Chapter 1

Understanding Adolescent Health

John Coleman

Department of Educational Studies, University of Oxford

Leo Hendry and Marion Kloep

Centre for Lifespan Research, University of Glamorgan

- Introduction
- What is Health?
- The Young Person's View of Health
- The Lifespan Developmental Model
- Influences on Adolescent Health
- Conclusion

Learning Objectives

After reading this chapter you should:

1. Understand adult concerns about adolescent health.
2. Be aware that health can be defined in a number of different ways.
3. Have an understanding of the contrast between adult and adolescent views of health.
4. Have learnt how the lifespan developmental model can help us to understand adolescent health.
5. Be aware of the different influences on adolescent health.

Introduction

It is often said that adolescents are the healthiest group in society. They make less use of health services than other age groups, and they appear to show less interest in health concerns than adults. However, the health of young people is a source of major anxiety to adults. This is what Professor Andrew Copp says in his introductory remarks on health in *Working with children 2006/2007*:

> *Many of our concerns about long-term health arise in adolescence. On many indicators, such as mental health, suicide and self-harm, obesity and lack of exercise, smoking, drinking and drugs, sexually transmitted diseases and teenage pregnancy, adolescents are getting less healthy, or at least giving cause for concern. As young people assume responsibility for their own health, they can become harder to reach with traditional health services. Yet, especially in an aging society, we need healthy, motivated and well-educated young people to keep our society vibrant, flourishing and productive. (Copp, 2005)*

Professor Copp is not alone in expressing these concerns. In the recent past, the British Medical Association published a major report on adolescent health (Nathanson, 2003) which had a predominantly gloomy tone, and Viner and Barker (2005) in their article 'Young people's health: the need for action' pointed out that adolescence is the one age group where there has been no discernible improvement in health over the last 20 years. For both children and older people there have been major health gains, and yet for adolescents there have either been adverse trends (as, for example, in obesity, sexually transmitted infections and so on) or there has been no change. As these authors argue, this has to be set in the context of a situation where the prevalence of diseases in children and young people such as asthma and diabetes is on the increase. Furthermore, over the last two decades mortality among adolescents has fallen much less than in children, primarily because the numbers of deaths resulting from injury and suicide have not decreased in this period.

Is this pessimism justified? It is certainly true that some of the indicators of health risk, such as substance use and problematic sexual behaviour, do show a deteriorating situation. It is also the case that young people in Britain have higher rates of drinking, illegal drug use, and teenage pregnancy than their peers in other European countries. However, the health of adolescents cannot be completely divorced from the health of children or adults. Obesity, for example, is a problem that applies to all age groups, and the increased incidence of mental health problems and of sexually transmitted infections are trends that can be seen in adults as well as in young people.

Another factor of significance here is that health services for young people have a long way to go before they address the needs of this population. Professor Copp, in his remarks quoted above, makes reference to the fact that young people are harder to reach with traditional health services than other age groups. There are many problems that are associated with the provision of appropriate services, including the need for confidentiality, the problem of access to services for those who attend school or college during normal clinic opening times, and transport for those who do not live within easy distance of health centres. There is little doubt that the medical profession has been slow to address these issues. While there are some encouraging trends in health care for adolescents, there is still

far too little energy and too few resources going into the provision of effective services for this age group.

It is also the case that, contrary to popular mythology, young people are in fact as concerned about health as adults. However, their concerns are slightly different. They do not necessarily worry about long-term health risks. A message about the consequences of smoking on life expectancy is not likely to have much of an impact. Yet they do worry about their appearance, their hair and skin, and about various aspects of their bodies. They are particularly concerned about how they compare with other young people of a similar age. They want health information, whether it is about sex, mental health or healthy eating. Good quality teaching on PSHE (personal, social and health education) is valued highly, and they make good use of books and web sites, as is demonstrated by the popularity of publications such as *The diary of a teenage health freak* (Macfarlane and McPherson, 2002).

In considering adolescent health it is important to point out that young people do go to the doctor, as has been shown in numerous research studies (Coleman and Schofield, 2005). They may be healthier than other groups, but they do get infections and injuries, and they do of course suffer from the same common complaints as adults. Also there are major health inequalities that affect young people as much as they do other age groups. The health of young people growing up in poverty and deprivation is significantly poorer than the health of less disadvantaged adolescents, so that it is essential to keep in mind that the health of young people is not the same across the social spectrum. As we shall see, adolescent health is a complex topic, yet one of profound importance to us all. In the following sections of this chapter we will explore some of these complexities.

What is Health?

One of the factors which contribute to the complexity we have just mentioned is that there are many different definitions of health. We will look at some of these here.

Population Health: a Demographic Approach

From a demographic point of view, the health of a population is measured by objective criteria, such as the mean life expectancy of the inhabitants of a country. Other measures considered in demographic research include malnutrition levels, the number of patients per doctor, distance to hospital or health centre, access to water and other services, housing conditions and so on. The latter ones are not measures of health per se, but rather factors which affect health. Nonetheless from this perspective one could state that the population of Britain (mean life expectancy at birth: males 75.7, females 80.7 years) is healthier than the population of Zimbabwe (mean life expectancy at birth: males 37.9, females 35.1 years) (Index Mundi, 2004).

This raises the question of whether health is equated with longevity. Is health calculated by the number of years added to the life course? Modern technology enables us to keep people alive for longer. If we keep terminally ill people alive with the help of complicated machines

that artificially sustain only the most vital life functions, are we maintaining health? Such a question leads us on to another way of defining health.

Objective Biomedical Assessments of Health

A second possible approach to health is to say that health is the absence of illness. A normally healthy person who comes down with flu for a fortnight would, according to this definition, be ill during the period of infection. There are measurable criteria against which to estimate an individual's health status. Such criteria include blood pressure, body temperature, amount of red and white blood cells, heart rate and cholesterol level. If all bodily functions are within the normal range and no infections or other negative medical evidence are apparent, then the doctor may consider the patient's health to be 'good'.

Of course it is possible that the individual may not agree with this diagnosis. The patient might be experiencing aches and pains, yet these can go undetected as they do not affect the criteria mentioned above. The doctor may believe that the individual is healthy, and yet the personal experience of the patient contradicts this. They do not feel 'healthy'. Alternatively, the doctor might identify some bodily malfunction that has not previously troubled the patient at all. In such a case the doctor might have difficulty convincing the person concerned that they are not healthy, and that they need medical treatment. This mismatch of perceptions takes us on to another possible definition of health.

Subjective Feelings and Well-Being

The perspective that considers subjective feelings is one that says: "if I feel healthy, then I am healthy". As Blaxter puts it:

> *The predominant concept of health in oneself (is) a psychological one. To feel good, happy, able to cope …. (Blaxter, 1987, p. 141)*

Of course feelings of well-being and life satisfaction are not unconnected with objective health assessments, but they are not necessarily highly correlated either. In a study by Herzog (1991) only 6% of respondents reported that they were not satisfied with their life, in spite of the fact that a high proportion of this particular sample (62%) suffered from at least one chronic medical condition.

It may be the case that people showing symptoms of minor physical conditions suffer subjectively more than people with serious illnesses. Whether this occurs will depend on the individual's coping skills, the social support received, personal resilience, and the impact of the condition on daily functioning. Interestingly it has been found that an individual's subjective perceptions of health predict longevity more strongly than health assessments carried out by medical personnel (e.g. McCamish-Svensson *et al.*, 1999). It is also of interest to consider what people regard as healthy. Asked to describe someone they know who is 'very healthy', the majority of people in a British study (Blaxter, 1987)

described a physically active, sporty, adult *male* figure. This finding suggests that masculinity, activity and fitness are the basic essentials of health in the eyes of the general population!

The World Health Organization (WHO) Definition

The best-known definition of health is perhaps that put forward by the World Health Organization:

> *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO, 1946)*

This definition is interesting, in that it emphasizes health as a positive force, defined by something more than the absence of illness. Indeed it adds other dimensions to a solely medical perspective on health. Yet there are problems with this definition:

- It is somewhat static, and rather too idealistic as a working model. Logically from this definition few, if any, can be completely healthy, because total well-being cannot be achieved.
- The notion of well-being is as difficult to define as the notion of health. Do we mean objective or subjective well-being?
- What does social well-being involve? Is it conformity to community/societal norms, or individualism and independence?

For these reasons commentators in the health field have tried to develop a new definition of health, the so-called 'open notion of health'. Admitting that a definition of health can never be completely objective, or value free, Wackerhausen (1994) proposes health to be:

> *The ability to realise one's goals (both in daily life and in the long term planning of one's life) under given life conditions.*

This definition allows for individual differences. For example, a young woman who is a cross-country runner will have different goals from another who has no sporting interests but has recently entered into her first sexual relationship. The first young woman may regard a pain in her foot as being of serious concern, whilst the second may hardly notice her foot, being preoccupied with different types of contraception.

This definition differs significantly from a strictly medical one, since it is relative. It also takes the focus away from solely physical conditions, and encompasses anything that prevents us from reaching our goals. Such features of health may include lack of competence, lack of confidence, poor psychomotor judgement, lack of knowledge about the task we are undertaking and so on. Also, there is a question as to whether health as defined here is synonymous with the ability to reach one's goal, or whether it is a means, or an obstacle to it. To what extent would young people consider their health as one of the factors which limits the activities in which they participate?

We have explored here a number of ways of defining health. Perhaps all these definitions are relevant and have their place, depending on what we need the definition for. It might

be required for deciding about medical treatment, for measuring the quality of life, for prevention, for investing in new services, or for creating possibilities for positive personal development. Additionally, it is important to recognize that any definition is only looking at one part of the puzzle. Possibly this is all that can be achieved. Systemic theory (e.g. Lerner, 1998) proposes that we take account of multi-level, two-way interactive factors from the gene to the cellular level, through biological and perceptual-motor individual factors, to the cultural and historical macro-level factors, all of which affect the individual's development. Yet realistically, in professional practice or in research, it seems likely that one cannot look at everything at once. We should be aware of the limitations of any one definition or analytical approach. The most important thing to realize is that there are many definitions of health, and we need to be careful about which one we use.

The Young Person's View of Health

Up to this point we have been considering adult definitions of health, but how do young people see this? We have stated that young people see health differently, and we can now look at this in more detail. Firstly, young people generally show less interest in discussing smoking, alcohol or drugs with health professionals, as these are seen as adult concerns. In the study carried out by Hendry *et al.* (1998) the opinion was expressed frequently that adults, and this included parents, teachers and adults in the community, did not necessarily understand what adolescent health concerns were. As evidenced by Backett and Davison (1992) these concerns related to fitness, appearance, attractiveness and peer acceptance. In this study, adolescents expressed the view that to be overly worried about health and lifestyle was 'boring' and 'middle-aged'.

In a school-based questionnaire survey of teenagers aged between 13 and 15 in London, young people indicated that their main health concerns were about weight, acne, nutrition and exercise (Epstein *et al.*, 1989). A series of interviews carried out by Aggleton and colleagues (1996) with young people between the ages of 8 and 17 support the view that young people's health worries extend beyond issues to do with smoking, drugs and sexual health. Rather, adolescents express concerns about their developing bodies as puberty progresses. The following quotes are taken from Shucksmith and Hendry (1998):

> *"Oh God, where did all this fat come from? It never used to be there or I never noticed it. I used to be able to eat loads of sweets and the only thing that grew were my feet!" (Girl, 15)*
>
> *"I worry a bit about health – well, quite a bit. I'm trying to keep a constant weight, making sure I'm not overweight. I don't want to look fat and horrible, and have people making jokes about me." (Girl, 15)*

Young people not only mention differing health concerns, but they often consider that adults overestimate the risks that are associated with behaviours such as drinking and smoking. This is particularly the case where the focus is on behaviour that is seen as normal in adulthood.

> *"Your father says don't smoke, and yet he has a cigarette in his hand. He says don't drink, when the following weekend he's out in the bar getting drunk!" (Girl, 14) (Shucksmith and Hendry, 1998)*

One important difference between the age groups is that young people do not see health in abstract terms. For adolescents health is very much about the here and now, and their needs are to do with having the best information, and also having the skills to manage the situations in which they find themselves, such as at a party where alcohol and possibly illegal drugs are available. Some commentators have made the point that health for young people is best seen as a trade-off between knowing what is good for you and dealing with pressure from peers and family. As Kalnins *et al.* (1992) put it:

> *They [young people] perceive health in terms of conflict situations in which courses of action are pitted against pressure from friends and family.*

Thus adolescents tend to adopt a subjective definition of health – in contrast to their parents – and give preference to learning skills that might enhance their well-being rather than simply avoid risks.

Where the provision of health information is concerned, a fine line has to be drawn between basic knowledge and social skills. Teenagers are not necessarily interested in receiving even more information about such things as alcohol and drugs, especially as they are often quite knowledgeable already. However, they are open about the fact that they lack the skills to manage the social pressures and to implement what they know in their daily lives. To take the example of smoking, most young people are aware of the risks of smoking, and many would like to give up, and yet they do not know how to achieve that goal in the face of peer encouragement. Long-term goals, such as the avoidance of lung disease in the future, do not seem sufficiently potent at the age of 14 (Turtle *et al.*, 1997).

To take another example, Hendry and Singer (1981) found that adolescent girls have positive attitudes to physical activity for health reasons, but assign low priority to their actual involvement in these pursuits because of conflicting interests. These interests are usually social,

involving spending time with friends and thus, it could be said, sacrificing long-term goals for the needs of the moment. As Coffield (1992) noted, teenagers find it difficult, if not impossible, to worry about the health of a 50-year-old stranger, that is, themselves 35 years in the future. However, a warning note needs to be sounded here. Are adults any better at making personal sacrifices for long-term health goals? If we think of our own behaviour, our weight, our lack of physical fitness, our use of alcohol at the weekends, we can recognize that some caution is needed before we make value judgements about a generation younger than ourselves.

This raises the interesting question of whether young people are more likely than adults to engage in health risk behaviour. An argument could be advanced that a certain amount of learning is inevitable for young people, and that risks are taken in order for this learning to take place. In the case of alcohol many young people describe their early experiences as being ones of losing control, but then finding ways to manage their behaviour better as they grow older. The following quotes are from Shucksmith and Hendry (1998):

> *"Yeah, I know about limits now, but not when I first started. I was drinking far too much, and I was just totally 'over the top'. I want to be able to control what I am drinking now…and be sensible." (Boy, 15)*
>
> *"You must do this, you must find your own limits. Try to, because if you are going to drink it is essential. It is part of growing up." (Girl, 14)*

Hendry and Reid (2000) found that having the basic skills to 'get along with others' is seen by young people as an essential component to a sense of health and well-being. Adolescents also believe that they should receive what they call 'emotional education' (how to cope with anger, recognize emotions and so on) if their health needs are to be addressed. We shall have more to say about this in the chapter on 'Emotional Health and Well-Being'. It is the view of young people that few adults appreciate the nature of teenagers' needs for what might be called 'social emotional learning' in the context of health education. Furthermore, young people experience a lack of empathy and understanding of their concerns on the part of adults. This is a serious gap, and requires more attention if we are to make a genuine attempt to improve the health of adolescents.

The Lifespan Developmental Model

Having looked at the views of both adults and young people, which is more correct in relation to health and healthy lifestyles in adolescence? We would suggest that both points of view have merit, and that health will always be a complex, multifaceted concept. We agree with Stone (1987), who suggested that health should be regarded not as a static ideal state, but as a dynamic concept involving movement in a positive (or negative) direction. According to this definition an individual can be more or less healthy at different points in the life course, and indeed at different times of the day, depending on different situations. To clarify this viewpoint, we will briefly introduce here the Lifespan Model of Developmental Challenge (Hendry and Kloep, 2002) and apply it to adolescent health.

We start by emphasizing that no event or behaviour is an isolated occurrence, but is embedded in a whole system of other events and behaviours, all of which influence each other. For that reason, no event has the same impact on different individuals, and not even on the same individual in different situations. This is why pursuits or activities that are healthy for one person can be unhealthy for another and without any health consequences for a third.

A teenager on a night out with his peers could be ostracized for refusing to drink alcohol, and this outcome might put his emotional health more at risk than if he were to drink. A young woman who is a talented tennis player and who spends all her leisure time training may be physically strong and fit, but may miss the chance to learn all the social skills her peers are acquiring during their adolescent years.

Within this theoretical framework we regard the individual's health as consisting of various elements, within a dynamic interactive system of resources. An individual has more or fewer resources at different times and in different circumstances. These resources, interacting with each other, can enhance or diminish other environmental and psychosocial resources. It is obvious that the more resources the individual has, the more likely it is that he or she will lead a healthy life. Some of the resources are ones we are born with, such as our genetic or constitutional characteristics. Thus an individual may be born with a genetic disposition to heart disease, or schizophrenia. Other resources, such as education, good nutrition and so on, are acquired during the life course.

Smoking, the misuse of alcohol or drugs, and lack of exercise potentially diminish health resources and so, according to this perspective the adult view of health is correct. However, social and interpersonal skills, such as coping mechanisms, can also enhance health resources, so the adolescent's view is equally correct. In some cases one has to make a choice between different priorities, since one may be able to strengthen one resource at the expense of another. Furthermore, resources interact together, enhancing or inhibiting each other. Mental well-being has an effect on physical health and vice versa. A happy person is more likely to engage in health-enhancing activities; one is more likely to catch a cold if one is stressed, and feelings of stress are more likely to occur if the body is not functioning well.

However, what exactly these resources can be used for is not really evident until we know what health challenges the individual encounters. Quite different resources may be needed to cope with a disease, to withstand peer pressure, to function satisfactorily in daily life, or to develop habits that have positive long-term health effects. Thus a young person managing peer pressure in relation to alcohol or smoking may require somewhat different resources from one dealing with a sports injury, or chronic illness.

In the context of these remarks, what is a healthy lifestyle for a young person? We suggest the following solution to this dilemma. A healthy lifestyle is anything that adds resources to the individual's dynamic resource pool. Since almost nothing we do or experience will only add resources, but will at the same time come at a cost, we regard a healthy lifestyle as anything that maximizes gains and minimizes costs, in both the short and long term.

As an example of this argument, we can recognize that young people often learn from what, on the surface, may appear to be unhappy or negative experiences. In resolving not to respond to a similar event in a similar manner again, they can develop a range of social skills which assist in the development of resilience and coping mechanisms for future use (Hendry and Kloep, 2002). Rutter and Smith (1995) have talked about 'steeling' experiences, small 'injections' of unlucky experiences that immunize young people against future risks in the same way as a vaccination works. From this viewpoint it is clear that even experiences that seem to be hazardous and risky from an objective perspective can add to the health resources of young people.

Writers on adolescent health (e.g. Eccles *et al.* 1996) have argued that there is a 'mismatch' between the needs of the developing adolescent and their experiences at school and in the home. This 'mismatch' may possibly have a negative effect on psychological and behavioural development. What do we mean? As we have seen, adult health concerns for young people centre on the *avoidance* of behaviours that could be a potential health risk. This approach

is often experienced as attempting to constrain young people, to hold them back, to prevent them doing things they want to do. On the other hand, adolescents emphasize the need for *engagement* with some health risk activities, as without this they cannot learn skills and gain resources to develop a healthy lifestyle.

These two differing views are not necessarily mutually exclusive, especially if there is a recognition that both aims can contribute to better health. Lerner (2002) argues that we should concentrate not only on diminishing risks, but also on building the strengths and qualities of young people so that they have the capacity for positive development. As he puts it:

> *Preventing a problem from occurring does not, in turn, guarantee that we are providing youth with the assets they need for developing in a healthy manner. (Lerner, 2002 p. 528)*

In sum, we suggest that what is healthy or unhealthy is a trade-off between different choices in the face of health challenges. The more resources the individual has, the more choices are possible. In order to achieve the greatest degree of resources, the individual needs to be proactive and aware, and even take risks sometimes. By simply doing nothing, no new resources are gained, and existing ones might become depleted. In meeting and coping with challenges, developing skills to assess and deal with risk, and balancing benefits and costs, young people stand the greatest chance of developing a healthy lifestyle.

Influences on Adolescent Health

It will be clear that young people vary hugely in their health status. Imagine for a moment two 16-year-old boys. One lives in a deprived inner city area. He has not seen a doctor or dentist for the last three years, he has a poor diet, he smokes and drinks, has never played sport, suffers aches and pains in his joints, and has frequent toothache. The second boy is a keen sportsman. He lives in a middle-class area, and has seen both a doctor and a dentist within the last year. He has no symptoms of ill-health. He does not smoke, but does drink alcohol at parties. His parents are interested in healthy food, and he regularly eats fruit and vegetables. It does not take much to see that the two boys are likely to have very different health outcomes as adults.

There is a wide range of factors that impinge on, or affect young people's health. Such factors include the family, cultural background and the environment, with poverty and disadvantage having a particularly strong effect on young people's health. In addition to these factors, gender plays a key role, as do social and geographical variables. As an example we will be looking at some international comparisons of substance use and teenage conceptions, where we can see marked variations which are not always easy to explain.

We will first consider gender, as it may be that this is the variable that has the greatest degree of influence on health status. We can think of a multitude of health indicators that vary according to gender. Thus, for example, from the earliest years boys are physically more active, and show a different pattern of health and ill-health to girls. When we come to adolescence, we know that puberty itself differs markedly between the two genders. Girls reach puberty earlier, and the sequence of events during the pubertal period is not the same for males and females. It is at this point that the marked differences in body shape, in size and in musculature become so apparent, and in addition we know that psychological factors come into play, with girls showing more dissatisfaction with their bodies than boys during this stage.

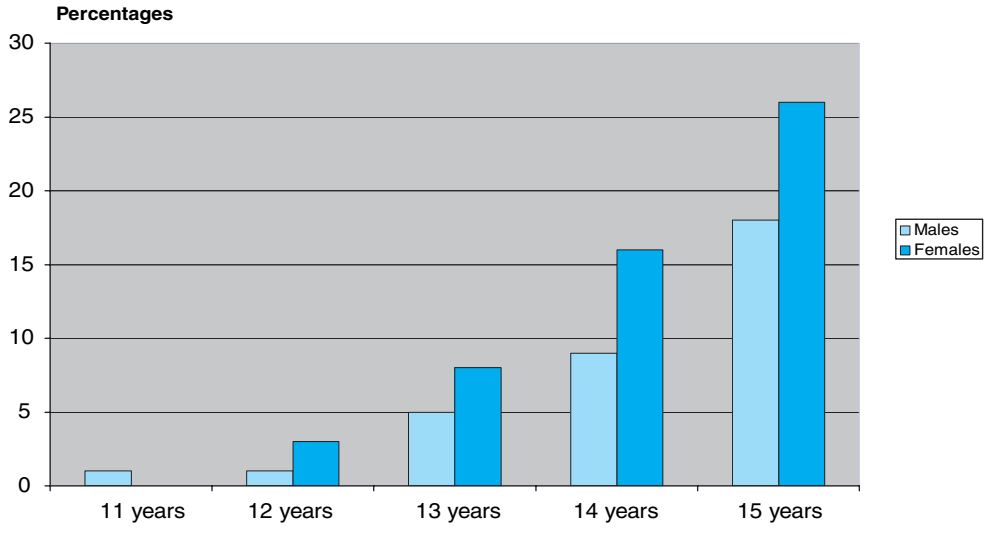

Figure 1.1 Proportion of 11–15 year-olds who were regular smokers, by gender, 2003 (Boreham and Blenkinsop, 2004).

As will be apparent, gender can be shown to have an impact on any number of health indicators and behaviours, and we do not have the space here to explore these in great detail. However, as one reflection of the importance of gender, we will consider the behaviours of smoking and drinking in this context. Evidence presented in Figures 1.1 and 1.2 shows that,

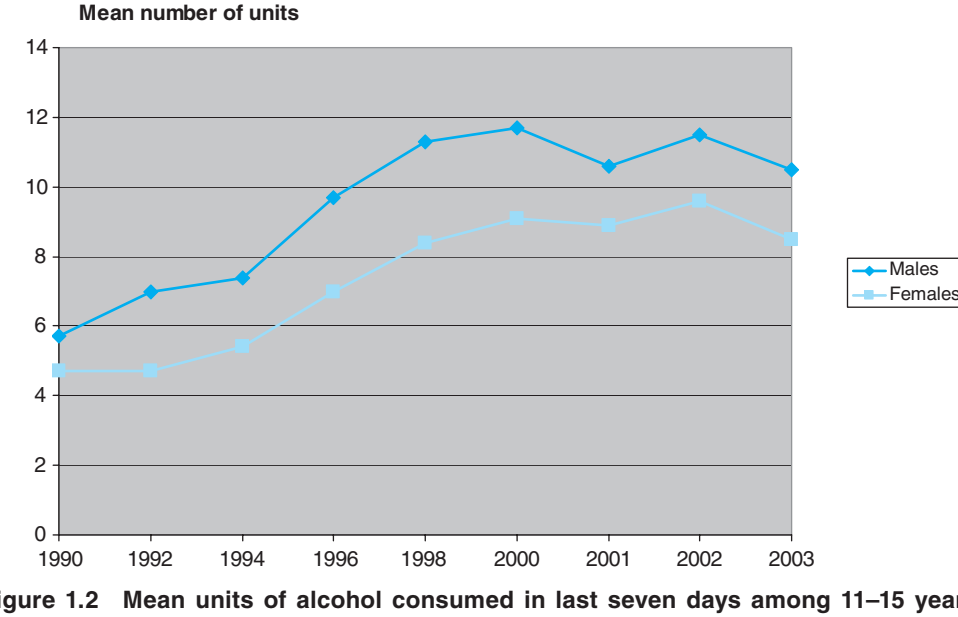

Figure 1.2 Mean units of alcohol consumed in last seven days among 11–15 year-olds, in England, by gender, 1990–2003 (Boreham and Blenkinsop, 2004).

while girls are very much more likely to be regular smokers in adolescence, it is the boys who are drinking more alcohol. Why should this be so? The argument set out in Lloyd and Lucas (1998) is that smoking can only be explained through notions of social identity. While factors such as family and stress may play their part, smoking behaviour is very much affected by identification with particular peer groups, and this is the primary explanation for the higher levels of smoking in girls. Much the same argument can be advanced for boys in relation to drinking alcohol. Thus gender impacts on the way in which social behaviour develops, and this in turn affects health.

As we noted, family factors play a key role as determinants of health in adolescence, and smoking reflects this as well as any other indicator. In the study by Lloyd and Lucas (1998) they looked closely at family factors, and were able to show that both family composition and the smoking behaviour of parents were influential in affecting adolescent smoking behaviour. Thus young people growing up in step-families or in lone parent households were significantly more likely to smoke than those growing up in two-parent households. This they explained in terms of higher stress levels among these young people. As far as the smoking behaviour of other family members is concerned, the evidence is clear.

> *We found a strong association between the smoking behaviour of most family members and adolescents' smoking behaviour.…Half the adolescents who reported that a parent smoked had tried a cigarette. Two thirds of pupils who had an older sibling who currently smoked had tried a cigarette themselves.…Parents influence their children's smoking both directly, and indirectly through their influence on older siblings.…When a family member was reported never to have smoked, it was much more likely that the adolescent reported that they had never smoked either. (Lloyd and Lucas, 1998, p. 64)*

It is of interest now to look briefly at international comparisons, since we know that health behaviours vary widely from country to country. One example that is frequently in the news is the fact that Britain has a higher rate of teenage births than any other European country. The differences between countries are illustrated in Figure 1.3. Many different explanations have been advanced for this finding, including inhibited attitudes to sex among British families, inadequate sex and relationships education in school, and low levels of investment in good quality sexual health services specifically targeted at young people. This issue will be discussed in more detail in Chapter 5.

Rates of conception are of course not the only health indicators that vary across countries. A recent large-scale WHO study (Currie, 2004) shows, for example, that British youth are more likely than their counterparts in most other countries to drink alcohol, and to indulge in binge drinking. Other countries with high rates of adolescent drinking include the Netherlands and Denmark. The use of cannabis among young people also varies greatly across countries, with Switzerland currently heading the league table. The most recent findings show that 40% of adolescents have used cannabis during the past year in Switzerland, as compared with 35% in England and 25% in France (Currie, 2004).

Lastly in this section, we will consider the impact of poverty and disadvantage on the health of young people. In the report by the British Medical Association (Nathanson, 2003) on adolescent health it was noted that there appears to be more health equality among young people than among other age groups. This is largely due to the fact that health risk behaviours such as drinking, smoking and substance use are widespread. However, the report went on to

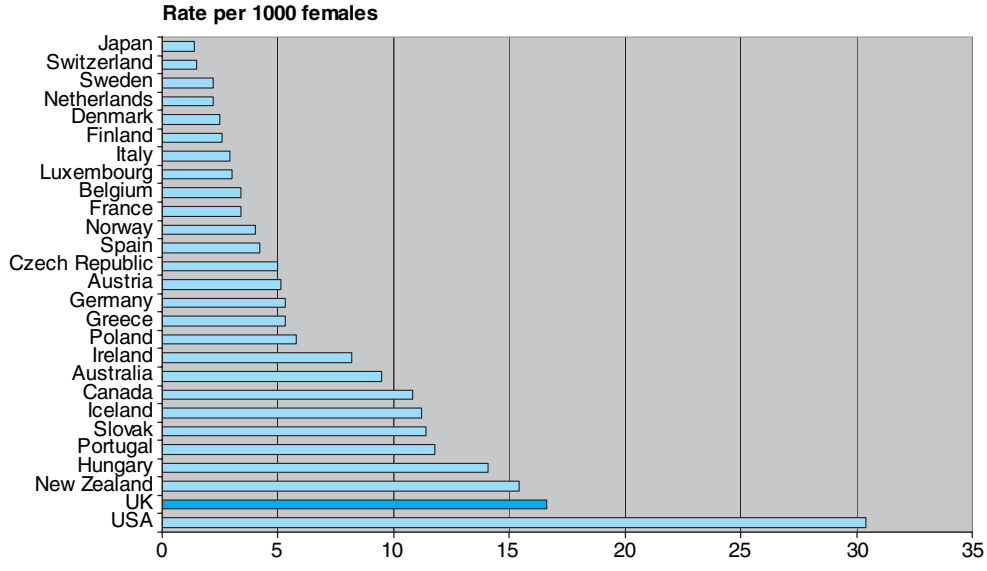

Figure 1.3 Birth rates for women aged 15–17 in OECD countries, 1998 (UNICEF, 2001).

accept that for a wide range of health concerns, those from less advantaged social backgrounds are likely to show higher rates of ill-health or health risk. Thus eating habits are related to social background, problematic drinking and drug use are more pronounced among disadvantaged groups, and mental health problems are closely associated with poverty and deprivation.

In Roker's (1998) study of young people growing up in family poverty, health was an issue which was frequently mentioned by those she interviewed. Many indicated that there was not enough money to buy food; "Sometimes it's that bad we rarely have enough meals to last us the week" and others complained of poor dental or physical health; "I smoke a lot and that makes my chest feel bad". The most striking descriptions related to the emotional health of the sample.

> *"I get problems with my nerves when our mum and dad's having a row. I wake up in the morning and my legs and arms are all shaking and that … I was going to leave the house, but I can't leave my (alcoholic) dad in case he gets any problems, so I just had to come back here." (Roker, 1998, p. 58)*

Since 1998 the Joseph Rowntree Foundation has been monitoring the changes in poverty and deprivation across the UK, and their publications have provided a valuable source of information on health, among other things. One of the indicators that the foundation has included each year has been suicide rates, and these have routinely shown the shocking disparity between different social backgrounds where severe mental health problems are concerned. As can be seen from Figure 1.4, young men who are from routine and manual backgrounds are three times as likely to commit suicide as those from professional and managerial backgrounds. Could there be a starker reflection than this of the impact of poverty and social background on health?

To conclude, we have explored here some of the factors that impact on the health of young people. As we have shown, a variety of factors play a part in determining health status,

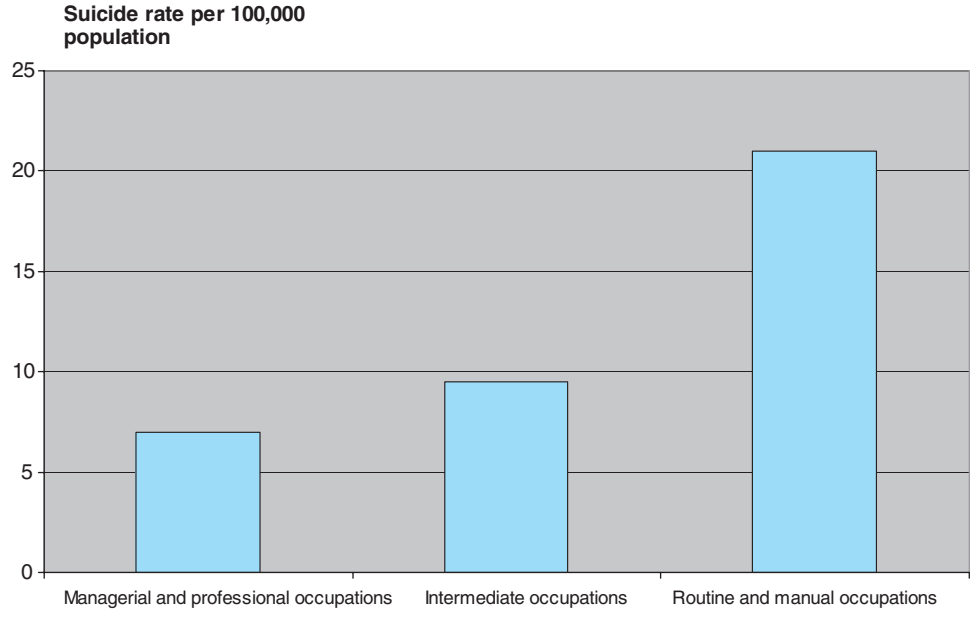

Figure 1.4 Suicide rates among young men from different social backgrounds: average rate for years 2001 to 2003.

although, of course, the factors we have selected are not the only ones that could be included in a discussion of variations in health outcomes. Particular populations are at particular risk, such as those in custody, or those who are looked after by local authorities. We have also paid little attention to the affect of culture on health, and this too could be a subject deserving more attention. For present purposes it is important to note that not all young people are the same where their health status is concerned. This conclusion, obvious as it sounds, is not always given sufficient attention in the planning of health services, or in the development of health promotion activities. It may be argued that there is more health equality among adolescents than among other age groups (Nathanson, 2003). Yet this is to miss the point. There is substantial inequality where adolescent health is concerned, and this should not be ignored or played down.

Conclusion

Understanding adolescent health is no simple matter. As we have seen in this chapter, there are many questions that arise when considering this subject, and few of them have easy or straightforward answers. Let us first look at the issue of how adolescents compare with other age groups in their health status. As we have noted, it is often argued that young people between the ages of 11 and 19 are the healthiest group in society. This assumption is based on two premises. One is that adolescents appear to use services less than other groups, and the second is that adolescents give the impression of being less worried about health than older people.

Both these premises are open to debate. As far as the use of services is concerned, many health professionals believe that young people would use services more if they were more easily accessible, and more adolescent-friendly. It is often the case that clinics are not always open at hours that are convenient for young people, and attendance may entail a journey on public transport that is costly for a teenager. Furthermore, the issue of confidentiality is high on the priority list for young people, and everyone knows the classic story of the young woman who goes to the GP (general practitioner) for contraceptive advice, only to find that the receptionist is one of her mother's friends. It is also important to note that, in fact, young people do visit the doctor. 75% of all teenagers under the age of 16 visit the doctor at least once a year, a figure which is comparable with the visiting rates of adults. Many people, including GPs themselves, are surprised at this finding.

Turning now to the possibility that young people worry less about their health than adults, one explanation for this is that adults and young people have different definitions of health. As we have pointed out earlier in this chapter, adolescents are not particularly concerned about long-term health risks. This is due to their having a relatively short-term time perspective, worrying about tomorrow, rather than about next month. Yet, in fact, teenagers are worried about health. They worry about their skin, their hair, their appearance, their weight, their body shape, nutrition, and about various aspects of sexual and emotional health which do not impinge on adults. Thus, young people may give the older generation the impression they are not worried about health, but this is misleading. It is just that health concerns for young people are different from the health concerns of adults. Indeed, as we pointed out, there are many possible definitions of health, and this fact is highlighted when we think about the way different generations understand their health.

A further dimension of the differences between adults and young people was exemplified when we discussed the idea of a 'mismatch' between different approaches to health education. As we saw, when approaching the notion of health risk, many adults take the view that avoidance is the most sensible option. The 'abstinence' movement in relation to sexual behaviour or the 'Don't do drugs' campaigns are good examples of this viewpoint. However, for many young people this is a counterproductive message. It makes the risk behaviour even more enticing, and creates the impression that sex, drugs and alcohol are associated with adult status, something that all young people want to attain.

Young people are more likely to take the view that some experience of risk is essential for healthy development. They wish to explore, to understand, and to learn what they can and cannot manage in order to develop the skills to cope with the risks inherent in their social settings. As we have said when talking about the notion of resources, if you do nothing (avoidance), you will not be able to develop any new resources. Unless health educators take these beliefs into account, it is unlikely that young people will engage with their programmes.

Our final thought in this introductory chapter has to do with the question of what is a healthy lifestyle for young people. There is much concern today about obesity, lack of exercise, poor mental health, unsafe sex, the use of drugs, and other behaviours that are anxiety-arousing for adults. We noted at the beginning of the chapter that the tone of many recent reports on adolescent health is gloomy to say the least. Is this pessimism justified? And if the health of young people is so much at risk, how would we define a healthy lifestyle for this generation? Firstly, it is important to note that there are some signs of progress. Services are improving, and there is more focus on the health of adolescents today than has been the case in the past. Good statistics and better research have helped to highlight the areas which need more

attention. Various chapters in this book will draw attention to promising developments both in health care and in our understanding of adolescent health-related behaviours.

On the other hand, it is certainly true that there has been less improvement in the health of young people than in the health of children and of adults. Furthermore, some indices of risk behaviour, such as alcohol use, and sexually transmitted infections, have shown worrying rises in recent years. The picture is mixed, and more government resources undoubtedly need to be directed to both services and effective health promotion. In this context, what about a healthy lifestyle? The answer to this question has been outlined in some of what we have said earlier. A key lies in the opportunity for young people to develop resources for health without incurring too much cost. In this context we understand health to have the widest possible meaning, and to include emotional as well as physical health. The notion of a healthy lifestyle is obviously relative, and will depend on the circumstances and risks to which any individual is exposed. We have called these 'health challenges'. We argue that a healthy lifestyle for an adolescent must include the acquisition of knowledge and skills, access to health services when required, and the opportunity to engage in moderate risk behaviour in order to enhance learning. It is this we mean when we say that a healthy lifestyle is something that 'maximizes gains and minimizes costs, in both the short and the long term'.

CASE STUDY 1.1

Some years ago, when I was interviewing a relatively small number of adolescents for a pilot study on health, I had to carry out four individual interviews in a local comprehensive school in Scotland.

After a couple of interesting conversations with second year pupils, I was waiting in a small office – possibly the interview room for visiting health care staff – when I heard giggles and banging noises coming from the corridor outside. I went to the door, opened it, and stepped outside to be joyfully greeted by a slightly built, almost puny boy in a wheelchair, guided by two girls.

He began by saying: "Hello Sir, I'm your next victim. My name is Charlie. What are you called?" With introductions over, I began the interview, which was attempting in an open and unstructured way to find out what young people perceived as a healthy lifestyle. As the conversation continued, Charlie revealed that he played a bit of soccer and swam, and together with a careful diet, he considered that he was fit and healthy and had indeed a very healthy lifestyle.

Later in the interview Charlie mentioned in passing that he required regular, intensive medical treatment. Since this was a pilot interview and confidentiality had been stressed, I did not enquire further as Charlie did not seem to regard his medical treatment as a matter of any consequence and neither of us developed the topic further. Rather he moved on to "really important" issues in his life, such as whether Glasgow Rangers or Celtic would win the league that year.

As it came to an end, I realized that this had been one of the most enjoyable interviews I had ever carried out.

However, the denouement came when I was having a cup of tea in the staff room after all the interviews were over. I said how much I had liked visiting the

school and thanked the Head Teacher for allowing the research team to carry out the interviews. I said that I would especially remember the little boy, Charlie, who was so cheerful despite his having to be in a wheelchair for extensive periods during the school year. "Yes" said the Head Teacher. "It's so very sad. The specialist estimates that Charlie will die of cancer in three to six months."

Source: Hendry *et al.*, 1998

CASE STUDY 1.1 QUESTIONS

1. Describe a person you know whom you regard as healthy. What were your criteria in choosing this person?
2. On which criteria does Charlie base his judgement of his health status?
3. Do you consider that Charlie's perceptions of his own state of health are correct? Why?

Further Reading

Bradshaw, J. and Mayhew, E. (eds) (2005) *The well-being of children in the UK*, The Save the Children Fund, London.

Coleman, J. and Hendry, L. (1999) *The nature of adolescence*, 3rd edn, Routledge, London.

Coleman, J. and Schofield, J. (2005) *Key data on adolescence*, 5th edn, The Trust for the Study of Adolescence, Brighton.

Heaven, P. (1996) *Adolescent health: the role of individual differences*, Routledge, London.

Roche, J., Tucker, S., Thomson, R. and Flynn, R. (2004) *Youth in society*, 2nd edn, Sage Publications, London.

Discussion Questions

1. Are adults right to be worried about adolescent health?
2. Do you consider some element of risk-taking essential for a healthy adolescent?
3. Many of the things that young people want from their health services are the same as those desired by adults. Should adolescents be given special treatment?
4. How does lifespan developmental theory help you to understand adolescent development?
5. What do you consider to be the major influences on adolescent health?