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Troubled youth: an island of misery in an ocean of happiness, or the tip of an iceberg of suffering?

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Abstract

Aim: To critically examine the orthodox view that young people's health and wellbeing are continuing to improve in line with historic trends.

Methods: Transdisciplinary synthesis is used to analyse and integrate a wide range of evidence on young people's health and wellbeing. Synthesis seeks coherence in the overall conceptual picture rather than precision in the empirical detail.

Results: The orthodox view rests mainly on declining mortality among teenagers and young adults, and findings that most say they are healthy, happy and satisfied with life. With health improving for most, the focus of attention is on social inequalities in health. However, mortality rates understate the growing importance of non-fatal, chronic health problems, especially mental illness; self-reported health and happiness are flawed indicators of overall wellbeing. Evidence suggests that rates of mental illness in young people have increased over time, and are higher than in older age groups. Explanatory factors include quite fundamental features of modern societies, which go beyond inequality and disadvantage; trends in these factors predict a deterioration in health and wellbeing.

Conclusion: Contrary to the dominant view that young people have never been healthier, their health and wellbeing may have declined over several generations. Which perspective is right has important implications for understanding and addressing youth mental health problems, implications that go well beyond medical interventions.

Key words

culture, mental health, young people, wellbeing

Introduction

As a broad generalisation, perceptions about young people's health and wellbeing fall into two clusters framed by two questions. Are those children, adolescents and young adults with serious health problems a small minority, while life continues to improve for the majority? Or do the serious problems of the few say something about young people as a whole, including the possibility of a decline in health and wellbeing over successive generations? With respect to mental health in particular, are troubled youth an island of misery in an ocean of happiness, or the tip of an iceberg of suffering?

The 'official story' conforms to the first view. It argues that, overall, the health and wellbeing of young people are continuing to improve in line with historic trends. This orthodoxy is implicit in the broad narrative of progress that characterises the times.^{1,2} It is explicit in statements by government agencies. The Australian Institute of Health and Welfare, for example, states: 'Most young Australians are in good health, as indicated by self-reported health status, and relatively low and declining morbidity and mortality'.³ Or, as it also says: 'Children under 15 years are generally much healthier than in previous generations, with a fall in their death rates of over 90% over the past 100 years and a halving over the past two decades'.⁴

A corollary is that, with overall health improving, attention needs to be focused on social inequalities in health, which remain marked and have even increased in some instances. As the Institute notes: 'While most young people in Australia are doing well, there are areas where further gains in health and wellbeing could be made, particularly among young indigenous Australians, young people in regional and remote areas and young people suffering socioeconomic disadvantage.'⁵

I want to argue against the orthodox position, while acknowledging the complexity of the picture of young people's health and wellbeing. In summary, I believe the conventional view overestimates the importance of declining death rates and underestimates that of adverse trends in a range of non-fatal, chronic health problems, especially mental disorders. These problems have their sources in quite fundamental features of modern societies, which go beyond socio-economic inequalities and disadvantage. Which 'story' is right has profound implications for how society addresses youth mental health problems.

My focus is on developed nations, where concerns about youth mental health are widespread (even Sweden, the model social democracy, has experienced adverse trends).^{1,2} However, the issues raised in the paper are also becoming increasingly relevant to developing nations as globalisation and modernisation transform their societies and the lives of their people.

Streams of evidence

My case is based on a transdisciplinary synthesis of several lines of research findings: evidence that youth have higher rates of mental disorder than older age groups; evidence of increased mental illness over time; widespread expert concern about young people's health and wellbeing; the perceptions and attitudes of parents and public about young people; and, finally, the evidence on explanatory factors and their trends, which predict a deterioration in health and wellbeing. I focus here on the first two and the last.

Synthesis emphasises the coherence of the overall conceptual picture rather than the precision of the empirical detail. I acknowledge that each stream of evidence can be challenged or open to other interpretations: for example, not every time-trend study has found a rise in disorders; reported increases might result from a greater willingness to admit to problems or mistakes in recall; high prevalences and professional concerns have been attributed to increased diagnosis and the ‘medicalisation’ of normal human emotions; parental and public perceptions might reflect changing attitudes to, or greater awareness of, the problems associated with ‘being young’. However, taken together, the evidence presents a compelling picture of increased and widespread psychological problems in young people (some recent evidence suggests trends may have plateaued in about the past decade).^{1,2}

About a quarter of older teens and young adults suffer a clinical mental disorder each year; perhaps a similar proportion experience psychological distress at a sub-clinical level.^{1,2} Prevalence declines with increasing age. 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 (Figure 1).⁶ Mental disorders are the largest contributor to the ‘burden of disease’ in young Australians aged 15-24, measured as both years of life lost due to premature death and years of healthy life lost due to disease, disability and injury (Figure 2).^{2,5} They account for almost half the burden, far more than the second biggest contributor, injuries; very little of this suffering is reflected in mortality rates (the burden of suicide and intentional self-harm is included under injuries).

[Insert Figures 1 & 2 about here.]

Most mental illness begins in adolescence and early adulthood and the burden of mental ill-health is carried mainly by younger people in the most productive years of life, increasing the personal, social and economic costs. In contrast, the burden of chronic physical diseases such as cancer, stroke and heart disease falls predominantly on the elderly.²

A survey of more than 10,000 Australian students from prep school (age 4-6) to year 12 (age 17-18) found that about 40% of students displayed lower levels of social and emotional wellbeing.⁷ Between a fifth and a half of students said they: were lonely (18%); had recently felt hopeless and depressed for a week and had stopped regular activities (20%); were very stressed (31%); had difficulty controlling how depressed they got (32%); lost their temper a lot (35%); worried too much (42%); and had difficulty calming down when upset (48%).

Recent results of national surveys conducted by the American College Health Association show that large proportions of students report strong negative emotions for both the previous twelve months and the previous two weeks.⁸ For example, 87% in the last twelve months (and 54% in the last two weeks) had felt overwhelmed by all they had to do; 82% (50%) had felt exhausted; 49% (19%) had felt overwhelming anxiety; 47% (17%) had felt things were hopeless; 39% (12%) had felt overwhelming anger; and 31% (10%) had felt so depressed that it was difficult to function.

Such figures are shocking, even hard to believe, and exactly what they mean for young people's health and wellbeing is not clear. They are certainly not the whole story of young people's lives. Had they been asked, 80-90% of the students would have said they were happy and satisfied with their lives;^{2,7} most would be leading seemingly normal lives: attending lectures, completing assignments, working, partying and dating. At the same time, these findings reveal something about being young today, including specific social problems such as youth violence and binge-drinking.

Twenge et al, 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 2002.⁹ Five times as many college students now score high enough to indicate psychological problems as they did in 1938. The increases translate into a greater likelihood of characteristics such as moodiness, restlessness, dissatisfaction and instability; unrealistically positive self-appraisal, overactivity and low self-control; feeling isolated and misunderstood; sensitivity and sentimentality; and being narcissistic, self-centred and antisocial.

Another new study by Collishaw et al found that English adolescents experienced considerably higher rates of emotional problems in 2006 than they did in 1986, especially girls.¹⁰ 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.

Both these studies address limitations of many earlier studies. For example, they use comparable data; they do not rely on recall of past episodes of illness; the MMPI allows researchers to test for changes in socially desirable and defensive responding; and the trend variations by symptom and severity in the Collishaw study also make it unlikely such changes account for the increased prevalence.

Explanations

What explains these patterns and trends? There are many possible social factors that research has implicated, although the strength of the evidence varies and it is often contested; in many cases, the associations are correlational rather than causal. The factors include: poverty, social exclusion and inequality; changes in the family, such as work-life pressures, conflict and poor parenting; increasing media and technology effects that promote violence, envy, consumerism, fear, social isolation and unrealistic expectations; the decline of religion, which 'packages' many sources of wellbeing; dietary changes, notably less nutritious, processed and 'junk' food; environmental degradation, including toxic chemical contamination; increased drug and alcohol use; and population-level personality changes such as increased neuroticism and narcissism, and less self-control.¹¹ Linked to many of these are cultural changes in Western nations, notably greater materialism and individualism, and it is on these that I will focus.^{1,2,11}

Of course, there have also been social improvements, including greater gender, religious, ethnic and racial equality and tolerance; and some environmental improvements, such as cleaner urban air and water in the developed world (notably

reduced lead pollution). I am focusing in this section on explanations for the apparent decline in health, especially mental health.

Rising materialism and individualism are defining characteristics of modern Western culture.^{1,2,11,12} Both have conferred benefits to people, including to their health and wellbeing. However, there is growing evidence of diminishing benefits and rising costs. The costs 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; the confusion of autonomy with independence; and a shift from intrinsic to extrinsic motivation.

Twenge and her colleagues considered – and rejected – the possibility that economic factors were responsible for the trends in MMPI scores that they discovered.⁹ Instead they favoured a cultural explanation – in particular, the shift from intrinsic to extrinsic values and goals. An intrinsic orientation means doing things for their own sake.^{9,13} Intrinsic goals tend to meet basic human needs for competence, affiliation and autonomy. They are ‘self –transcending’ and good for wellbeing.

An extrinsic orientation means doing things in the hope or expectation of other rewards, such as status, money and recognition. It is ‘self-enhancing’ in the sense of being concerned with self-image. It is not good for wellbeing. A focus on the external trappings of success and ‘the good life’ increases the pressures to meet high, even unrealistic, expectations, and so the risks of failure and goal conflict.

The results of regular surveys over more than forty years of how American college students rate the importance of various life goals support such a shift in motivation.^{14,15} The biggest changes in the proportion of students who said the goals were very important or essential have occurred with the two goals of ‘developing a meaningful philosophy of life’ and ‘being very well off financially’. Meaning declined in importance by almost half during the 1970s and 1980s, while money almost doubled to become the highest rated goal (trends have remained relatively stable since).

The change is not just a matter of greater vanity, selfishness and greed (although many people express concerns about these traits).¹ It is something deeply existential and relational, about how people think of life and how they see themselves in relation to others and the world, and this profoundly affects their wellbeing. Australian novelist Ruth Park, in describing growing up in New Zealand during the Depression, says of young people then: ‘Whatever hardship came our way was all on the outside. Inside we knew, without doubt, that Life was aware of us and somehow had us in its care’.¹⁶ She does not elaborate, but she is not talking specifically of God or religion; she appears to be describing a sense of intrinsic worth and existential confidence.

There are other streams of research and scholarship that enhance this picture. Deresiewicz, in a literary essay on solitude, observes that the contemporary self wants to be recognised, connected, visible.¹⁷ ‘This is how we become real to ourselves – by being seen by others. The great contemporary terror is anonymity.’ He lays blame on media technologies, not so much for creating this situation, but for exacerbating it. ‘If

boredom is the great emotion of the TV generation, loneliness is the great emotion of the Web generation. We lost the ability to be still, our capacity for idleness. They have lost the ability to be alone, their capacity for solitude.'

A related, more complex, perspective comes from sociology, linked to concepts of social integration and alienation. For example, Selznick argues that modernity tends towards 'cultural attenuation', with a shift away from densely textured structures of meaning to less concrete, more abstract forms of expression and relatedness.¹⁸ 'Modernity, especially in its early stages, is marked by an enlargement of individual autonomy, competence, and self-assertion. In time, however, a strong, resourceful self confronts a weakened cultural context; still later, selfhood itself become problematic.'

These perspectives on the causes of declining wellbeing among young people are echoed in recent studies. A report of an inquiry by the Children's Society in Britain says it deals with the experiences of children in general because the world in which most children grow up is more difficult than it should be.¹⁹ It points the finger at an 'excessive individualism', which holds that people's main duty is to make the most of themselves and to be as successful as possible, 'a struggle of each against all'.

Stavropoulos, writing from the combined (and unusual) perspectives of political science and psychotherapy, says that depression reveals 'the strain and effect of living with the disjuncture between the individualist "ideals" of liberalism and the relational reality of our lives'.²⁰ The depressed often berate themselves for failing to live up to these 'ideals', she says. Focusing on the individual experience alone artificially detaches people from the wider sociopolitical context, which never ceases to influence emotional wellbeing. 'Recognising the politics of depression is a prerequisite of its healing.'

In a broad analysis of the health impacts of modern Western culture, I have argued that one of the most important and growing costs of modern life is 'cultural fraud': the promotion of images and ideals of 'the good life' that serve the economy but do not meet psychological needs, nor reflect social realities.¹² To the extent that these images and ideals hold sway over people, they encourage goals and aspirations that are in themselves unhealthy. To the extent that people resist them because they are contrary to their own ethical and social ideals (and, indeed, health promotion messages), these images and ideals are a powerful source of dissonance that is also harmful to health and wellbeing.

Conclusion

If health professions accept the 'island of misery' hypothesis - that is, mental health problems in youth are the price of progress, making life better for most people but at a cost to a small minority - then societies are justified in focusing health interventions on the minority of people at risk. If, on the other hand, they choose the 'tip of an iceberg' hypothesis that I have argued for - that is, modern Western societies are harming a substantial and growing proportion of young people to varying degrees because they are failing to meet basic human needs - then societies need, in addition to specific interventions, a much broader effort to reform, even transform, themselves.

An epidemiological perspective supports the 'tip of the iceberg' position in showing that there is a relation between the mean of a health characteristic in a population and

the prevalence of the related disorder.²¹ If social changes have increased the overall population risk of mental illness (the mean), then more people will fall within the high-risk end of the population distribution, and this high-risk group will grow and keep replacing itself - so making more demands on mental health services - until society acts to reduce the population risk.

To address this situation, there needs to be more emphasis on: the ‘big picture’ of young people’s 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 social and cultural, as well as economic and material, resources.²²

Possible responses across different sectors and scales include: (health) more emphasis on public and mental health, especially to address the immediate need; (research) more funding for science synthesis and communication to improve understanding and application; (education) refocusing its goal on wellbeing in the broadest sense; (business) better regulation to uphold young people’s right to protection from abuse, exploitation and harmful influence; (politics) making better health, not greater wealth, the central purpose of government; and (culture) creating a new narrative of sustainable development, which seeks a better balance and integration of social, economic and environmental goals than is achieved by the current dominant narrative of material progress.²

Thus addressing youth mental health extends far beyond the usual roles and responsibilities of health professionals. Nevertheless, it is important they appreciate the broader, social dimensions of the challenge. They are the main source of information about the issue for governments, the media and the public. Social conditions will determine the demand for their services. And, finally, the social perspective may help them to understand better the causes of mental disorders and so to improve the interventions they devise and apply.

Acknowledgments

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Captions

Figure 1. Prevalence of selected mental disorders, Australia . 2007.

People aged 16-85 years who met criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months prior to interview. A person may have had more than one mental disorder.⁶ (Reproduced with permission from ABS.)

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.⁵ (Reproduced with permission from AIHW.)

Figure 1

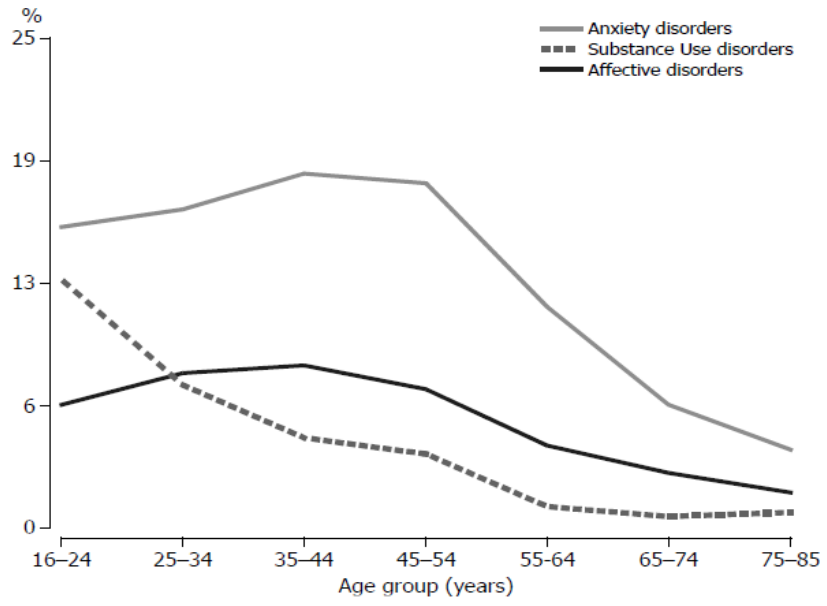


Figure 2

