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Editorial

Adolescents and risks: Why not change our paradigm?

In a hilarious and thought-provoking book, Bill Bryson depicts the increasing interest—if not the obsession—that American people have developed over the last decades for the prevention of risk [1]. To be fair, they share this fascination with many individuals around the world. However, European professionals involved in the field of adolescent health have generally adopted a different approach to the concept of risk.

As health professionals, we need to question some of the ideas and perceptions that underlie the concept of risk in adolescence. A great many articles in the scientific literature and in our *Journal*, including the present issue [2–7], refer to the notion of risk. Various expressions, such as risky behavior, risk-taking behaviors, psychosocial risk, and problem behavior, have been used to explore this area. In some instances, the wide use of these expressions is fraught with conceptual and ethical problems.

Conceptual issues

In reading much of the current literature, one may come away with the impression that teenagers who present identifiable risk factors are automatically risk behavior participants; conversely, readers may incorrectly assume that teenagers who do not have these risk factors are not going to be involved with risky behaviors. Clearly, this is not the case: risk factors and risk behaviors are two distinct aspects of the general concept of risk, and one cannot generalize from population-level data to the individual [7].

Behaviors depicted as risky are often ill-defined and may not inherently present risks for one's health. For instance, although it is indisputable that unprotected sex can potentially lead to the transmission of sexually transmitted infections (STIs), sexual activity in general should not be considered a risk-taking behavior, per se. Indeed, in many European countries—Switzerland in particular—sexual intercourse, at least from the age of 15 or 16 years, is considered acceptable and even part of normative adolescent behavior. Consequently, Switzerland has not developed any abstinence and abstinence-only education programs [8], and

has addressed the issue through safe-sex education since the 1970s; the rate of abortion and adolescent pregnancy remains quite low in this country [9]. In the same perspective, in countries where the consumption of legal and illegal substances is widespread and accepted, moderate use over one's lifetime is not indicative of any substantial risk. Thus, the concept of risk-taking is reserved for situations in which adolescents engage in misuse (i.e., repeated binge drinking or frequent/daily use of cannabis), an approach that is partially confirmed by the Baskin-Sommers and Sommers article in this issue [2]. For instance, several longitudinal surveys have tracked substance use over time; although vulnerable adolescents progressively develop heavier use of multiple substances, these cohort studies show that most adolescents who use substances during a certain period of their lives tend to abandon them over time [10]. Simply stated, much adolescent drug use is time-limited, and many so-called risky behaviors are essentially exploratory or experimental. This exploration is part of the individual's need to discover new sensations and conditions, to master progressively those situations that are potentially detrimental to their health or impose specific threats. Consequently, expressions such as "risk-taking adolescents" are inappropriate and provide a static view of adolescent health that ignores the importance of change and development as central processes of adolescence.

Furthermore, although the clustering of risk behaviors has been well established in some groups, it is not the norm. The results of several studies suggest that the "risk behavior syndrome" theory may be specific to some contexts, thus more related to cultural determinants than to the adolescent status itself [7]. For instance, as far as sexual behavior is concerned, we have demonstrated that Swiss adolescent dropouts who are heavy drug consumers use condoms as often as their counterparts involved in professional training and high school [11]. In fact, this absence of a clear correlation between sexual "risky behavior" and substance misuse is one of the conclusions of the Baskin-Sommers and Sommers article in this issue of the *Journal* [2]. It would thus appear that the concept of clustering has to be applied with caution.

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Ethical issues

Risk behaviors appear to arise more from situations that bring new, unexpected challenges to an inexperienced young person, than to characteristics inherent to the individual. Focusing on risk-enhancing situations rather than on risk behaviors underlines the impact of environmental factors and context on health. For example, research has shown that migrant youth tend to be more “at risk” than their indigenous peers, at least in some areas [12]. Inherent to some of the studies in this area is the idea that the behavior of migrant adolescents is linked with specific individual characteristics, while in fact the host society may subtly or overtly create unsupportive surroundings and atmosphere. The same may apply to other subpopulations, such as socially marginalized young people. For instance, we have demonstrated that substance misuse among adolescent drop-outs is more a consequence than a cause of unemployment [13,14], a conclusion shared by Scandinavian authors [15]. Undeniably, we have to understand that there are aspects of adolescent behavior that constitute the only possible outcome in some extreme situations. For instance, for individuals who live in poverty, behaviors that are usually considered deviant may represent a solution for survival.

Over the last two decades, our conceptualizations of health and illness have evolved. Violent behaviors or the use of illegal substances are increasingly considered to reflect ill health rather than simple transgression. Lifestyle has become a central concept in the field of adolescent medicine and health. The time has come to stop concentrating exclusively on risk behaviors of young people, and thereby ignoring the devastating effect that this approach has had on the way the adult population looks at youth [16]. As we have tried to outline, stigmatization of “deviant” behavior and a focus on individual risk factors is ethically questionable. Often, when one’s behavior does not conform to social norms, and when illness results, public perception is that the individual caused his or her illness, ignoring or deflecting societal responsibilities—the so-called “blaming the victim” tendency. This contradiction appears problematic or even hypocritical to many adolescents. Indeed, in a world where they are overwhelmed with hypersexual advertising, television, and Internet content, why should we ask them to abstain from sexual intercourse [8,17]? Why ask our teenagers to be prudent, while we promote high-speed vehicles in every other media campaign? The concept of risk places too much emphasis on individual responsibility for health, ignoring the collective responsibility of the society in promoting dangerous behaviors. Moreover, it implies that a negative definition of health influences the way we, as health professionals, work with adolescents. Too often, risk is used as a static concept, dismissing the fact that exploration and experimentation are important aspects of the adolescent developmental process.

Implications

As certain authors have pointed out, one simple way to address the limitations of the risk paradigm would be to adopt expressions such as “exploratory” or “experimental” for behaviors that are common during adolescence but do not inherently lead to health-compromising situations, such as safe sex, moderate consumption of alcohol or cannabis, or even extreme sports such as rock climbing or off-piste snowboarding [17–21]. More than a simple change in terminology, the adoption of these expressions would imply a shift in our conceptual framework, a change in our attitude towards adolescents’ behavior. This paradigm shift entails that we, as health professionals, instead of labeling behaviors as risky, attempt to understand the role, the meaning of the motives, and the potential consequences of these behaviors for each teenager. Such a paradigm shift has implications in the fields of clinical care, research, public health, and policy. Indeed, exploring the adolescent’s resources instead of systematically targeting problems and burdens is a way to boost autonomy: it allows the adolescent patient to participate actively in their treatment in developing their own solutions [22]. The training curriculum developed by the European team called EuTEACH provides one example of an approach that gives as much importance to the assessment of risks as it does to resources [23].

In the field of research, an example of this conceptual attitude is provided in this issue by the Zask et al article [6] in which the authors managed to include in their study both harmful as well as so-called protective behaviors. Focusing on protective factors and more broadly on adolescent competencies and the support of their surroundings is promising, as shown by the growing interest in resilience [24] which reflects the person’s capacity to master difficult situations and which includes important perceptive variables such as moral/religious beliefs or family and social connectedness [25]. One important question linked with such a conceptual shift from risk towards resource- and resilience-oriented research is that it implies a broadening of the scope of outcomes measures. Within the field of resource-based clinical approaches to health promotion, we are no longer dealing only with discrete behaviors, such as unplanned pregnancy or substance misuse, but rather the development of wide-ranging concepts such as that of well-being [26]. One way to assess health in a holistic way is to concentrate on the subject’s quality of life, the subject of several articles in this issue [27–29]. As other authors have before, Raju et al convincingly demonstrate that it is possible to evaluate the quality of life of individuals as young as eight years of age [29,30]. Moreover, these authors show that it is feasible to use this instrument across various cultural and linguistic backgrounds in relation to healthcare needs and use of healthcare services. As two other articles in this issue reveal, the assessment of quality of life can be correlated

various outcomes, such as perceived satisfaction with services or morbidity [27,28].

Finally, as demonstrated in areas such as substance use and misuse, public health interventions should place less emphasis on risk and danger and more emphasis on life skills, thus increasing the margin of safety within which experimental behaviors occur [31,32]. In other terms, rather than preventing behaviors, more and more youth-focused interventions attempt to enhance healthy development of young people through interventions that promote a safe and encouraging environment. The Gatehouse project, which has been run for several years in Melbourne, Australia, is a good example of an intervention that focuses on resources, connectedness, and well-being instead of problems and risks [33]. Interestingly, this approach seems to reduce substance use in those schools that have implemented the program, in comparison with control schools [34].

In conclusion, one of our crucial tasks is to advocate a positive attitude toward youth on the part of our colleagues and administrators, our politicians, the media, and the general public. Shifting the paradigm from risk-taking adolescents to adolescents who are exploring the world will enable us to advocate for youth from a positive position.

Pierre-André Michaud, M.D.
Associate Editor
Lausanne, Switzerland

References

- Bryson B. The risk factor. In: *I'm a Stranger Here Myself*. New York, NY: Broadway Trade Paperback, 2000:85–8.
- Baskin-Sommers A, Sommers I. The co-occurrence of substance use and high-risk behaviors. *J Adolesc Health* 2006;38:609–11.
- Huber JC, Carozza SE, Gorman DM. Underage driving as an indicator of risky behavior in children and adolescents. *J Adolesc Health* 2006;38:612–6.
- Mattila VM, Parkkari JP, Rimpelä AH. Risk factors for violence and violence-related injuries among 14- to 18-year-old Finns. *J Adolesc Health* 2006;38:617–20.
- Youngblade LM, Curry LA, Novak M, et al. The impact of community risks and resources on adolescent risky behavior and health care expenditures. *J Adolesc Health* 2006;38:486–94.
- Zask A, van Beurden E, Brooks LO, et al. Is it worth the RRISK? Evaluation of the RRISK (Reduce Risk Increase Student Knowledge) program for adolescents in rural Australia. *J Adolesc Health* 2006;38:495–503.
- Jessor R. Risk behavior in adolescence: a psychosocial framework for understanding and action. *J Adolesc Health* 1991;12:597–605.
- Santelli J, Ott MA, Lyon M, et al. Abstinence and abstinence-only education: a review of U.S. policies and programs. *J Adolesc Health* 2006;38(1):72–81.
- Narring F, Roulet N, Addor V, Michaud PA. Abortion requests among adolescents in comparison with young adults in a Swiss region (1990–1998). *Acta Paediatr* 2002;91(8):965–70.
- Chen K, Kandel D. The natural history of drug use from adolescence to the mid-thirties in a general population sample. *Am J Public Health* 1995;85:41–7.
- Michaud PA, Delbos-Piot I, Narring F. Silent dropouts in health surveys: are nonrespondent absent teenagers different from those who participate in school-based health surveys? *J Adolesc Health* 1998;22(4):326–33.
- Brindis C, Wolfe AL, McCarter V, et al. The associations between immigrant status and risk-behavior patterns in Latino adolescents. *J Adolesc Health* 1995;17(2):99–105.
- Ferron C, Cordonier D, Delbos Piot I, et al. La santé des jeunes en rupture d'apprentissage: une recherche-action sur les modalités de soutien, les déterminants de la santé et les facteurs favorisant une réinsertion socio-professionnelle. Lausanne: Institut Universitaire de Médecine Sociale & Préventive; 1997.
- National Research Council, Panel on High-Risk Youth. *Losing Generations: Adolescents in High-Risk Settings*. Washington, DC: National Academy Press, 1993.
- Hammarstrom A. Health consequences of youth unemployment. *Public Health* 1994;108(6):403–12.
- Irwin CE Jr. Adolescent health at the crossroads: where do we go from here? *J Adolesc Health* 2003;33:51–6.
- Tomkiewicz S. Les conduites de risque et d'essai. *Neuropsychiatr Enfance* 1989;37:261–4.
- Brown JD, Halpern CT, L'Engle KL. Mass media as a sexual super peer for early maturing girls. *J Adolesc Health* 2005;36:420–7.
- Arietei, ed. *S. American Handbook of Psychiatry, Vol 2: Caplan, ed. G. Child and Adolescent Psychiatry, Sociocultural and Community Psychiatry*. New York, NY: Basic Books, 1974.
- Irwin CE Jr, ed. *Adolescent Social Behavior and Health*. San Francisco, CA: Jossey-Bass, 1987.
- Irwin CE Jr, Vaughn E. Psychosocial context of adolescent development: study group report. *J Adolesc Health Care* 1988;9:11S–9S.
- Michaud P. La résilience: un regard neuf sur les soins et la prévention. *Arch Pédiatr* 1999;6:827–31.
- Michaud PA, Stronski S, Fonseca H, Macfarlane A. The development and pilot-testing of a training curriculum in adolescent medicine and health. *J Adolesc Health* 2004;35(1):51–7.
- Luthar S, Cicchetti D, Becker B. The construct of resilience: a critical evaluation and guidelines for future work. *Child Dev* 2000;71(3):543–62.
- Resnick MD. Protective factors, resiliency, and healthy youth development. *Adolesc Med* 2000;11(1):157–64.
- Ottawa Chart for Health Promotion; An International Conference. Ottawa, ON: Health and Welfare Canada, 1986.
- Grant J, Cranston A, Horsman J, et al. Health status and health-related quality of life in adolescent survivors of cancer in childhood. *J Adolesc Health* 2006;38:504–10.
- Mah JK, Tough S, Fung T, et al. Adolescent quality of life and satisfaction with care. *J Adolesc Health* 2006;38:607.e1–607.e7.
- Rajmil L, Alonso J, Berra S, et al. Use of a children questionnaire of health-related quality of life (KIDSCREEN) as a measure of needs for health care services. *J Adolesc Health* 2006;38:511–8.
- Raphael D, Rukholm E, Brown I, et al. The Quality of Life Profile—Adolescent Version: background, description, and initial validation. *J Adolesc Health* 1996;19(5):366–75.
- Botvin GJ. Preventing drug abuse in schools: social and competence enhancement approaches targeting individual-level etiologic factors. *Addict Behav* 2000;25(6):887–97.
- Griffin KW, Botvin GJ, Nichols TR, Doyle MM. Effectiveness of a universal drug abuse prevention approach for youth at high risk for substance use initiation. *Prev Med* 2003;36(1):1–7.
- Bond L, Patton G, Glover S, et al. The Gatehouse Project: can a multilevel school intervention affect emotional wellbeing and health risk behaviours? *J Epidemiol Community Health* 2004;58(12):997–1003.
- Bond L, Thomas L, Coffey C, et al. Long-term impact of the Gatehouse Project on cannabis use of 16-year-olds in Australia. *J Sch Health* 2004;74(1):23–9.

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