

Discussing Health Risk Behaviors in Parent-Child Communication: Influences on Communicative Competence

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This study analyzes the amount of influence that age, sex, educational attainment, socio-economic status (SES) and religion contribute to the communicative competence of individuals in discussing certain types of health risk behaviors. Competence is a product of social experience or is highly dependent on the context in which the interaction takes place. Through secondary data analysis, this study examines competency levels in discussing smoking, drugs, alcohol and sex and correlates them with the parent's age, sex, educational attainment, SES and religion. Results show that some selected variables are associated with communicative competence, although mostly weak. The parent's sex, age, and education are not significantly predictive of communication competence in discussing smoking, drugs, and alcohol, but there are significant differences on the basis of SES. Competencies to discuss sex vary. The results of the study are useful to those who seek to minimize health risk behaviors through the development of strategic communication campaign plans and programs.

Key words: communicative competence, health risk behavior, parent-child communication

Communication scholars have long grappled with the concept of communicative competence. In a seminal publication, Chomsky (1965) articulated two concepts on competence: linguistic competence and performance. Linguistic competence refers to the native speaker's innate ability to produce grammatical sentences of a language, while linguistic performance refers to the actual use of language. His work is solely preoccupied with an ideal speaker-listener in a completely homogeneous speech community that knows its language perfectly and is unaffected by such grammatically irrelevant conditions as memory limitations, distractions, shifts of attention and interest, and errors (Chomsky, 1965: 3).

It is this preoccupation with the "innateness" of competence that drew sharp criticism from Hymes (1972) who is known to have coined the term communicative competence. For Hymes (1972), Chomsky's transformational generative grammar failed to account for the socio-cultural features of language and language use. He argues that communicative competence should not only

focus on grammatical competence but appropriateness—one that is integral to attitudes, values, and motivation concerning language (Hymes, 1972: 277–278).

Other scholars have been using Hyme’s concept of communicative competence in their research. Edelsky (1977) provided empirical support for Hymes’ theoretical contribution with her study of gender stereotypes among adults and their acquisition by school-age children. The results of her study demonstrated that communicative competence is acquired at an early age and that knowledge about the gender appropriateness of linguistic events is part of this competence. People not only talk; they interpret language (including its absence) in the light of their expectations that the social structure will be enacted linguistically (Edelsky, 1977: 225).

For other scholars, communicative competence is more than mere use of language. Allen and Brown (1976) concluded that communication competence, unlike linguistic competence, involves awareness of the transactions that occur between people. Competence, in this perspective, is tied to actual performance of the language in social situations (Allen & Brown, 1976: 248). Communicative competence is also the ability of an interactant to choose among available communicative behaviors in order that he may successfully accomplish his own interpersonal goals during an encounter while maintaining the face and line of his fellow interactants within the constraints of the situation (Wiemann, 1977: 198). It is also the ability of an individual to demonstrate knowledge of the appropriate communicative behavior in a given situation (Larson, Backlund, Redmond & Barbour, 1978: 16).

The concept of communicative competence is further developed by Canale and Swain (1980) to mean grammatical competence, discourse competence, sociolinguistic competence, and strategic competence. For Canale and Swain (1980), *grammatical competence* emphasizes skills and knowledge that are used to speak and write correctly; *sociolinguistic competence* emphasizes sociolinguistic context; *discourse competence* emphasizes spoken and written utterances and the ability to combine these; and *strategic competence* emphasizes using language to meet communicative goals by using both verbal and non-verbal behaviors.

This concept was echoed by Janice Light (1986) who suggested that communication competence has four major components: *linguistic competence*

or adequate mastery of the native language (vocabulary and grammar) plus mastery of the code (e.g. signs or symbols); *operational competence* or mastery of technical skills required to operate the system, i.e. the motor and cognitive skills required to signal a message or to operate specific device features; *social competence* or knowledge and skill in the social rules of communication; and *strategic competence* or the flexibility to adapt a communicative style to suit the receiver.

Gumperz (1981) even encourages communication scholars and linguists “to go beyond mere description of language usage patterns, to concentrate on aspects of shared knowledge and cognitive abilities which are every bit as abstract and general as the knowledge that it is glossed by Chomsky’s more narrowly defined notion of linguistic competence” (Gumperz, 1981: 323).

This paper looks at communicative competence as a product of social experience, as it is highly dependent on the context in which the interaction takes place, and can have consequences on health risk behaviors among risky individuals, specifically children and adolescents. Communication, including parent-child communication, is a transaction that occurs between the conversant and interactant (Wiemann, 1977). We adopt the definition that communicative competence is the ability of an individual to demonstrate knowledge of the appropriate communicative behavior in a given situation (Larson, Backlund, Redmond & Barbour, 1978), and examine the correlates of parents’ perceived competence of their own abilities to communicate about risky behaviors to their children. A greater understanding of communicative competence of parents can have important applications in interventions that seek to stem risky behavior-taking among youth.

Determinants of Communicative Competence

The role of interpersonal communication (IPC) among interactants and conversants has been the subject of numerous studies given its role in generating awareness and ultimately promoting positive behavior change. Central to IPC is the knowledge, ability, capacity and capability of individuals to interact with others as they can determine the failure and success of information sharing and the meaning-making of conversations. Hence, developmental sociolinguists and communication practitioners have given communicative competence in relation to a number of variables much thought and study for decades.

In a study that investigates the relationship between and among age, socioeconomic status (SES) and children's persuasive communication strategies, Piche, Rubin and Michlin (1978) showed that older subjects accommodated their messages to target the conversant's varying role characteristics and produced more role-oriented conversations compared with younger subjects. No statistically significant differences between high and low SES were, however, detected. The overall lack of SES differences indicated the need for caution in assuming any direct relationship between social class and children's communicative appeals (Piche, Rubin & Michlin, 1978).

Alvy (1973) also took SES and age into consideration in studying frequency and quality of listener-adapted communications. Unlike the previously mentioned study, this showed marked differences between SES categories and age. As per results, middle- and upper-class children, compared with those from the lower-class families, exhibited greater skill in message accommodation—a difference that became more pronounced with age (Alvy, 1973).

Gender is also one of the factors that may influence communication outcomes. Boggs and Wiemann (1994) examined the influence of gender on students' responses to teachers' communication in the classroom by looking at 220 students' evaluation of teaching assistants' (TAs) communicative competence, effectiveness and appropriateness and their satisfaction in communicating with both genders. The study showed no significant gender differences in communicative competence ratings of men and women TAs.

Kompetent Sya (He is Competent), A multi-factor study by the Department of Communication Research of the university of the Philippines (UP) College of Mass Communication (2007), also showed that gender is not a factor in ascertaining communicative competence. The study revealed that there are no significant differences between male and female respondents on almost all aspects of communication competence. The two groups only differed significantly in their perceived level of competence in communicating with their family.

In the same UP study, age was, however, an influencing factor. While there was no significant difference found among the young, middle-aged and old respondents' assessment of their competence as communication source, communicating in small and large groups, with friends and superiors, face-to-face, or even in using confrontational communication strategies, there were significant differences as receiver of communication, communicating with

the family and peers and using a third language or dialect (Department of Communication Research, 2007). The study further showed that the younger the respondents were, the higher their perceived competence in listening, reading, speaking, writing, reasoning, communicating in English and Filipino, using mediated communication, and new media.

Religious preference was also one of the independent variables that communication scholars found to be influencing communicative competence. Regnerus (2000) suggested that parental public religiosity curbs the frequency of conversations about sex and birth control. Despite notable relationships with religious affiliation, age, race, and gender still shape parental communication patterns most consistently (Regnerus, 2000).

Health Risk Behaviors

The issue of health risk behavior has been given much attention by scholars. For some, health risk behaviors are volitional involvement in established patterns of behavior that threaten the well-being of teens and limit their potential for achieving responsible adulthood (Resnick & Burt, 1996). These are also commonly referred to as problem behaviors. Health risk behaviors have been categorized into sexual and non-sexual behaviors (Cruz, 2003). Sexual risky behavior include those involving pre-marital sex and commercial sex while non-sexual risky behavior are those involving smoking, drinking, drug use, suicide, violence and dropping out from school (Cruz, 2003). On top of these categories, Cruz (2003) further discussed the existence of another set of risk behaviors that are practiced by the youth: distal and proximal social risk behavior. Distal risk behaviors refer to certain social activities that adolescents normally engage in, usually with their peers. These activities include going to parties, discos, excursion/picnics, sports activities, movie houses, fraternity/sorority activities (Cruz, 2003). On other hand, proximal risk behaviors are those social behaviors which present greater risks to the adolescent compared to the distal risk behaviors. These include patronizing massage parlors, spending nights out with friends and going to strip shows, nightclubs and beer houses (Cruz, 2003).

For this investigation, no categories were adopted as it was limited to the health risk behaviors in the UP study (Department of Communication Research, 2007) which only has four variables on risky behaviors associated with drugs, smoking, alcohol and sex. The study used these variables in the context of parent-child communication which has gained interest among scholars as a

possible arena of change in health communication campaigns. Scholars have argued that although informal interpersonal communication processes occur in several types of social settings (e.g., socialization with peers, siblings, parents), it is the family context of interpersonal communication through the parent-child communication setup that is believed to have the greatest influence on socialization (Moschis, 1985). The importance of parent-child communication about drug use is also reflected in family-based approaches to drug use prevention, most of which focus on improving family functioning and parenting skills, including communication (Ashery, Robertson & Kumpfer, 1998; Grover, 1998). This importance was further highlighted in a study on Philippine youth, which found that parenting style and level of strictness, on top of the young's perception of their parents, affect the type of behavior exhibited by the youth towards activities considered risky (Cruz, 2003). One study on parent-child communication, however, asserted that contrary to assumptions, parent-child communication was not related to initiation of smoking or drinking, arguing further that that parent-child communication about rules and discipline predicted escalation of use (Ennet et al., 2001).

A useful framework for understanding communicative competence was designed by Spitzberg and Cupach (1984) and is known as the component model of competence because it is composed of three specific dimensions: motivation (an individual's approach or avoidance orientation in various social situations), knowledge (plans of action, knowledge of how to act, procedural knowledge) and skill (behaviors actually performed). The component model asserts that communicative competence is mutually defined by the interdependency of the cognitive component (concerned with knowledge and understanding), the behavioral component (concerned with behavioral skills) and the affective component (concerned with attitudes and feelings about the knowledge and behaviors) by interactants in an interpersonal encounter within a specific context. An important caveat: communicative competence is dependent on the context in which the interaction takes place (Cody & McLaughlin, 1985; Rubin, 1985). Hence, communicative competence may differ given the effect of various factors such as age, religion, SES, sex and educational attainment that affect competence.

Method

Data

This current investigation uses secondary data taken from the *Kompetent Siya* study (Department of Communication Research, 2007). The UP study,

which made use of both quantitative and qualitative approaches, used a six-page survey questionnaire to gauge the self-perceived competence of 1,076 randomly selected residents from 13 of the 17 towns and cities of Metro Manila on four aspects: 1) communication roles, 2) communication modes, 3) communication strategies, and 4) parent-child communication.

The current study is most interested in parent-child communication where the parent-respondents with children between 12-18 years old were asked to rate their level of communicative competency in discussing various topics. Four of the listed topics are central to this study, namely, communicative competence in discussing with their children the following: smoking, drugs, alcohol and sex. These are the only variables that contain references to competency in discussing risky behaviors in the parent-child communication setup.

Measures

Competence was measured using a six-point scale ranging from Not Competent At All (1) to Very Competent (6). The response options Not Applicable, Don't Know and Refused were also provided to accommodate instances where a particular question was not relevant to a respondent, a respondent was not able to assess his/her level of competence, or a respondent did not want to answer the question, respectively. The competence measures were re-coded into dichotomous competent/non-competent variables for the analysis.

The competencies mentioned above are correlated with the following independent variables: (i) Age, categorized into young (18-30 years old), middle-aged (31-50 years old) and old (51 years old and above); (ii) Sex; (iii) Highest Educational Attainment, categorized into none, elementary, high school, vocational, college and post-graduate; (iv) Socio-economic Status (SES), categorized into low, middle and high (using monthly income as a proxy measure); and (v) Religion, categorized into Catholic, Protestant, Iglesia ni Cristo, Others and No Answer.

Sample

Out of 1,072 respondents who stated their age, 412 (38.4 %) were middle-aged or 31-50 years old. The young ones (18-30 years old) comprised 33.5% while the old (51 years old and above) made up 28.1% of the sample. Majority of the respondents were female, 669 or 62.2% of the sample. Male respondents comprised the remaining 37.8%. From 1,073 respondents, 619 (57.7%) were

college graduates while only five (0.5%) obtained no formal education. Note that 6.2% finished elementary education, 26% received high school education, 4.7% went to a vocational school while 4.9% had a post-graduate degree. Almost half (46.5%) of the respondents had a high socio-economic background. Out of 1,074 valid responses, low SES families comprised 26.1% while 27.5% came from middle SES. Most of the respondents were Catholics, making up 86.2% of the sample. Other religious affiliations were: Protestant (2.2%), Iglesia ni Cristo (1.9%) and other religions (8.4%). Only 15 (1.4%) did not answer this part of the questionnaire from a total of 1,064 respondents. Since the focus of this study revolves around a parent-child communication setting, a new sample was taken out from the original 1,076 respondents. This new sample is composed of parent respondents with children 12-18 years old during the study. Of the 1,076 original respondents, 247 or 22.9% were parents with adolescent children. This number may slightly vary when correlating with competency variables since some respondents may have invalid answers.

Results

This study looks into the influence of five independent variables, namely, age, sex, highest educational attainment, SES and religion, on parents' communicative competencies in four health risk behaviors, namely, smoking, illegal drug-taking, alcohol-drinking, and unsafe sex. Descriptive statistics were utilized and significance tests were conducted for associational statistics. Table 1 reports the subgroup distributions for the results. The relatively small number of parent-respondents resulted in low statistical power and many subgroup comparisons that were not statistically significant. However, there remain interesting differences in distributions of competency levels.

Smoking

Out of 206 parent-respondents who answered the question on whether they are competent in discussing smoking with their children, a big majority 151 (72.6%) expressed competence in discussing with their children while 57 (27.4%) did not feel competent. The older respondents are less likely to feel competent in discussing smoking with their children (69%), compared to the middle-aged groups (73%), and the young group (83%). Based on statistical analyses, obtained Chi square value is 0.822, Cramer's V is 0.063 but not statistically significant ($p = 0.663$).

Table 1. Percent of Parental Competence in Discussing Risky Health Behaviors with Children (n=247)

	SMOKING	DRUGS	ALCOHOL	SEX
Competent	73%	76%	76%	63%
Age				
Young	83	75	86	83***
Middle	73	78	77	66
Old	69	67	71	51
Sex				
Male	77	79	80	60
Female	70	74	74	64
Education				
Elementary	69	64	81	25***
High School	67	74	69	57
Vocational	73	86	75	71
College	74	76	78	69
Post-graduate	85	80	79	64
Socio-Economic Status				
Low	56***	66 [^]	61***	47***
Middle	76	79	84	67
High	82	81	80	70
Religion				
Catholic	71	75	75	60

***p<.05; [^]p<.1 in appropriate association test

Comparisons by sex yielded non-significant results indicating an absence of differences in perceived communicative competence by sex of parent. Obtained Chi square value is 0.922 while Phi (Φ) is 0.067. A simple comparison of percentages, however, suggests that female parents (77%) tend to be slightly more competent than males (70%) in discussing smoking with their children as a health risk behavior.

Competency among respondents in discussing smoking with their children was compared across groups according to their highest educational attainment. Eighty-three (74%) out of 113 respondents who finished college degrees expressed competence in discussing health risks. For those with vocational education it was 73%, for those with up to a high school diploma it was 67%

and for those with elementary education, 69%. Based on statistical analyses, obtained Chi square value is 1.512 while Cramer's V is 0.085 ($p=.825$). While not significantly different statistically, the distribution of responses by educational attainment shows that parents with higher educational attainment tended to be more competent in discussing smoking as a health risk behavior.

Among respondents who said that they felt competent in discussing smoking with their children ($n=150$), 40% came from families with high SES, 38% from middle SES, and 22% from low SES. As one moves up the SES groups, a larger subsection of parents says that they are competent in discussing smoking with children. Based on statistical results, a Gamma (G) value of $-.401$ ($p<.05$) is obtained. SES is therefore associated with competence in discussing smoking as a health risk such that those with higher economic status are more likely to discuss smoking with their children.

Among competent respondents, 124 (83.8 %) were Catholics. Competent respondents who were Protestants, Iglesia ni Cristo and those belonging to other religions were 4.1%, 1.4% and 8.1%, respectively. Only 51 out of 175 (29.1%) of Catholic parent respondents did not feel competent about discussing smoking to their children. Based on statistical results, no relationship exists between religion and competence in discussing smoking as a health risk behavior. Obtained Chi square value is 1.146 while Cramer's V is 0.084 ($p=.836$).

Illegal Drug-Taking

Out of 201 parent-respondents, a big majority of 152 (75.6%) expressed competence in discussing prohibited drugs with their children while 49 (24.4%) did not feel competent.

A total of 33% of old parents in the sample viewed themselves as not competent, 22% among the middle aged, and 33% among the young. This suggests that as they got older, parents seemed to express less competence in discussing the use of prohibited drugs with their children, although this difference is not statistically significant. Obtained Chi square value is 2.235 while Cramer's V is 0.105 ($p=.327$). Analysis of subgroup comparisons by sex yielded no significant difference with an obtained Chi square value of 0.490 and Phi (Φ) of 0.049 ($p=.484$).

Competency within groups based on highest educational attainment was also compared. The higher up the education ladder a parent found himself/

herself in, the more likely he/she felt competent in discussing prohibited drugs with their children. Among those with an elementary education, 64% said they were competent. Among those with postgraduate degrees, 80% believe they were competent (Chi-square=1.879; $p=.758$). Data showed parents with higher educational attainment tended to be more competent in discussing prohibited drugs as a health risk behavior, although this pattern is not statistically significant.

Across the three SES groups, the lower-income parents were less likely to feel competent about discussing prohibited drugs with their children compared to those who in the higher income levels. A marginally significant Gamma (G) value of -.251 is obtained ($p<.10$). Subgroup comparisons by religion yielded no significant results.

Alcohol Drinking

Out of 221 parent-respondents, a big majority 167 (75.6%) expressed competence in discussing alcoholism with their children while 49 (24.4%) did not feel competent. As with discussing the other risky behaviors, younger parents appeared more likely to discuss alcohol (86%) compared to older parents (71%), although this difference is not statistically significant (Cramer's $V=0.067$; $p=.607$). There is also no significant relationship between sex of the parent and competence in discussing alcohol use.

Competency within groups based on highest educational attainment was also compared. Seventy-eight percent (78%) who finished college degrees viewed themselves as competent, while 69% of those with a high school degree and 81 percent of those with elementary education expressed confidence in their competence. Based on statistical analyses, obtained Chi square value is 2.158 while Cramer's V is 0.098 ($p=.707$), indicating no significant relationship.

Among the 168 competent respondents, 39.3% came from middle SES families, 37.5% from high SES and 23.2% from low SES families. Among 54 not-competent respondents, 25 (46.3%) come from low SES families. Competency among three SES groups was also compared. A total of 25 out of 64 low SES respondents viewed themselves as not competent; 13 out of 79 middle SES respondents saw themselves as the same. A larger proportion of the high-SES subgroups expressed competence in discussing alcohol, at 84% and 80% among those with higher SES and 61% among the low SES group. Based on statistical

analyses, a Gamma (G) value of $-.298$ is obtained ($p < .05$). SES is therefore associated with competence in discussing alcoholism as a health risk. There is no statistically significant association by religion.

Unsafe Sex

Out of 199 parent respondents, a majority of 62.8% expressed competence in discussing unsafe sex with their children while 37.2% did not feel competent. Among the competent respondents, majority are middle-aged individuals (76.8%). Based on the distribution of responses by age subgroup, younger parents are significantly more likely to feel competent in discussing sex with their children than older parents (Pearson's $r = .148$; $p < .05$).

Among the competent respondents, 112 (70.6%) are female. Difference by sex is not statistically significant, however, with a Chi square value of 0.347 and a Phi (Φ) of -0.042 ($p = .556$).

Competency in discussing sex within subgroups based on highest educational attainment was also compared. Based on statistical analyses, obtained Chi square value is 10.311 while Cramer's V is 0.226 ($p < .05$). This indicates the existence of a significant relationship between educational attainment and competence in discussing unsafe sex as a health risk behavior. The distribution shows that parents with higher educational attainment are more likely to rate themselves as competent in discussing sex with their children.

Out of 200 parent respondents, a big majority of 125 (62.5%) expressed competence in discussing with their children unsafe sex while 75 (37.5%) did not feel competent. Among the 125 competent respondents, 40% came from families with high SES, 38.4% from middle SES and 21.6% from low SES. Among the 75 respondents who were not competent, 30 (40%) came from the low SES group. Competency within three SES groups was compared. A total of 30 out of 57 low SES respondents felt that they were not competent; 24 out of 72 middle SES respondents felt the same. Only 21 out of 71 high SES respondents felt that they were not competent in discussing with their children unsafe sex. Based on statistical analyses, a Gamma (G) value of $-.301$ is obtained. As a Proportional Reduction Error (PRE) measure, this indicates that there would be 30% fewer errors if the parents' SES were known in predicting communicative competence in discussing unsafe sex. SES is therefore associated with competence in discussing unsafe sex as a health risk but the relationship is negative. This means that SES is inversely related with

communicative competence, i.e. the higher the SES, the more the parents perceive that they are not competent in discussing unsafe sex.

While there are no by-religion differences, it is interesting to note that among Catholics, a smaller percentage of parents felt competent about talking to their children about sex (60%), when compared to their self-rated competence in discussing other risky behaviors such as taking drugs and alcohol (75%).

Summary of Findings and Conclusion

The current investigation finds that the five independent variables, namely, age, sex, educational attainment, socio-economic status (monthly income as a proxy measure) and religion, are variously associated with communicative competence in parents discussing unsafe sex, illegal drugs, smoking, and alcoholism with their children. The study clearly shows that (i) young parents feel more competent in discussing health risk behaviors; (ii) parents with higher educational attainment tend to be slightly more competent; and (iii) those in the lowest category in terms of socio-economic status are much less likely to feel competent discussing risky health behaviors with the children compared to those who are in the higher categories.

The results of the study are important for researchers, government health policy planners and health campaign managers. Future researchers may wish to consider providing a better operational definition of communicative competence. At the same time, a clearer instrument should be developed to further capture a nuanced meaning of competence in a parent-child setting during data gathering.

The results of the study also can be very useful for government health planners and health campaign managers. The results of the study can form part of the “situation analysis” in the development of strategic health communications plan along with epidemiological studies and formative research. The results of the study can be applied in many ways. In audience segmentation, campaign planners may choose to concentrate on female parents, those with higher educational attainment, and the older ones as behavior change agents in promoting the performance of healthy behavior as they tend to be more competent in discussing health risks behavior as per results of the study. On the other hand, campaign planners may choose to invest more resources in the young parents, those with a lower level of education and male parents.

For instance, given the government policy of reducing health risks among the youths, they can focus their investments and resources on parental subgroups that have been found to have less competence in discussing risky behavior with their adolescent children. The results of the study can also help in identifying “health spokespersons” and “campaign champions” in the roll-out of campaign programs.

Results of the study highlight the importance of campaigns that include strong interpersonal communication programs as a key ingredient in a behavior change campaigns. An interpersonal communication program using the parent-child communication setup could be a major campaign strategy in persuading children to delay or all together avoid engaging in health risk behaviors.

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