assumes one factor (Kline, 2016), and this is not the case because we have additional factors in the overall model. Furthermore, Cronbach's alpha is influenced by the number of items, and the potential range of responses to those items (Loewenthal, 2001). Third, we computed second-order CFAs (Muthén & Muthén, 1998–2012). The model fit was evaluated utilizing a three-index approach (Hu & Bentler, 1998, 1999): (a) comparative fit index (CFI), (b) the standardized root mean square residual (SRMR), and (c) the root mean square error of approximation (RMSEA). Good model fit is represented as CFI ≥ 0.95 , RMSEA ≤ 0.05 , and SRMR ≤ 0.06 , and adequate fit is represented as CFI ≥ 0.90 , RMSEA ≤ 0.08 , and SRMR ≤ 0.08 (Little, 2013). Analyses were conducted using *Mplus* version 7 (Muthén & Muthén, 1998–2012).

Results

Step 1: Item Relevance and Testing Normality Assumptions

Based on the criteria to exclude any items that less than 5% of participants reported having experienced, we retained all 18 items in subsequent analysis. Tests of normality assumptions found some items to have a normal distribution, whereas other items were positively or negatively skewed. Investigators have indicated that the stipulation for multivariate

normality is too stringent, and that both EFA and CFA are relatively robust against violations of normality (Floyd & Widaman, 1995). Therefore, we did not correct for skewness (Cervantes et al., 2012).

Step 2: EFA

Four items had factor loading <0.32 , and therefore, the item pool was reduced from 18 to 14 items. EFA using geomax rotation yielded a three-factor solution (Tables 1 and 2). We labeled the first factor *community support and condom self-efficacy* ($\alpha = .60$), consisting of five items that assess community support, confidence in the ability to refuse sexual behaviors if pressured to do so or if a sexual partner refuses to use condoms, and confidence to discuss condom use with a sexual partner and friends. A five-point Likert-type scale, ranged from 0 (*not at all*) to 4 (*very supportive*), was used to record responses. A sample question was, “Do you feel your neighborhood and community are supportive places?” The second factor we labeled *adult support* ($\alpha = .83$), with six items reflecting participants’ experiences with supportive adults, including love and support, interest in the well-being of the participant, and clarity with respect to behavioral expectations of the participant. A sample question was, “How often do the adults in your life express interest and concern in your well-being?” The response choices ranged from 0 = *never* to 4 = *all of the time*. The third factor we called *civic engagement* ($\alpha = .59$) consisting of three items, capturing the extent to which an individual engages in volunteer activities in his or her community and participates in developmentally appropriate programs, including clubs and sports. A five-point Likert-type scale, ranged from 0 (*never*) to 4 (*all of the time*), was used to record responses. A sample question was, “How often do you take part in clubs or groups in school or out-of-school? (this could be like a crew, or group of friends that meets in an organized way).”

Step 3: Second-Order CFA

As shown in Figure 1, CFA showed that all three indicators loaded significantly onto a single latent social capital construct. The standardized factor loadings were 0.59, 1.15, and 0.27 for community support and condom self-efficacy, adult support, and civic engagement, respectively. The model fit indices also suggested an adequate fit, $\chi^2(72) = 137.97$, $p < .001$; CFI = 0.90, SRMR = 0.058, and RMSEA = 0.068 (Little, 2013).

Discussion

The main contribution of this study is the development of a parsimonious measure, the “Brief Social Capital for Youth Sexual and Reproductive Health” (BSC-Youth) scale, that integrates social capital and self-efficacy for sexual and reproductive health. Currently, there is a void of such measures in the literature. Moreover, the BSC-Youth scale was developed with a racially and ethnically diverse sample. Youth were the exclusive participants in the study. Thus, we identified an opportunity to consider whether measures commonly used to assess social capital could be validated for youth, but found several limitations with the use of previously developed scales for adults. We also recognized that the influence of self-efficacy on sexual and reproductive health among youth is important, but not included in existent measures (Buhi & Goodson, 2007; Malcolm et al., 2013; Voisin et al., 2013).

The results from the EFA are supported by the CFA, resulting in a single parsimonious valid measure of social capital for youth related to sexual and reproductive health with three factors: one for community support and condom self-efficacy, one for adult support, and one for civic engagement. Of the three factors, the heavy emphasis on adult support is especially notable, as it is consistent with other research showing the importance of adult support in facilitating healthy sexual behaviors for youth (Sutton, Lasswell, Lanier, & Miller, 2014).

The EFA and CFA results support our original consideration that self-efficacy is an important element of sexual risk and protective behavior, and also suggests that the role of adults and civic participation are critical for youth sexual and reproductive health. Overall, results suggest that the construct of social capital is different when operationalized for youth in comparison with adults, likely because of differences in the developmental stage. Although measures of social capital for adults are similar inasmuch as they emphasize civic engagement, other elements of adult social capital—such as shared values, reciprocity, and affective bonds—may not be applicable to a valid latent variable measuring the concept of social capital for youth.

Briefly, the BSC-Youth is a short 14-item instrument that in the context of sexual and reproductive health can be used to assess perceptions of community support and condom self-efficacy, adult support, and civic engagement for youth. The BSC-Youth can be subsequently used to explore the relative impact that social capital has on sexual and reproductive health behaviors. This is particularly important given the positive, yet inconsistently measured, association between social capital and sexual health among youth. Future research can also investigate whether this is a reliable and valid scale to use with a more representative sample of youth. Moreover, the BSC-Youth can potentially be used to assess effects of behavioral interventions designed to affect any of the constructs represented by the scale's latent variable.

Given the importance of each of the constructs in the BSC-Youth, it might be valuable for others interested in sexual and reproductive health among youth to consider whether and how to combine the variables of particular interest to explore their influence on sexual risk behaviors. It may be necessary to ensure that measures such as BSC-Youth—developed for and tested explicitly with youth—offer increased explanatory value in research models compared with more established measures of social capital that have been developed for use with adult populations.

The present study has important research implications. A next important step in this line of research is to further refine the BSC-Youth. For example, future research should examine divergent and convergent correlation of the BSC-Youth to other existing scales. Furthermore, there is a need to evaluate whether and the extent to which the BSC-Youth is applicable to other youth subpopulations. For example, given that research has shown that the influence of social capital on sexual risk behaviors varies as a function of gender (Pronyk et al., 2008; Pronyk, Harpham, & Morison, 1999), future research should conduct multigroup analysis to ascertain whether and the extent to which variations by gender on the BSC-Youth instrument and condom self-efficacy, civic engagement, and adult/parent support subscales exist. The

present study represents the initial step in the development of the BSC-Youth and studies investigating its constructs will help advance this assessment tool.

Limitations and Contributions

Findings should be interpreted with caution given that study sample is not representative of the U.S. youth population, and thus, findings may not be generalized to other youth populations nationally and internationally. Future research should examine whether and to what extent the BSC-Youth scale is psychometrically sound to be used with different youth populations. Here, researchers interested in developing a fuller understanding of the ways in which condom self-efficacy, civic engagement, and adult parent support shape reproductive and sexual health among youth from diverse backgrounds can utilize the BSC-Youth in research. Second, the relatively small sample size was not sufficient to conduct separate analyses (e.g., multigroup analysis) based on varying sample characteristics such as gender, age, and socioeconomic status. Finally, our inclusion criteria required participants to have the ability to read and write in English, thus excluding Spanish-speaking and other multilingual youth. Health and mental health outcomes among Latino youth can vary as a function of acculturation and cultural stressors (Schwartz, Unger, Baezconde-Garbanati, et al., 2015; Schwartz, Unger, Zamboanga, et al., 2015), thus including a more heterogeneous sample of Latino youth in future research is warranted. Notwithstanding these limitations, the BSC-Youth scale constitutes an important contribution toward understanding the role of social capital on youth's sexual and reproductive health. Although the BSC-Youth scale has been developed and tested, the scale needs to be further investigated to assess whether it is a valid and reliable measure of such constructs among various youth populations.

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Figure 1.

Factor structure of the Brief Social Capital for Youth Sexual and Reproductive Health Scale. Note. $N = 200$. Model fit indices are as follows: $\chi^2(72) = 137.97$, $p < .001$; CFI = 0.90, SRMR = 0.058, and RMSEA = 0.068. CFI = comparative fit index; SRMR = standardized root mean square residual; RMSEA = root mean square error of approximation.

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

Table 1

Item Content Descriptive Statistics of the Brief Social Capital for Youth Sexual and Reproductive Health Scale.^a

Item	<i>M</i>	<i>SD</i>	Range
A. Community support and condom self-efficacy			
1. Community and neighborhood are supportive	2.29	0.992	0–4
2. Confident to refuse sex if pressured to	2.72	0.656	0–3
3. Confident to refuse sex if partner refuses condom use	2.67	0.689	0–3
4. Confident discussing condom use with sex partners	2.78	0.846	0–4
5. Confident discussing condom use with friends	2.53	0.814	0–4
6. Confident discussing condom use with adults	2.03	1.16	0–4
B. Adult support			
7. Adults give you information on how to do things	2.85	1.047	0–4
8. Ask the adults in your life for advice	2.22	1.161	0–4
9. Adults express interest/concern in your well-being	3.26	0.969	0–4
10. Adults talk about things I'm interested in	2.68	1.081	0–4
11. Adults provide love and support	3.52	0.839	0–4
12. Adults clear what they expect	3.33	0.911	0–4
C. Civic engagement			
13. Volunteer in the community	2.08	1.119	0–4
14. Take part in clubs/groups	2.37	1.263	0–4
15. Participate in arts	1.62	1.379	0–4
16. Participate in sports	1.93	1.493	0–4

The Brief Social Capital for Youth Sexual and Reproductive Health Scale is available upon request.

Table 2

Factor Loadings of the Brief Social Capital for Youth Sexual and Reproductive Health Scale.

Factor and item	1	2	3
A. Community support and condom self-efficacy			
1. Community and neighborhood are supportive	0.38[*]	0.02	-0.01
2. Confident to refuse sex if pressured to	0.52[*]	0.02	0.15[*]
3. Confident to refuse sex if partner refuses condom use	0.32[*]	-0.06	0.27
4. Confident discussing condom use with sex partners	0.53[*]	-0.02	-0.01
5. Confident discussing condom use with friends	0.33[*]	-0.08	0.04
6. Confident discussing condom use with adults	0.44[*]	0.32[*]	-0.01
B. Adult support			
7. Adults give you information on how to do things	-0.30 [*]	0.78[*]	-0.004
8. Ask the adults in your life for advice	0.05	0.60[*]	0.05
9. Adults express interest/concern in your well-being	-0.003	0.84[*]	-0.08
10. Adults talk about things I'm interested in	0.16	0.67[*]	0.03
11. Adults provide love and support	0.15	0.67[*]	-0.09
12. Adults clear what they expect	-0.21	0.56[*]	0.06
C. Civic engagement			
13. Volunteer in the community	-0.14	0.02	0.53[*]
14. Take part in clubs/groups	0.01	0.09	0.87[*]
15. Participate in arts	0.17	0.04	0.29[*]
16. Participate in sports	-0.02	0.20	0.41[*]

Note. $N = 200$.*
 $p < .05$.