A new narrative of young people's health and wellbeing

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Abstract
Young people's health is continuing to improve in line with historic trends. Death rates are low and falling, and most young people say they are healthy, happy and enjoying life. For most, social conditions and opportunities have got better. Health efforts need to focus on the minorities whose wellbeing is lagging behind, especially the disadvantaged and marginalised. This is the widely accepted story of young people's health.

There is another, very different story. It suggests young people's health may be declining - in contrast to historic trends. Mortality rates understate the importance of non-fatal, chronic ill-health, and self-reported health and happiness do not give an accurate picture of wellbeing. Mental illness and obesity-related health problems and risks have increased. The trends are not confined to the disadvantaged. The causes stem from fundamental social and cultural changes of the past several decades.

Which story is the more accurate matters. Stories inform and define how governments and society as a whole address youth health issues. The usual narrative says interventions should target the minorities at risk. The new narrative argues that broader efforts to improve social conditions are also needed.

Key words : Children; culture; health; mental health; narrative; trends; young people; wellbeing.

Introduction

This paper poses two questions:

- What would we do differently if young people's health, overall, was not improving, but declining?
- What would we do differently if the social factors behind young people's health problems were not primarily those of 'marginalised minorities', but the characteristics of 'mainstream majorities'?

The answer, clearly, is that we would have to do a great deal differently. While I will elaborate a little on this towards the end of the paper, my primary aim is to argue the need to ask these questions.

The paper is a variation on a theme in my research and writing going back over 20 years (Eckersley 1988, 2008). This work is, in turn, part of a wider, transdisciplinary analysis of human progress and wellbeing (eg, Eckersley 2005). So my concern is not only with what young people's health means for them, but also what it reveals about today's societies and their future.

The paper covers some of same ground of my earlier papers, which discuss some of the issues in more depth and detail. Elements of this perspective are also addressed in the work of others (eg, West 2009, Wyn 2009). However, this paper extends the analysis by contrasting the old, 'official', story of young people's health and wellbeing and an emerging new story in order to highlight deep conceptual differences. Neither youth-health research nor youth sociology has adequately engaged with this shift in narrative, let alone accepted its implications.

Youth sociology can, in fact, be resistant to aspects of the new story (Eckersley 2005, pp. 147-169). Youth studies have a tradition of defending young people against social criticism and control, especially by the media and governments. Concerns about them are dismissed as 'moral panics' about young people as victims or problems, a recurring historical myth. The focus of attention needs to shift from problems to solutions, from negative to positive attributes, outcomes and conditions. These perspectives can be valid, but they can also work against accepting the new story. For example, emphasising young people's 'agency' and autonomy can reinforce the dominant health focus on individual responsibility to the neglect of powerful social and cultural determinants.

Even more problematic is how to contribute to a more positive view of youth while arguing against the orthodoxy that they are the healthiest of generations. (A newspaper once ran a report on one of my publications under the headline, 'Youth of today fat, nervy and depressed'. I complained in a letter to the editor that my report was not criticising young people, but the social conditions in which they were growing up. 'Society, government failing youth' would have been more accurate.)

However, the sociological literature does present a much richer, more refined analysis of social changes, of modernisation and individualisation and their effects, than the health research. This analysis is central to the new story. The health literature also has strengths and weaknesses in this regard. Much of the evidence base of the new story derives from empirical health research conducted over the past two decades. Yet its consideration of the causes of youth-health problems focuses on nearer influences such as individual risk factors, family and peer influences; beyond these, it emphasises socio-economic factors such as disadvantage and inequality – a narrow, rather 'clunky' approach. As with other complex social issues, youth health would benefit from more transdisciplinary collaboration and synthesis.

The issue is one of different ideologies, disciplinary concepts, scales of inquiry and levels of intervention. These differences need to be better acknowledged and addressed (Eckersley 2005, pp 147-69, Eckersley *et al*. 2006). They are not necessarily contradictory, but they can be

seen to be. While 'pro-youth' views deserve promotion, they should not be confused with, or distract from, the need to address the health impacts of social changes for which societies (and governments on their behalf) must take responsibility.

The focus of this paper is on developed nations, which share (although to varying extents) similar patterns and trends in youth health and wellbeing. However, the issues raised are also of increasing importance to developing nations as modernisation and globalisation impact on the lives of their young people. I use 'health' to describe all states of body and mind, going beyond death and disease to include non-clinical and positive dimensions, and so many dimensions of 'wellbeing' – hence the use of both terms. Social factors such as education, poverty and employment – sometimes used as indicators of wellbeing – I treat as among its determinants. While I mention children and childhood as a broad age category, my focus is on adolescents and young adults.

The old story
The conventional view of the health of young people today is that it is good and getting better; they are the healthiest generation and the healthiest age group (AIHW 2007, Eckersley 2008, 2009a, Wyn 2009). Fewer are dying; most say they are healthy, happy and satisfied with life. The improvement is in line with historic trends in health, where death rates have fallen as a result of better nutrition, sanitation and housing; better education, social welfare and working conditions; and medical advances.

To take Australia as an example of the developed world, mortality rates for young people aged 12-24 have halved in the past 20 years. Today, the major causes of death among this age group are, in order: road accidents, suicide, accidental poisoning (including drug overdoses) and cancer. Building on the long-term decline in infectious-disease mortality, deaths from road accidents and other injuries have fallen over the past 40 years. There has also been a decline in about the past decade or so in deaths from suicide and drugs, which had risen in previous decades.

About 70% of young people rate their health as excellent or very good. About 80-90% say they are happy and satisfied with their lives, including lifestyles, work or study, relationships with parents and friends, accomplishments and self-perceptions. About the same proportion is optimistic about their future.

With the health of youth people getting better overall, the story goes, the key goal (along with maintaining improvement) is to address social inequalities in health, which remain marked and have even sometimes increased. The focus of intervention should be on those with poorer health: the disadvantaged and socially disengaged and excluded, including poor, unemployed, poorly educated, homeless, geographically isolated and indigenous youth. This goal is closely aligned with a wider, social-justice agenda. The trends in these areas have been generally favourable in many countries because of the economic boom of the 1990s and 2000s, although the global financial crisis has now dramatically changed this picture.

So the usual narrative of young people's health and wellbeing, which provides the framework for public policy, is compelling. It is not surprising that many reports paint a positive overall picture. However, an alternative, and very different, story can be told from the evidence.

The need for a new story
The new story of young people's health and it's contribution to their wellbeing derives from two main arguments: mortality and self-reported health and happiness, which form the core of the current narrative, do not give us a complete and accurate picture of health; and socio-economic

disadvantages and inequalities are not the only, or even the most important, factors affecting health (Eckersley 2008, 2009a).

The new narrative reflects our improved understanding of how fundamental features of modern society, including those that have contributed to past progress, are now working against better health. Whereas in the past, advances in medicine and other healthcare were part of a pattern of economic and social development that improved health, they now appear to be offsetting the adverse impacts of societal changes.

Mortality rates (which are the basis of life expectancy, the dominant measure of health) do not reflect adequately the growing importance to health of chronic health problems. Death claims very few young people each year; chronic ill health affects large numbers. And while over 80% of young people say they are healthy, happy and satisfied, 40-50% experience frequent symptoms of malaise (headaches, indigestion and sleeplessness), psychological distress, or low levels of social and emotional wellbeing. While most young people are optimistic about their personal futures, an increasing majority is pessimistic about the future of society and the world, and this is also a dimension of their wellbeing.

Overweight and obesity have increased, including among children and youth, and it has become a major public-health concern in the past decade. Globally there are now more people who are overweight than underweight, and the numbers are diverging rapidly (Popkin 2007). Being overweight or obese places young people at risk of a wide range of health problems, including diabetes, heart disease, some cancers and mental illness. Significant minorities of young people already have risk factors for diabetes, heart disease and liver disease, with the overweight and obese much more likely to be at risk. The trends have led to predictions that for today's young people life expectancy will fall (National Preventative Health Taskforce 2009). (Chronic degenerative diseases such as cancer, heart disease and stroke often have a lag of decades between exposure and ill-health, between living conditions and lifestyle behaviours and the illnesses they cause; thus young people's attitudes, behaviours and lifestyles will affect their later adult health and so future population health (Eckersley 2008).)

However, the most compelling argument for a new narrative of health is based on mental health, the significance of which has been underestimated by health authorities and governments and remains neglected. Mental disorders are the biggest contributor to the burden of disease and suffering in young people (accounting for about half the burden in Australia), although they contribute little to mortality (suicide being counted under injuries) (AIHW 2007, Eckersley 2008, 2009a). While some mental illness is minor and transient, other problems can be severe and recur throughout life. The burden of chronic physical illness falls largely on the elderly, that of mental illness on younger people, so taking a higher personal, social and economic toll.

The 2007 Australian national survey of mental health and wellbeing found 26% of those aged 16-24 experienced a 12-month disorder (most commonly anxiety, substance-use and affective disorders), compared to only 6% of those 75-85 (ABS 2008). The survey may underestimate prevalence because it excluded some categories of illness, including conduct disorders, which are highest in young people. A large survey of school students aged 4-18 found that, while 89% said they were happy, about 40% scored in the lower levels of social and emotional wellbeing; between a fifth and a half said they were lonely, were very stressed, lost their temper a lot, worried too much, or had difficulty calming down when upset or controlling how depressed they got (Bernard *et al*. 2007).

While the issue remains contested, international research points to increasing rates of mental disorders among young people over time in Western nations. For example, an American study, comparing the results of a widely used psychological test, the Minnesota Multiphasic Personality Inventory, or MMPI, going back to the 1930s, found a steady decline in the mental

health of college students between 1938 and 2007 and high-school students between 1951 and 2002 (Twenge *et al*. 2010). Five times as many college students now score high enough to indicate psychological problems as they did in 1938. A British study found that English adolescents experienced considerably higher rates of emotional problems in 2006 than they did in 1986 (Collishaw *et al*. 2009). The greatest changes were for worry, irritability, fatigue, sleep disturbance, panic and feeling worn out or under strain; the more severe the reported symptoms, the larger the increase over the two decades.

The contrast between the old and new stories is graphically illustrated by these Australian statistics: about 40 per 100,000 young people die each year and the rate is falling; 26,000 per 100,000 (26%) suffer a mental disorder each year and the rate has probably risen. Which statistic says more about young people's wellbeing?

There are also several, indirect lines of evidence that support concerns about the patterns and trends in young people's health and wellbeing, and so the need for a new narrative. They include:

Widespread expert concern. The report of a recent British inquiry into childhood says it deals with the experiences of children in general rather than the problems of disadvantaged groups because 'the world in which most children grow up is more difficult than it should be' (Layard and Dunn 2009). In 2006, the British newspaper, *The Telegraph*, published a letter, signed by 110 researchers, psychologists, educators, writers and others, saying they were 'deeply concerned at the escalating incidence of childhood depression and children's behavioural and developmental conditions' (Abbs *et al*. 2006).

The perceptions and attitudes of parents and public. An Australian survey says there is a growing sense among parents that childhood is at risk because 'the daily environment in which children live is perceived to be increasingly less safe, stable and predictable'(Tucci *et al*. 2005). Another found that, overall, about 60% of adult Australians thought young people's physical and mental health was worse today than in previous generations; only about 10% thought their health was better (Auspoll 2009). Britain's Joseph Rowntree Foundation (2008) found in its public consultation on today's 'social evils' that young people were among people's top concerns - as victims or perpetrators.

The perceptions of young people themselves. The Australian Government's 'National Conversation' with young people reveals clearly the importance of health and wellbeing in their lives, especially mental health, body image, sexual health, and drug and alcohol problems (Australian Government 2010). They want government 'to respond broadly and holistically to the needs of all young people'.

Two counter issues to this picture of declining health warrant mention:

Medicalisation. Some researchers have argued that today's high rates of mental disorders reflect the 'medicalisation' of normal human emotions (Horwitz and Wakefield 2007). This is part of a wider concern about the medicalising of life itself, and 'disease mongering': widening the boundaries of illness to expand the markets for treatments (Moynihan and Henry 2006). However, medicalisation does not explain away the patterns and trends in youth health. Beyond issues of definition, diagnosis and treatment, the disability associated with mental health problems is generally higher than for other chronic conditions widely accepted as illness (Eckersley 2008).

Recent trends. Some evidence suggests adverse trends may have levelled or even improved in the past decade or so; for example, youth suicide and drug-related deaths have fallen (Eckersley 2008, 2009a, Maughan et al 2008). However, these trends need to be interpreted cautiously as broader indicators of youth health. The recent trend in youth suicide does not appear to reflect an improvement in mental health as measured by other indicators such as

hospitalisations for mental health problems and intentional self harm (which increased in Australia over the period the youth suicide rate fell). Should new evidence show improvements are real and broadly based, they may reflect increased awareness, better intervention and treatment, and improved parenting, which are offsetting adverse social pressures, and improved economic conditions (until the global financial crisis hit). They may even reveal the beginnings of social changes in attitudes, goals and values the new story seeks to encourage (Eckersley 2005)

Explanations
The new story about youth health is reinforced by the evidence about the causes and correlates of health problems and their trends over time (AIHW 2007, Patel *et al*. 2007, Eckersley 2008, 2009a, Collishaw 2009, Sweeting *et al*. 2010, AIHW 2011). They include:

Health behaviours. There have been long-term, adverse trends in a wide range of behavioural factors implicated in health: sleep, diet (processed, 'junk' food and drink and not enough fruit and vegetables), drug and alcohol use, violence, physical inactivity, risky sex and outdoor play (smoking, however, has declined).

Societal factors. Beyond individual behaviours lies a complex array of social, economic, cultural and environmental factors, including: poverty, social exclusion and inequality; changes in the family (work-life pressures, conflict and parenting); educational pressures; the growth of mass and social media; the decline of religion; changes in youth culture, leisure and entertainment (including the growth of the night-time economy); and environmental degradation (for example, chemical pollution and contamination, climate change).

Many of the explanatory factors are inter-related and linked to cultural changes in Western nations, notably greater materialism and individualism, which underpin modern consumer culture (Eckersley 2005, 2006, 2008, 2009a). These cultural factors also have more intangible, pervasive effects that affect wellbeing, including: a heightened sense of risk, uncertainty and insecurity; a lack of clear frames of reference; a rise in personal expectations and a perception that the onus of success lies with the individual; too much freedom and choice, which is experienced as a threat or tyranny; the confusion of autonomy with independence or separateness; and a shift from intrinsic to extrinsic goals such as money, status and recognition.

For example, a cultural focus on the external trappings of 'the good life' increases the pressures to meet high, even unrealistic, expectations, and so heightens the risks of failure and disappointment . It leads to an unrelenting need to make the most of one's life, to fashion identity and meaning increasingly from personal achievements and possessions and less from shared cultural traditions and beliefs. It distracts people from what is most important to wellbeing: the quality of their relationships with each other and the world, which, ideally, contribute to a deep and enduring sense of intrinsic worth and existential certainty. As Goethe warned, things that matter most must never be at the mercy of things that matter least.

The orthodox story, in focusing on structural and material factors, does not reflect the multiplicity of influences and the complexity of effects. This is apparent in the changing worlds of the family, education and work. Research often shows little if any socio-economic differences in youth mental illness (and some studies have found higher levels among the better-off); nor do socio-economic factors explain adverse trends over time (Eckersley 2008, 2009a, Collishaw *et al*. 2010, Twenge *et al*. 2010, Sweeting *et al*. 2010).

Not only parental poverty and unemployment, but also parental job quality (such as security, flexibility, control and paid parental leave) affects children's health (Strazdins *et al*. 2010). Income-rich parents are often 'time poor', and young people in rich families can face greater pressures to achieve and greater isolation (both physical and emotional) from their

parents. British research suggests parental supervision and monitoring have increased in recent decades, but parental wellbeing may have declined, and this, too, is a risk to young people's health (Nuffield Foundation 2009, Sweeting *et al.* 2010).

The worlds of education and work are similarly multidimensional. The orthodox view is that poor mental health in young people is linked to social vulnerability and disengagement, and concerns about mental health have become part of government efforts to ensure all young people are 'engaged' in either work or education. However, Australian research shows most young people who suffer mental illness are in education and work (the proportion is about the same as for those who have not been ill); even most of those with severe impairment are engaged in this sense (ABS 2010).

A major problem could, in fact, be 'over-engagement'. A recent Australian study found 48% of university students were psychologically distressed, placing them at high risk of developing or having a mental disorder (Leahy *et al.* 2010). This was more than four times the rate in non-students of the same age. Results of national surveys of American college students show that large proportions report strong negative emotions (ACHA 2009). About 30-90% had, in the last twelve months, felt: overwhelmed by all they had to do, exhausted, overwhelming anxiety, hopeless, overwhelming anger, or so depressed that it was difficult to function. About 10-50% had felt one or other of these emotions in the previous two weeks. (However, had they been asked, most of the students would have said they were happy and satisfied with their lives; most would be leading outwardly normal lives.). Thus while the usual story sees increased education as wholly positive, the new story acknowledges the pressures that come with it, especially in the context of rising expectations and competition.

The growth of media and communication technologies is another area of change that the old story of young people's health tends to underestimate. While their impacts remain debated, the mass media and social media are among the most distinctive features of modern times: powerful and ubiquitous, employing stunning technologies, dominating young people's leisure time. For all their value in entertainment, education and work, they are also powerful vehicles for adverse influences on both mental and physical health, including the encouragement and promotion of: poor diet, alcohol abuse, aggression and bullying, poor body image, sedentary lifestyles, loss of sleep, cognitive impairment, reduced social cohesion, social isolation, sexualisation of children, negative images of society and the future, invidious social comparisons, and extrinsic goals and expectations based on financial success, social status, looks and lifestyles (Eckersley 2005, pp. 126-146, ACMA 2007, AIHW 2011).

Thus a central dimension of the changed trajectory in health over recent decades, and which underpins the new story, concerns the declining significance of material and structural determinants of health and the growing importance of existential and relational factors to do with identity, belonging, certainty and purpose in life. There is a shift in emphasis from socio-economic causes of ill-health to cultural; from material and economic deprivation to psychosocial deprivation; from a problem of material scarcity to one of excess. With this has come a shift in significance from physical health to mental health.

This argument is not to suggest sharp, categorical distinctions and clear breaks from the past. Physical and mental health are closely interwoven and interdependent. Infectious diseases still matter (rates of sexually transmitted disease are rising). Disadvantage and inequality still matter. Indeed, the cultural changes of past decades may well have exacerbated their effects by making material wealth and status more important to how people see and judge themselves. Environmental problems such as climate change have serious implications, including the risk of possible catastrophic effects on human health.

Nor is the argument at the core of the new story intended to repudiate all social changes over recent decades, such as greater gender, religious, ethnic and racial equality and tolerance, better educational and other opportunities, and environmental improvements. Rather it highlights the complexity of effects and the mix of costs and benefits, especially the often subtle, indirect and delayed impacts of excessive materialism and individualism.

Implications of the new story

How societies address social problems and challenges depends on how these are represented or framed. Changing the representation, or story, of young people's health would have the immediate effect of underscoring the need to expand and improve healthcare services, which dominate current policy considerations. However, the new narrative has more profound implications, not just for young people (on which, obviously, youth research focuses), but also for society as a whole and national goals and priorities.

Staying with the old story of young people's health - health problems in youth are 'the price of progress', which is making life better for most people but at a cost to a few - means that health interventions will continue to focus on the minority of people at risk, especially the disadvantaged. Adopting a new story - recent 'progress' has harmed a substantial and growing proportion of young people to varying degrees – suggests that, in addition to specific, targeted interventions, a much broader effort is needed to change social conditions.

To give effect to the new story of young people's health, more emphasis is needed on: the 'big picture' of their changing world; total health and wellbeing, and 'living well', not a narrow focus on ill-health; the mainstream of society, not just the marginalised and disadvantaged; and developing the social and cultural, as well as economic and material, resources available to young people (Eckersley *et al*. 2006).

Possible responses across different sectors and scales include:

- *Research.* More emphasis on transdisciplinary synthesis and science communication to improve conceptual coherence, understanding and application.
- *Health.* More attention to public and mental health, especially to address the immediate need.
- *Education.* Making teaching and the curriculum more relevant to young people's world and their hopes and fears, including refocusing the goal of education on improving their understanding of the world and themselves, and so enhancing their health and wellbeing in the broadest sense.
- *Business.* Better regulation to uphold young people's right to protection from abuse, exploitation and harmful influence, especially the growing 'commodification' of childhood and adolescence: the commercial manipulation and indoctrination of young people into an unhealthy, unsustainable, hyper-consumer lifestyle.
- *Politics.* Making better health and wellbeing, broadly defined, the central purpose of government, its governing principle.

Conclusion

Over the past 20 years, there have been important gains in young people's health and wellbeing, especially in turning around rising youth suicide and drug-related deaths. However, it appears that decades of concerted policy action, health interventions and substantial increases in health spending, together with a long economic boom, have not improved more fundamental features of their health.

It is not surprising, given the complexities of social changes and their effects, that the topic is a vexed and contentious one, marked by contradictory and ambiguous evidence and disciplinary and conceptual differences. Notwithstanding these uncertainties, there is a strong case to review the usual narrative that describes young people's health and defines what is done about it.

The contrast between the old and new stories of young people's health and wellbeing is part of a larger contest between the dominant narrative of material progress and a new narrative, sustainable development (Eckersley 2005, pp. 229-251). Material progress sees economic growth and a rising standard of living as paramount; sustainable development seeks a better balance and integration of economic, social and environmental goals to produce a high, equitable and enduring quality of life.

Material progress represents an outdated, industrial model of progress: pump more wealth into one end of the pipeline of progress and more welfare flows out the other. Sustainable development reflects (appropriately) an ecological model, where the components of human society interact in complex, multiple, non-linear ways. Not only does sustainable development better fit the new story of youth health, it is likely to achieve better outcomes in relation to the old story's focus on socio-economic disadvantage and inequality because it less intent than material progress on economic growth and efficiency.

Related to this contest, the new story of youth health also challenges the orthodox story of human development, which places Western nations at its leading edge (Eckersley 2009b). It shows that the dominant measures of development – not just income, life expectancy or happiness, but also education, governance, freedom and human rights – are not enough. However desirable these things may be, they do not capture the more intangible cultural, moral and spiritual qualities that are so important to wellbeing. And it is in these respects that Western societies do not do so well.

The health of young people should be a focal point in the larger contest of social narratives. They should, by definition, be the main beneficiaries of progress; conversely, they will pay the greatest price of any long-term economic, social, cultural or environmental decline and degradation. If young people's health and wellbeing are not improving, it is hard to argue that life is getting better.

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Note: All Eckersley references are available at: www.richardeckersley.com.au. ABS, AIHW and other organisational reports are available from their websites.

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