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Progress, culture and young people's wellbeing

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INTRODUCTION

The orthodox view of young people's health and wellbeing is of continuing improvement, in line with historical trends. In this chapter, I argue against this view because it over-estimates the importance of declining death rates and underestimates that of adverse trends in a range of non-fatal, chronic health problems, both physical and mental. These problems have their sources in quite fundamental features of modern societies, and optimizing wellbeing will mean making correspondingly fundamental social and cultural changes.

Young people reflect best the tenor and tempo of the times because they are growing up in them. Because of their stages of biological and social development, they are also most vulnerable to social risks. Many of the attitudes and behaviours - even the illnesses - that largely determine adult health have their origins in childhood, adolescence and early adulthood. So the health of young people shapes the future health of the whole population: their health is not only important in its own right, or for their sake, it is crucial to assessing the overall state and fate of societies.

I define health very broadly to include all aspects of wellbeing, not just clinical disease, disorder and disability. I use the terms 'health' and 'wellbeing' somewhat interchangeably and sometimes together to emphasize their many dimensions: illness and wellness, physical and psychological, objective and subjective. My focus, however, is on mental health and wellbeing; physical health is discussed in Chapter XX.

Conceptual framework

Much of the evidence on which I draw comes from epidemiology. The analysis is informed by a psychosocial theory of health which states that the social determinants of health, and health inequalities, are not primarily, or fundamentally, material - resulting from differences in material exposures and experiences - but psychosocial - stemming from people's position in the social hierarchy and their perceptions of relative disadvantage (Eckersley 2006a). I have extended this theory beyond socio-economic inequality and disadvantage - the focus of epidemiology - and applied it to culture: that is, cultural factors can also influence people's perceptions and expectations, reducing social support and personal control, and causing stress, depression, anxiety, isolation, insecurity and hostility.

However, the way I think of culture - as a system of meanings and symbols that shape how people see the world and their place in it and give meaning to personal and collective experience - owes more to anthropology than to epidemiology, which

understands 'culture' mainly in categorical terms of 'subcultures' or 'difference', especially ethnic and racial, and so, often, as one dimension of socio-economic status (Eckersley 2006a). On the other hand, anthropologists are often sceptical of the notion that whole societies can be characterized by a few dominant themes, such as materialism and individualism. Instead, they focus on the details of population patterning and distribution, individual and group differences, and culture as local knowledge and daily life. So I also take from psychology and sociology, disciplines in which these cultural qualities are a major focus of research.

PATTERNS AND TRENDS IN YOUNG PEOPLE'S WELLBEING

Consistent with a belief in human progress, the orthodox, or official, view of young people's health (and health generally) is that it is continuing to improve. For example, Lomborg (2001: 351-2), in a statistical assessment of the state of the world, concludes that humanity's lot has improved vastly in every significant measurable field and that it is likely to continue to do so: '...children born today – in both the industrialized world and developing countries – will live longer and be healthier, they will get more food, a better education, a higher standard of living, more leisure time and far more possibilities...'

At the national level, to take Australia as an example of the developed world, the official position, as articulated by the Australian Institute of Health and Welfare (AIHW 2004: 187), is that young people generally enjoy a level of health that is good and getting better. A corollary is that, with overall health improving, attention needs to be focused on those disadvantaged groups that lag behind (AIHW 2007: x).

Historically, the health of young people follows the overall trends in population health (Eckersley 2005). The toll of infectious diseases has fallen as a result of improved hygiene, nutrition and living and working conditions, and medical advances such as antibiotics and vaccines. The dramatic rise in life expectancy, which globally has more than doubled in the last 100 years, is one of humanity's greatest achievements. Mortality rates continue to decline, including among children and youth, and life expectancy to rise.

While mortality might have been a valid indicator of overall health historically, this is now questionable (especially in developed nations, but also increasingly in developing nations). Mortality and life expectancy do not reflect adequately the growing importance to health and wellbeing of non-fatal, chronic health problems. Nor is this shift in importance simply a result of the success in reducing mortality, or more (or better) diagnoses of chronic conditions. Modern medicine has contributed to the 'measurement problem' in keeping more people alive, but without, in many cases, preventing or curing disease and disability. However, there is increasing evidence that chronic problems are becoming more common for other reasons to do with changing lifestyles and social conditions. Just as we often wrongly equate quality of life with standard of living, we confuse how well people live with how long they live.

There are, therefore, growing 'scale anomalies' in generalizing about health trends from mortality rates. The figures for Australia illustrate this well. On the one hand, death now strikes only about 40 out of every 100,000 young people (0.04%) each year, so falling

mortality affects few people (AIHW 2007: 64). Moreover, the biggest cause of death among young Australians today is road accidents, and the drop in the road toll explains much of the decline in their mortality in recent decades. This has been a result of factors such as better roads, safer cars, seat belts and random breath tests, and says little about overall health and general living conditions.

On the other hand, large national studies have found that 27% of Australians aged 18-24 experienced mental health problems in the previous year - the highest prevalence of all age groups – and that 14% of children and adolescents (aged 4-17) were suffering mental health problems at the time of the survey (Eckersley 2005: 154-5, Eckersley, in press). Among Australians aged 15-24, mental disorders now account for 49% of the burden of disease, measured as both death and disability (and 61% of the non-fatal burden) (AIHW 2007: 20-1). This is by far the biggest contribution, well ahead of the next most important contributor, injuries, at 18%.

Research in several developed countries suggests 20-30% of young people are experiencing significant psychological distress at any one time, with less severe stress-related problems (including frequent headaches, stomach pains and sleeplessness) affecting as many as 50% (Eckersley 2005: 147-69). Long-term trends in mental ill-health are very difficult to establish conclusively because of the lack of good, comparative data, and the issue remains contentious; not all studies show an increase. However, the evidence, both direct and indirect, taken together, produces a coherent and compelling, if still provisional, picture of declining psychological resilience and wellbeing. For example:

- A major US study has shown almost a half of Americans will experience a clinical mental disorder during their lives, and over a quarter will do so in any one year (Kessler, Chiu et al 2005, Kessler, Berglund et al 2005). The lifetime risk increases for successive generations: people aged 18 to 29 have an estimated lifetime risk four times that of those aged 60 and over.
- A UK study of health surveys carried out in 1974, 1986 and 1999 found a rise in some mental health problems among both boys and girls aged 15-16 (Collishaw et al 2004). Overall, the prevalence of conduct problems increased from 7% to 15%, and that of emotional problems from 10% to 17%. The preliminary results from a more recent analysis of English health survey data from 1986 and 2006 also show that today's adolescents experience considerably higher rates of emotional problems, with the increases becoming more marked with increasing symptom severity (Collishaw et al 2007).
- Swedish data suggest mental health has declined among children and youth, at least since the late 1980s (Hjern 2006, Stefansson 2006). The proportions of boys and girls who said they were often or always felt unhappy rose markedly between 1988 and 2002. In 2001-2, 20-30% of boys aged 11-15, and 30-40% of girls, said they experienced every week one or more psychosomatic symptoms such as

abdominal pains, headaches and disturbed sleep; the proportions have increased continuously since the mid-1980s.

- A large Australian survey of students from prep school to year 12 found that about 40% of students could be described as displaying lower levels of social and emotional wellbeing (ASG 2007). From a fifth to a half of students said they: were lonely, worried too much; were very nervous or stressed; had recently felt hopeless and depressed for a week and had stopped regular activities; lost their temper a lot; and had difficulty calming down when upset (indicating poor resilience).

Findings such as these not only challenge the picture presented by declining mortality, they run counter to other evidence that is used to support the orthodox view of young people's wellbeing: most say they are happy and satisfied with their lives. An Australian study found that over 80% of young people aged 19-20 were satisfied with their lives – including lifestyle, work or study, relationships with parents and friends, accomplishments and self-perceptions. However, 50% were experiencing one or more problems associated with depression, anxiety, anti-social behaviour (including illicit drug use) and alcohol use (Smart and Sanson 2005). The explanations for the apparent contradiction are complex, and include that evaluating one's happiness involves illusions, rationalization and mitigation, and that 'unhealthy' moods and behaviours do not necessarily equate to unhappiness and dissatisfaction (Eckersley, in press).

EXPLANATIONS

An introductory commentary on a series of paper on adolescent health in the medical journal, *Lancet*, states the papers incorporate three fundamental principles: rapidly changing social contexts promulgate new and sometimes unexpected health threats; health and ill-health are understood best as a result of the complex interplay between biological, psychological and sociological factors; and the sociological factors have global reach in their effect on young people (Resnick and Bowes 2007). A wide range of such factors has been implicated in the patterns and trends in young people's health and wellbeing (Eckersley 2005, in press):

- Changes in the worlds of family, work and education such as family conflict and breakdown, poverty and unemployment, job stresses and insecurity, and education pressures (the most commonly cited factors).
- Cultural changes – for example, excessive materialism and individualism (discussed later), and the emergence of a youth culture that isolates young people from adults and increases peer influence.
- Increased media use and changing media content, linked to violence, consumerism, loss of community and social cohesion, vicarious life experiences, invidious social comparisons, and pessimism about global conditions and futures.
- The decline of religion, which 'packages' many sources of wellbeing, including social support, spiritual or existential meaning, a coherent belief system and a clear moral code (paradoxically, at a population or national level, research suggests religion is a health burden).

- Changes in diet, which have been implicated in many chronic health problems. For example, a large increase in the ratio of omega 6 to omega 3 fatty acids has been linked to cardiovascular disease and mood disorders.
- Comorbidity, especially between drug use and mental illness, but also between mental and physical problems such as the links between obesity and depression, and depression and heart disease.
- Environmental degradation, including widespread toxic chemical pollution, which affects neurological development and immune function.

Environmental changes loom large as a future risk to health, including mental health, especially global warming and its consequences. A major WHO report (Corvalan et al 2005) warns that the dual trends of the growing exploitation of ecosystems and their generally declining condition are unsustainable. There is an increasing risk of ‘non-linear changes’ in ecosystems, including accelerating, abrupt and potentially irreversible changes, which could have ‘a catastrophic effect on human health’.

There are several important points to note about these explanatory factors:

- They interact with other biological and social factors to produce individual, age and generational differences.
- The health effects are not usually independent, direct and immediate; rather the causal pathways are complex, effects being often interdependent, indirect, delayed, and spanning different levels or layers of causation.
- Trends in some factors provide indirect corroboration of evidence that psychosocial problems have risen among youth.
- Some of the factors that explain social patterns of health may not be implicated in the trends over time.

The last is especially important in extending explanations beyond the usual social and economic focus. Studies typically show socio-economic gradients in mental health problems (that is, higher prevalence in lower-income and single-parent and blended families). However, the UK research (Collishaw et al 2004, 2007) on time trends shows the rise in problems occurred across all family types and social classes, as does the Swedish research (Stefansson 2006) with socio-economic status. This suggests changes in these areas are not the main reasons for the trends.

Materialism, individualism and cultural fraud

The more fundamental explanatory factors include the defining features of modern Western culture, materialism and individualism (Eckersley 2005:77-104, 2006a). Research shows materialism (the pursuit of money and possessions) breeds, not happiness, but dissatisfaction, depression, anxiety, anger, isolation and alienation. People for whom ‘extrinsic goals’ such as fame, fortune and glamour are a priority in life tend to experience more anxiety and depression and lower overall wellbeing - and to be less trusting and caring in their relationships - than people oriented towards ‘intrinsic goals’ of close relationships, personal growth and self-understanding, and contributing to the community.

As materialism reaches increasingly beyond the acquisition of things to the enhancement of the person, the goal of marketing becomes not only to make people dissatisfied with what they have, but also with who they are. As it seeks evermore ways to colonize their consciousness, consumer culture both fosters and exploits the restless, insatiable expectation that there must be more to life. In short, the more materialistic people are, the poorer their quality of life.

Individualism (the relaxation of social ties and regulation and the belief that people are independent of each other) is supposed to be about freeing people to live the lives they want. Historically, it has been a progressive force, loosening the chains of religious dogma, class oppression and gender and ethnic discrimination, and so associated with the liberation of human potential. However, individualism is a two-edged sword. As sociologists have noted, the freedom people have is both exhilarating and disturbing: with new opportunities for personal experience and growth also comes the anxiety of social dislocation.

The costs of individualism relate to a loss of social support and personal control, both of which are important to resilience and wellbeing. These include: a heightened sense of risk, uncertainty and insecurity; a lack of clear frames of reference; a rise in personal expectations, coupled with a perception that the onus of success lies with the individual, despite the continuing importance of social disadvantage and privilege; a surfeit or excess of freedom and choice, which is experienced as a threat or tyranny; increased self-esteem, but of a narcissistic or contingent form that requires constant external validation and affirmation; and the confusion of autonomy with independence or separateness.

Mistaking autonomy for independence (or, to put it somewhat differently, redefining ‘thinking *for* ourselves’ as ‘thinking *of* ourselves’.) encourages a perception by individuals that they are separate from others and the environment in which they live, and so from the very things that affect their lives. The more narrowly and separately the self is defined or construed, the greater the likelihood that the personal influences and social forces acting on people are experienced as external and alien. The creation of a ‘separate self’ could be a major dynamic in modern life, impacting on everything from citizenship and social trust, cohesion and engagement, to the intimacy of friendships and the quality of family life. It is no accident that the drugs most popular among youth today – such as alcohol and party drugs like ecstasy - are those that dissolve the boundaries of the self and induce a sense of belonging, a merging with others, so easing the pain of isolation.

In summary, the evidence suggests that individualism and materialism are powerfully and mutually reinforcing in their negative impacts. Broadly speaking, it would seem that they have produced a self that is socially and historically disconnected, discontented, insecure; pursuing constant gratification and external affirmation; prone to addiction, obsession and excess. Large numbers of people are medicating themselves to ‘take the edge off the 21st century’, to use one expression. We see these failings clearly in the lives of Hollywood-style celebrities, whose glamour, fame and wealth are so often a glittering veneer over deep insecurities, addictions and self-absorption.

Thus one of the most important and growing costs of our modern way of life is ‘cultural fraud’: the promotion of images and ideals of ‘the good life’ that serve the economy but do not meet psychological needs or reflect social realities. To the extent that these images and ideals hold sway over us, they encourage goals and aspirations that are in themselves unhealthy. To the extent that we resist them because they are contrary to our own ethical and social ideals (and to public health messages), they are a powerful source of dissonance that is also harmful to health and wellbeing.

Material progress and sustainable development

Most, if not all, of the explanatory factors are associated with a particular form or model of national development, material progress, which focuses on economic growth and material welfare ((Eckersley 2005, Eckersley 2006b). Together with other evidence, the factors point to a state of ‘overdevelopment’, where social changes that were once beneficial to health have now become harmful. The various lines of evidence represent an intricate and complex web of cause and effect. They show that material progress does not simply and straightforwardly make people richer, so giving them the freedom to live as they wish. Rather, it comes with an array of cultural and moral prerequisites and consequences that affects profoundly how people think of the world and themselves, and so what they do.

The costs to health and wellbeing can no longer be regarded as unfortunate side-effects of a model of progress whose major effects remain largely beneficial; they are a direct and fundamental consequence of how societies and cultures define and pursue progress. Consequently, material progress is coming under growing challenge from a new model, sustainable development, which does not accord economic growth overriding priority. Instead, it seeks a better balance and integration of social, environmental and economic goals and objectives to produce a high, equitable and enduring quality of life.

CONCLUSION

I have argued that, notwithstanding the complexities and uncertainties, the totality of the evidence suggests that fundamental social, cultural, economic and environmental changes are impacting adversely on young people’s health and wellbeing, especially in Western societies. These changes make it harder for young people to feel accepted, loved and secure; to know who they are, where they belong, what they want from life, and what is expected of them: in short, to feel life is worthwhile and meaningful.

There are several reasons why such a broad analysis of whether or not life is getting better or worse for young people is warranted:

Research: The broad perspective is important as a framing or conceptual device. However elusive a definitive answer might be, the question generates questions that otherwise would not be asked. It encourages more transdisciplinary dialogue and synthesis, creating new perspectives and insights into many, more specific, issues about health.

Health: Whether young people's health is located within a social world that is improving or deteriorating will determine what approaches we should take to health. If quality of life is improving for the majority, attention can legitimately be focused on the minority at risk; if not, then health promotion must include broader social reforms. The picture I have presented is despite huge increases in health expenditure in rich countries, from an average 5% of GDP in 1970 to 9% in 2004 (OECD 2005); prevention and public health programs receive only about 3% of this expenditure. This trend is unsustainable and some reallocation of resources is essential.

Society: We manage our societies with the aim of making progress, of increasing quality of life; we need to consider, and weigh, the patterns and trends in health and wellbeing in judging if this is the case. If young people's wellbeing is improving, then this challenges a major theme in contemporary social criticism; if it is declining, this substantially weakens the case for continuing on our present path of social development, a central tenet of which is that health is continuing to improve.

Historically, health professions, notably medicine, have been part of a broad, progressive movement that has increased life expectancy and quality of life. Today, they appear to be, at best, countering the growing harm to health of adverse social trends. At worst, they are becoming part of the problem because of an emphasis on a biomedical model that focuses on the treatment of individual cases of disease, at the expense of a social model of disease prevention and health promotion.

This emphasis limits the political significance of health. The politics of health is seen largely as the politics of healthcare services; it should be the politics of everything, the defining goal of government. The central purpose of our present social system is to create wealth; we need to make that purpose to create health. Making this change requires more than a change in policies. It means rethinking 'the defining idea' of how we make life better, redesigning the conceptual framework, or worldview, within which policy decisions are made.

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