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Commentary on Trzesniewski and Donnellan (2010): A transdisciplinary perspective on young people's wellbeing

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Abstract

The health and wellbeing of young people are important not only for their own sake, but also to the future health of populations and societies. Yet the debate about the patterns and trends in young people's wellbeing, and their causes, is marked by uncertainty and contradiction. This paper draws on evidence from trend analyses, cross-sectional studies, research on explanatory factors, expert opinion, and public-attitude surveys, to argue that social changes of the last half century have harmed successive generations of young people because of their developmental vulnerability; and that these young people have carried their enhanced risk into later life.

Key words: adolescents, health, trends, youth, well-being

Introduction

There are three possibilities for the trends in young people's wellbeing in many Western nations, including the United States, over the past several decades: wellbeing has improved, it has declined, or it has remained much the same. Each possibility has its proponents who claim supporting evidence.

Trzesniewski and Donnellan (2010, this issue) favor the last, arguing there has been remarkably little change in psychological profile of high school seniors between 1976 and 2006. Much of their paper concerns technical questions of the analysis and interpretation of psychological data; it covers a wide range of psychological constructs, going beyond measures of wellbeing; and it questions, in particular, the notion that the current generation of young people (or at least those born after 1970) is unique in its (poor) psychological status.

In contrast, I will argue in favor of the second possibility – declining wellbeing. I will bypass the statistical technicalities; focus on wellbeing measures; and argue that changing social conditions of last half century have harmed successive generations of

young people because of their developmental vulnerability; and that these young people have carried their enhanced risk into older age. (As I understand it, this is a combination of period effect, age effect and cohort effect – *Figure 1*.)

My approach is based on transdisciplinary synthesis (Eckersley, 2007a). Instead of creating new knowledge to improve our understanding of the world through empirical research, synthesis involves combining existing knowledge from various disciplines and fields to this end. In particular, I look for coherence in the overall picture, rather than precision in the empirical detail.

I do not dismiss the need to seek greater rigour, but synthesis offers another, complementary path that allows us at least partially to side-step the many ‘ifs’ and ‘buts’ that apply to specific research findings (as this debate makes so clear). It also enables us to move beyond limited disciplinary boundaries and perspectives. Different disciplines develop different models for studying the world, which generate different research questions, produce different results and lead to different interpretations of reality.

Direct and indirect streams of evidence on wellbeing

The evidence I present draws on several different lines of research, so allowing a form of ‘triangulation’ on the central question of trends in young people’s health and wellbeing and their causes: time-trend analyses; cross-sectional studies; research into various explanatory factors and their trends; expert opinion; and attitude surveys. I acknowledge much of the evidence is indirect and circumstantial. Nevertheless, when the various streams of evidence are taken together, they produce a coherent and compelling (if still provisional) picture of declining resilience and wellbeing among young people. More detailed accounts of the evidence and arguments are provided elsewhere (Eckersley, 2005, 2006, 2007b, 2008, 2009, in press).

Time-trend analyses show increases in psychological distress in young people. A British study (Collishaw, Maughan, Goodman, & Pickles, 2004) found increases in adolescent conduct and emotional problems between 1974 and 1999. The preliminary results from a more recent analysis (Collishaw, Pickles, Natarajan, & Maughan, 2007) shows that English adolescents experienced considerably higher rates of emotional problems in 2006 than they did in 1986, with the differences becoming more marked with increasing severity of symptoms.

Putnam (2000, pp. 263-265) showed malaise (a composite measure of headaches, indigestion, and insomnia) had increased since the 1970s, with successively younger age groups showing larger increases. For those aged 18 to 29, the proportion ranking high on symptoms of malaise rose from 31% to 45%. Sweden, the model social democracy that performs well in international comparisons of young people’s wellbeing, has not been immune to the adverse trends, with research showing mental health has declined from at least the 1980s to the early 2000s (Hjern, 2006; Stefansson, 2006).

Youth suicide rates, especially for males, increased between the 1960s and 1990s in many Western nations, tripling or more among males aged 15 to 24 in the US, Australia, Canada and New Zealand (*Figure 1*) (Eckersley, & Dear, 2002). While

male youth suicide has fallen in all four countries since then, the evidence suggests this is because more young people are seeking and getting help, not that fewer need help. In Australia, psychological distress among young people and hospitalizations of young people for intentional self-harm and emotional and behavioral problems increased over the period that suicide fell (Eckersley, 2007b, 2008, in press). However, I acknowledge not all trend studies have found increased psychological problems.

Cross-sectional studies show high levels of social and emotional problems among youth, higher than in older age groups. The US National Comorbidity Survey Replication (Kessler, Berglund, Demler, Jin, & Walters, 2005) found the estimated lifetime risk of clinical mental disorders increased for successive generations: those aged 18 to 29 had an estimated lifetime risk four times that of those aged 60 and over. The increases were ‘at least partly due to substantive rather than methodological factors’. An Australian national mental health and wellbeing survey (ABS, 1998) found those aged 18-24 had the highest 12-month prevalence of mental health problems (27%), with the rate declining with age to 6% for those aged 65 and over.

A US study (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007) found 47% of a community sample of adolescents engaged in some form of non-suicidal self-injury within the past year, 28% at a moderate or severe level, and averaging 13 incidents of self-harm. A large Australian survey (Bernard, Stephanou, & Urbach, 2007) of students aged 4 to 18 found over 40% scored in the lower levels of social and emotional wellbeing.

In Australia (and this would be broadly true of the United States and other similar nations), mental disorders are by far the largest contributor to the burden of disease among young people, accounting for half the total burden, measured as both mortality and disability (*Figure 2*). It is possible, but improbable, that it was ever thus, and we are only now discovering the extent of the problems.

[Insert Figures 1 & 2 about here.]

Trends in social factors implicated in mental health predict a decline in wellbeing. Many social factors have been associated, through both empirical research and scholarship, with psychological health problems, although the associations remain contested in some cases (Eckersley, 2005, 2006, 2007a, 2007b, 2008, 2009, in press). They include: family conflict and breakdown, work-life pressures, poverty and inequality, media, religion, cultural qualities such as materialism and individualism, diet, and chemical pollution. Past changes in many of these explanatory factors imply worsening psychological health. (Of course, there have also been social improvements, including greater gender, religious, ethnic and racial equality and tolerance; and environmental improvements, such as cleaner urban air and water. I am focusing here on the explanations for the apparent decline in wellbeing.)

Many professionals in child and adolescent health and development express concerns about young people’s wellbeing. On 9 September 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 behavioral and developmental conditions’ (Abbs

et al., 2006). On 10 September 2007, the same newspaper published a second letter, this time with 270 signatories, which drew attention to the importance of play – ‘particularly outdoor, unstructured, loosely supervised play’ – to children’s health and wellbeing (Abbs et al., 2007). ‘Many features of modern life seem to have eroded children’s play’, the letter states.

Public opinion surveys show growing concerns about social conditions and trends. Many studies over the past decade, both qualitative and quantitative, reveal levels of anger and anxiety about changes in society that were not apparent thirty years ago (Eckersley, 2005, pp. 105-125). The studies show many people are concerned about the materialism, greed and selfishness they believe drive society today, underlie social ills, and threaten their children’s future. They yearn for a better balance in their lives, believing that when it comes to things like individual freedom and material abundance, people don’t seem ‘to know where to stop’ or now have ‘too much of a good thing’.

A US survey (Center for a New American Dream, 2004) found large majorities believed that the country was not focused on the right priorities, with too much emphasis on work and money and not enough on family and community; and that American society was too materialistic, with serious consequences for children, society, the environment and the world. Surveys of young people also reveal concerns about social trends and future prospects, with implications for their wellbeing (Eckersley, Cahill, Wierenga, & Wyn, 2007).

Evidence for adaptability, or flawed data?

Where do the findings of the Trzesniewski-Donnellan paper fit into this picture? That young people’s psychological profile appears to have changed so little despite all the social changes of the past thirty years would seem to support Dostoyevsky’s comment that we are beings who will become accustomed to everything. Certainly, as a species, humans show remarkable resilience and adaptability, so in this sense the findings could be ‘real’. It is also worth noting that the authors are challenging not only the ‘declining wellbeing’ school of thought, but also the orthodox or official view of health authorities (at least in Australia) that young people today are much healthier than previous generations (based on declining mortality and high levels of self-reported health and life satisfaction) (Eckersley, 2007b, 2008, in press).

However, there are a number of qualifications that need to be made about the meaning and significance of the paper’s findings. The base year of 1976 is not ‘pre-impact’ in terms of social changes and their psychological effects. Indeed, taking youth suicide as an indicator, the sharpest rise in the US occurred between about 1960 and 1980 (Eckersley, & Dear, 2002).

Happiness and life satisfaction are not adequate or complete measures of psychological wellbeing. One of their puzzling features is their stability over many decades of profound social change; they seem to reveal differences between groups, but not between times. Is this a measure of adaptability in the absence of the day-to-day social comparisons that influence happiness and shape cross-sectional differences? Measures of happiness and life satisfaction also contrast markedly with other, more comprehensive measures of wellbeing and illbeing (Eckersley, 2008). In

the Australian survey (Bernard et al., 2007) that found 40% of students showed low social and emotional wellbeing, 89% said they were happy. Another study (Smart, & Sanson, 2005) found that over 80% of young people were satisfied with their lives – including lifestyle, work or study, relationships with parents and friends, accomplishments and self-perceptions; yet 50% were experiencing one or more problems associated with depression, anxiety, anti-social behaviour and alcohol use (including illicit-drug use and frequent binge-drinking).

Psychological measures seem highly sensitive to the wording used. Happiness measures are relatively stable over time, as noted, but Swedish research found marked increases between 1988 and 2002 in the percentages of boys and girls who said they often or always felt unhappy (Hjern, 2006). Trzesniewski and Donnellan's findings of, at best, 'subtle' cohort effects contrast with the marked shifts in annual surveys of new college students in the rated importance of various life goals. These include a near doubling to over 70% since 1970 of the proportion saying that being 'very well off financially' was very important or essential (Putnam, 2000, pp 259-260; Myers, 2001, pp. 127-128). Likewise, it is doubtful that some of the other indicators used in their analysis, such as that for individualism, are adequate for the task; other studies show a rise in individualism (eg, Halpern, 1995).

Trzesniewski and Donnellan caution against the ecological fallacy, where associations at a population or group level are applied at the individual level. But there is also a danger of the individualistic fallacy, where analyses at the individual level are inappropriately used in seeking to determine environmental causes of disease and disorder (Eckersley, & Dear, 2002). When it comes to societal responses to health issues, rather than individual actions, the population is the more appropriate level of analysis. As Rose (1992) has noted from an epidemiological perspective, causes of cases can differ from causes of incidence; in other words, explanations for health differences between individuals may be different from those for differences between populations.

I can give an interesting example of this, one where, as the authors state, the correlation can change sign as we move from one level to another. A colleague and I (Eckersley, & Dear, 2002; Eckersley, 2005, pp. 170-184) found strong positive correlations between youth suicide rates in developed nations and several measures of individualism, including young people's 'freedom of choice and control over their lives'. Other research, however, has shown that individuals with a high sense control (measured as locus of control) are less likely to be suicidal – that is, the correlation is negative. Thus, while this individualistic orientation may serve individuals well, at the population (or societal) level it may reduce social cohesion and support, leading to more personal isolation and alienation, and so to higher suicide rates. (Another possibility is that the population indicators of individualism were measuring independence or separateness, which is not the same thing as autonomy or control, and may even reduce it.)

Conclusion

In summary, I do not believe that Trzesniewski and Donnellan have settled the debate about the trends in young people's psychological wellbeing, despite the purported rigour of their analysis; rather, they have added to the uncertainties and contradictions

that already bedevil the issue. Indeed, the task of unraveling these trends and their drivers may be beyond science, such is their complexity. Is precise measurement possible of inherently imprecise phenomena, which are both highly subjective and involve multiple entities interacting in often weak, diffuse and non-linear ways? On the other hand, transdisciplinary synthesis handles this ‘fuzziness’ well (Eckersley, 2005, pp. 8-15, 2007a). The totality of the evidence, both direct and indirect, presents a picture of declining psychological health among young people that is more coherent and consistent than a picture of improvement or stasis.

The health of young people is not only important in its own right, or for their sake; it is crucial to assessing the overall state and future of nations. The young reflect best the tenor and tempo of the times by virtue of growing up in them. Because of their stages of biological and social development, they are most vulnerable to social risks and failings. Many of the attitudes and behaviours - even the illnesses - that largely determine adult health have their origins in childhood, adolescence and early adulthood.

Thus the health of young people shapes the future health of the whole population and, in a broader social sense, the health of society. We cannot wait for scientific ‘proof’, which may always remain beyond our reach, before taking political action – in health, education and the media, for example - to address the social and cultural forces harming young people’s health and wellbeing.

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Figures

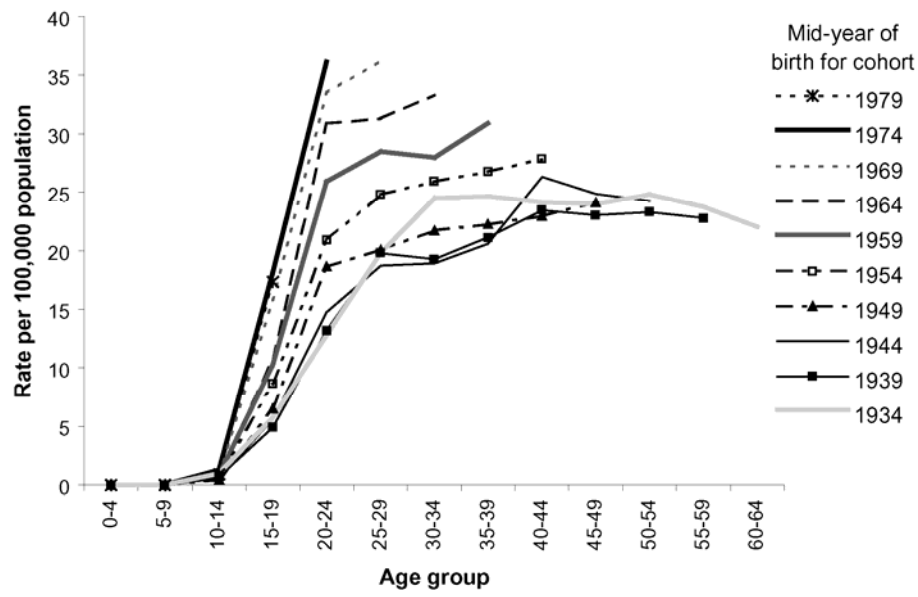


Figure 1: Male suicide by age and birth cohort, Australia (Steenkamp, & Harrison, 2000).

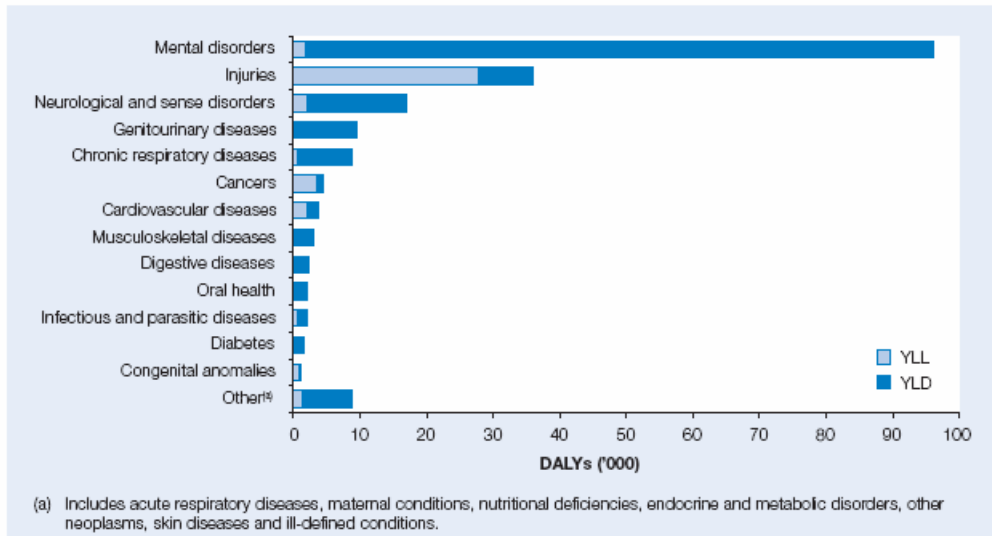


Figure 2. Burden of disease by major disease groups for Australians aged 15-24, 2003. DALYs, disability-adjusted life years, represent lost years of healthy life; YLL, years of life lost, measures premature death due to disease or injury; YLD measures years of healthy life lost due to disease, disability or injury (AIHW, 2007, p. 20).