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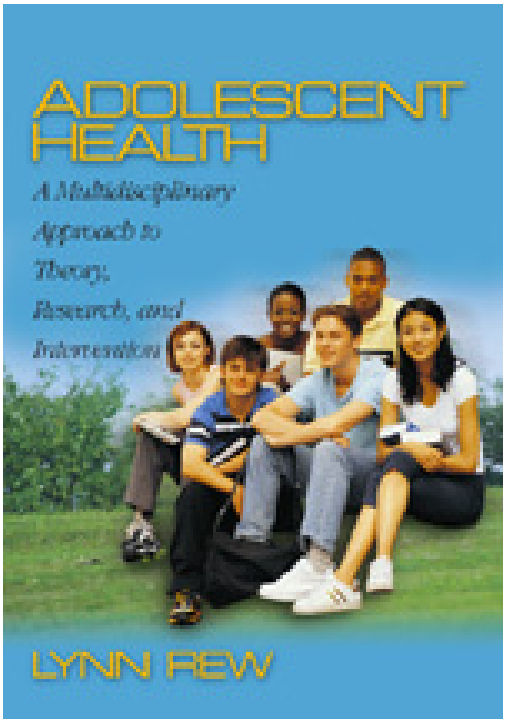

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Adolescent Health: A Multidisciplinary Approach to Theory, Research, and Intervention

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Front Matter

Chapters

Back Matter

Dedication

This book is dedicated to my twin children, Richard and Carina, who safely navigated their adolescence to become competent, caring, and compassionate young adults.

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Foreword

How refreshing to find a single volume that not only tells us where we've been, but clearly illuminates the critical pathways we must travel for the foreseeable future of interdisciplinary adolescent health research. A generation of insights has led us to some inescapable truths: No one discipline has a monopoly on the theories, methods, and skills needed to adequately describe and understand the health, behaviors, and social contexts of youth. Breadth of perspective is a necessary ingredient for scholars and practitioners alike who are engaged in the science and skills of adolescent health. And our learners, more diverse than ever before, are in need of accessible yet sophisticated material that grounds them in a field characterized by rapidly expanding boundaries and a dazzling array of theory and methods to guide and propel their research.

It would have been so much easier to write a book like this one 20 years ago—but even then, it would have been a daunting task. Instead, Dr. Lynn Rew, with the insights of a clinician and the imagination of an adolescent health researcher unfettered by disciplinary parochialism, has provided us with a thoughtful and comprehensive work that will, at once, accomplish two things: It will guide and inspire learners at multiple levels, and it will provide well-organized and richly articulated material for the teachers of that interdisciplinary audience.

In this last generation, we have nurtured a group of adolescent health investigators who often lack formal schooling in relevant theory and the skills and logic of theory testing. For many, that lack of formal preparation is offset to a large extent by a substantial dose of practical wisdom arising from clinical and programmatic interactions with young people. However, the transition to scholarly sensitivities requires deliberate instruction that is often lacking among those who have not grown up through the mechanisms of classic academic research training. This volume does an extraordinary job of helping such learners understand theory as a guide to and framer of their understanding. Rew also thoroughly grounds the reader in contemporary threats to the health of young people, the principles of adolescent development, and the organized response to those health threats as reflected in national objectives to improve the health of young people.

Through a well-orchestrated and thoughtful progression, this book provides us with the theories to frame our questions and the language to give those questions real substance and application. This work helps us to reach across the divides of discipline-specific thinking and methods and leaves us enriched, ultimately, and better able to collaborate with each other. Our field, and the needs of young people, deserve no less.

Michael D.Resnick Ph.D. Professor and Director of Research, Division of General Pediatrics and Adolescent Health, Director, Healthy Youth Development, Prevention Research Center, University of Minnesota

Acknowledgments

I am grateful to many professional colleagues, friends, and family members for their support while I was writing this book. Dr. Lorraine Walker, professor in the School of Nursing at The University of Texas at Austin, is not only the author of the theory construction book on which most of Chapter 2 of this book is based, but provided encouragement and review as I began to put my ideas into words. She is a wonderful role model and friend. Dr. Kay Avant also reviewed chapter 2 and provided helpful comments. Dr. Sharon Horner is another colleague who consistently provided “reality checks” for me, and I appreciate her thoughtful critique and support throughout this writing process.

Not only did I receive critiques and support from my peers, I also received these gifts from my doctoral student, Jane Kass-Wolff, and three of my research assistants, Dann Coakwell, Kate Jackson, and Lou Riesch. They all completed their work in such a way that I was freed up many afternoons to go home and write. I had also learned that Dann Coakwell had great computer skills in drawing figures, so I hired him to work on the weekends, drawing some of the original figures that are in this text. Then there is Margaret Hill, Assistant Dean for Administration at the School of Nursing: I learned that she was also interested in my writing project and was willing to be employed part-time on weekends to proofread the first drafts of chapters. Her eagle eye and gracious support were a great help.

A book like this does not happen without significant guidance and wisdom from the publisher. I must take this opportunity to thank Dan Ruth at Sage for his assistance in introducing me to Jim Brace-Thompson and Karen Ehrmann. I had worked with Dan for about 6 years as editor of the *Journal of Holistic Nursing* when I told him about my idea for this book. He immediately put me in contact with Jim, and the ensuing association with these folks has been wonderful.

None of this would have happened without the mentorship of Michael Resnick from the University of Minnesota and my husband, dick (yes, he prefers the lower case spelling of his name—something left over from late adolescence, being a math major in college, and differential equations). These two men have nurtured me in phenomenal ways, each providing just the right balance between challenge and opportunity. They believed in my vision, my creativity, and my ability to produce.

Finally, I especially want to acknowledge a family friend, John Langford, who provided a sincere and thoughtful blessing when the book was completed.

All of these individuals placed their fingerprints on early drafts of this book, but, more important, each made

an indelible print on my heart. We rarely take the opportunities we have to thank the important people in our lives. So my last words of thanks must go to my parents, Charles and Clara Cannon. I am thankful that they did not abandon me when I went through my adolescence and that, at 88 years of age, my mom still has the patience to listen to me and to care about my work.

Introduction

The 1995–1996 academic year was a defining time period in my professional development. Metaphorically speaking, you could say it was the adolescent phase of my professional development. With funding for a Faculty Research Award from The University of Texas at Austin and a senior fellowship award (1 F33 NR07126–01) from the National Institute of Nursing Research, National Institutes of Health, I participated in a multidisciplinary postdoctoral program at the University of Minnesota School of Medicine. Working with internationally known and caring mentors such as Robert W. Blum, Michael D. Resnick, Lyn H. Bearinger, and Cheryl Perry, I was able to redirect my identity as a researcher and focus my research program on adolescent health-risk behaviors. Not only did I improve and increase my research skills, I also began to connect with an incredible network of researchers, educators, and practitioners in this fascinating field. Through this network I have fielded many questions about the existence of a comprehensive textbook of theories about adolescent health and health-risk behaviors suitable for graduate students in various disciplines. At last, I decided to submit a prospectus to Sage Publications, Inc., for such a book. Their reviewers really liked the idea; thus I've done my best to turn that dream into a reality.

Writing a book for readers from a variety of disciplines has been a great challenge. The size limitations of the book meant that I had to make critical choices in determining which theories to include and which to leave out. Also, although I am clearly not an expert on all the theoretical perspectives and models that are found in this text, I hope I have given enough details to motivate students and their mentors to think more broadly and deeply about the science of adolescent health.

Adolescent Health and Health-Risk Behaviors

Adolescent health is a topic of great interest to members of several professions. In fact, it is probably of greater interest to us than it is to adolescents themselves. Compared to their parents, who may exchange information with friends and coworkers about how to avoid specific diseases such as cancer or how to reduce complications of chronic illnesses such as diabetes mellitus or hypertension, adolescents spend little time discussing their health with one another. Yet adolescents engage in activities on a daily, sometimes hourly, basis that may threaten their immediate safety or their long-term health and well-being. Patterns of health-risk behaviors established in this critical stage of development such as overeating, smoking, and minimal physical activity can have long-term health consequences. What is the health status of adolescents in America at the dawn of the 21st century?

Overview of Adolescent Health Status

The current health status of America's youth may be assessed in several ways. *Morbidity* refers to those conditions that are considered to be pathological or threatening to a person's health; *mortality* refers to conditions that cause a person's death. Morbidities include both acute and chronic conditions, such as upper respiratory infections (acute), which are common among all adolescents, and asthma (chronic), which is not common among most adolescents.

Another way to assess the health status of adolescents is to identify their access to and use of health-care services and institutions (Ozer, Park, Paul, Brindis, & Irwin, 2003). Remaining healthy over time may be related to periodic examinations by a health professional; routine prophylaxis, such as dental cleaning or immunizations; and judicious application of technology, as in the use of x-rays and surgical techniques to detect and set broken bones. Access to these resources, however, depends on the adolescent's knowledge of them and familiarity with how to use them. Access also depends on the ability to pay for services, either with cash or through health insurance. For millions of American adolescents, neither of these options is available.

Still another way of viewing the health status of adolescents is to examine those behaviors that increase the risk for morbidities or mortalities. These behaviors have been identified by many different terms, including *problem behaviors, risk-taking behaviors, deviant behaviors, risky behaviors*, and *health-risk behaviors*. This group of behaviors is related, either directly or indirectly, to the major mortalities of youth. And many of these

behaviors lead directly or indirectly to chronic health problems. Finally, the overall health of adolescents may be assessed by examining indicators of well-being as reported by the Federal Interagency Forum on Child and Family Statistics (2002). According to this report, indicators of adolescents' well-being include economic security, mortality rates, birth rates for adolescents, cigarette use, and violent crime victimization and offending.

Health Status

Health status refers to the meaning that individuals and groups ascribe to their personal experiences of health. With respect to adolescent health, various groups may ascribe very different meanings to similar experiences. In general, adults, particularly parents, may be more concerned than their adolescent children are about developing good health habits or a healthy lifestyle. Parents may also underestimate their adolescent children's involvement in health-risk behaviors (Stanton et al., 2000). Similarly, adult professionals, such as teachers, psychologists, nurses, and physicians, may attach still other meanings to health status. The teacher may be concerned about how an adolescent's chronic illness interferes with his or her cognitive development and academic progress. The psychologist may focus on the way stress is expressed as somatic complaints. Nurses and physicians may anticipate health problems before they occur and provide guidance to parents and youth to help them avoid predictable threats to health and well-being.

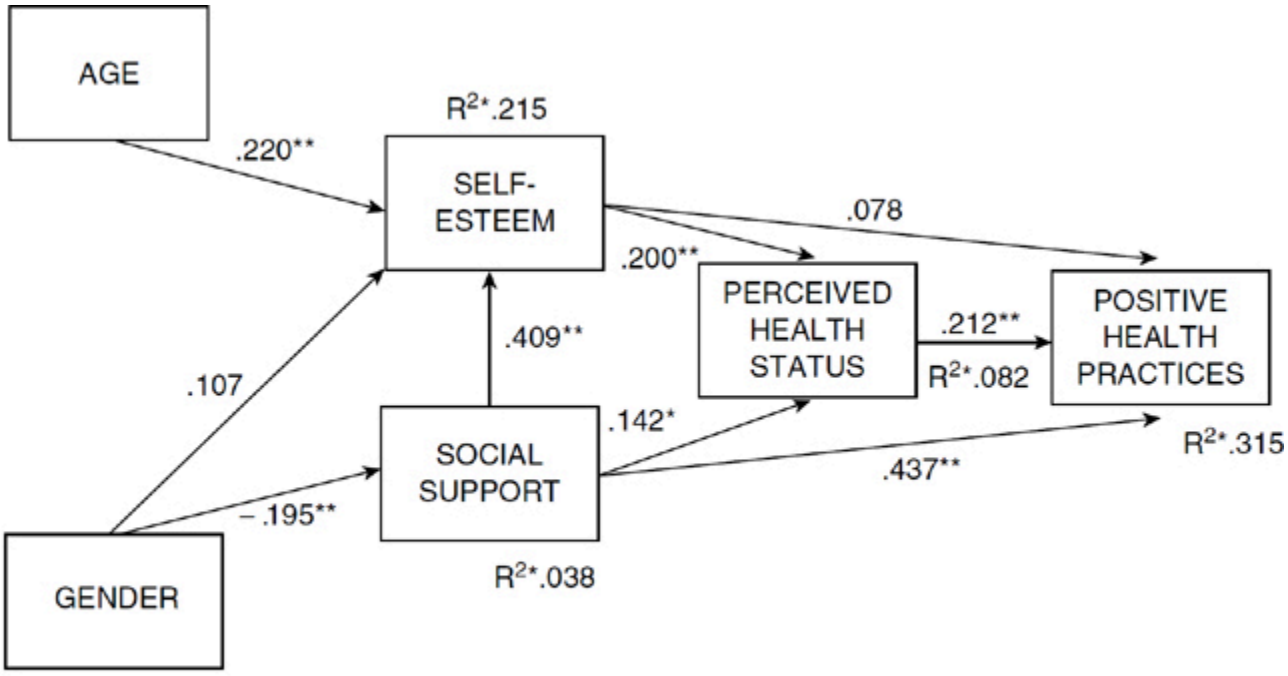
Adolescents themselves have their own view of how healthy they are, which is often not congruent with the views held by the adults in their lives. Their concerns about health are unique to their developmental stage. Other variations are related to gender, ethnicity, and socioeconomic status. Perceptions of health status among adolescents are also related to their beliefs and knowledge about health and their feelings of invulnerability to adverse health outcomes (Millstein, 1993). In this chapter, recent research about adolescent health status and associated health-risk behaviors is presented to provide the context for the remainder of the book, which focuses on the role of theories and conceptual frameworks to guide further scholarship and intervention development in multiple adolescent health disciplines.

Perceived Health Status in Adolescents

Perceived health status has been hypothesized as a factor that influences positive health practices among adolescents. Yarcheski, Mahon, and Yarcheski (1997) tested two alternate causal models to test this hypoth-

esis. With data from a sample of 202 adolescents (91 males and 111 females) who were between 15 and 21 years old (M = 18.65 + 2.24), they tested the models through structural equation modeling, using the LISREL 7 program. The goodness-of-fit index and the adjusted goodness-of-fit index were 0.99 and 0.98, respectively, indicating good fit with the data. Results of testing the first model did not support the proposed direct and indirect effects among theoretical variables. However, the second model, shown in Figure 1.1, showed significant direct effects of self-esteem and social support on perceived health status and significant direct effects of perceived health status and social support on positive health practices.

Figure 1.1 A Model of Positive Health Practices in Adolescents



* $p < .05$; ** $p < .01$.

SOURCE: Yarcheski et al. (1997). Reprinted with permission.

Meaning of Health to Adolescents

Adolescence, roughly defined as the second decade of life, is a time of transition and experimentation. It is a time when children undergo multiple physical, social, psychological, and cognitive changes that propel them toward physical maturity and an adult lifestyle. Adolescence is viewed as consisting of three general develop-

mental stages: (a) early adolescence, from 10 to 13 years old; (b) middle adolescence, from 14 to 17 years old; and (c) late adolescence, from 18 to 21 years old (Radzik, Sherer, & Neinstein, 2002). On the whole, adolescents enjoy relatively good health. In the 21st century, they can reap the benefits of scientific technology that protects them from the ravages of deadly communicable diseases, such as polio, smallpox, and scarlet fever. Nonetheless, some have been born with conditions that create chronic health problems, such as those associated with spina bifida or cerebral palsy. But these are the exceptions rather than the rule.

The concept of health is evolving and has been defined in a number of ways by members of various disciplines. The World Health Organization (WHO, 1946) emphasizes wholeness in its definition: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (p. 100). Another definition of health is “the state of being sound, or freedom from defect or separation” (Smith, 2002, p. 6). Other definitions include the biological model, with its focus on the absence of disease or injury, and broader definitions, such as the biopsychosocial model, which focuses on a person's individual experiences of well-being (Millstein, Petersen, & Nightingale, 1993). Health has also been described as an expansion of consciousness that encompasses all life processes (Newman, 1994).

Perry (1999) notes that health is more than absence of disease or prevention of an untimely death. She describes health as a dynamic state of well-being, with physical, social, psychological, and spiritual dimensions. Perry maintains that a broad view of health that includes all these dimensions is very important when considering the health behaviors of adolescents, because the outcomes of health-risk behaviors may occur in more than one dimension of a young person's life. Researchers have used these various definitions of health to develop scales to enable them to study health status in adolescents and adults. However, a single self-rated item in which a person is asked to rate her or his health as poor, fair, good, or excellent compared to others is the most widely used measure of this phenomenon (Ratner, Johnson, & Jeffery, 1998).

How do adolescents view the concept of health? Millstein (1993) notes that adolescents and adults apply similar criteria to define health. That is, health is associated with positive affective states; living up to one's potential; and functioning in physical, psychological, and social domains. Millstein asserts that through the process of maturation, adolescents conceptualize health in more abstract and inclusive terms than they did at younger ages. This means that they are more able to recognize their personal responsibility for health as they mature.

Weiler (1997) conducted a study of 419 high school students who lived in a rural area of the Midwest. From this convenience sample, he collected data about the participants' health concerns and those of their peers.

He found that the top 10 health concerns of the adolescent participants were centered primarily around their future and their relationships (see Table 1.1).

Table 1.1 Top Ten Concerns of a Sample of Rural Adolescents

The Future	*Relationships*
1. Being successful	5. Getting along with friends
2. Selecting a career	6. Dating
3. Getting good grades	7. Attending college
4. How I want to be in 10 years	8. Having a romantic partner
	9. Having my own family
	10. Getting along with parents

SOURCE: Based on study by Weiler (1997).

Other concerns of these adolescents were related to personal health, such as acne, body shape, weight, fitness, and personal attractiveness. Human sexuality concerns were related to having sexual intercourse, using contraceptives, and teenage pregnancy. Substance use and abuse, including driving under the influence of alcohol, and personal safety were also expressed as concerns. In comparing themselves to their peers, participants reported that their best friends and other adolescents had greater concerns about substance use and abuse; they also thought these other two groups were less concerned about the future.

Using data from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls and Boys, Ackard and Neumark-Sztainer (2001) examined adolescents' sources of information about health and their beliefs about what information health providers should share with them. From a representative national sample of 3153 males and 3575 females, they found that these adolescents received most of their information about health from their mothers. They identified five topics that adolescents wanted information about from health providers. In order of frequency of identified topics, they wanted more information about (a) drugs, (b) sexually transmitted diseases, (c) smoking, (d) good eating habits, and (e) alcohol use.

Health and Behavior

Recently, the Institute of Medicine's (2001) Committee on Health and Behavior defined positive health as comprising the following constructs: “a healthy body; high-quality personal relationships; a sense of purpose in life; self-regarded mastery of life's tasks; and resilience to stress, trauma, and change” (p. 23). From this definition, it can be seen that the concept of health encompasses more than having a body free from disease or dysfunction. Personal relationships, mastery of tasks, and resilience to stress and change suggest action or behavior. The institute's report proposed a model of the intersection of health and behavior based on two assumptions: (a) a variety of factors that are genetic, behavioral, and social interact reciprocally to influence health over time, and (b) because health is a function of biological, social, and psychological variables, many factors previously considered as irrelevant to health status may be critical to individuals and specific populations (p. 27).

Health behavior can be broadly defined as those actions taken by individuals, groups, and organizations to improve quality of life (Glanz, Lewis, & Rimer, 1997). Behavior directed toward promoting, maintaining, or restoring health may be motivated by beliefs, needs, and desires. Health behavior encompasses related terms, such as *health protection* and *health promotion*. Health-protecting behavior is generally directed at prevention. The individual who engages in health-protecting behaviors is motivated to protect health by preventing disease or injury or by decreasing the disability and discomfort associated with such health conditions. Health-protecting behaviors include active measures such as obtaining immunization against hepatitis B or participating in regular screening for cervical, breast, or testicular cancers. The focus of health protection is the avoidance of the negative states of disease, injury, or disability. In contrast, health-promoting behaviors focus on the positive states of well-being and self-actualization. Health-promoting behavior is associated with a lifestyle for which high quality of life is a highly probable outcome (Pender, Murdaugh, & Parsons, 2002).

Variations in Health and Health Behaviors

Some children come from backgrounds that place them at high risk for health problems in adolescence and beyond. Children living at or near poverty levels, in families with no health insurance, may not have the knowledge or opportunity to engage in either health-protecting or health-promoting behaviors. These children approach adolescence with compromised physical and mental health statuses. They may have inadequate immunizations against the usual childhood diseases, and their nutritional status may have contributed to phys-

ical and mental development that means they are functioning at less than their full potential. Other children come from backgrounds that place them at low risk for health problems. These children approach adolescence with complete immunizations, a regular pattern of routine physical examinations, and health-promoting diets and activity levels. Some of the children who come from disadvantaged backgrounds (i.e., those that place them at high risk) do very well in spite of their levels of risk. Similarly, some children who come from advantaged backgrounds, placing them at low risk for adverse health outcomes, end up engaging in behaviors that threaten their health and safety.

Professionals in health fields such as nursing and medicine have a great stake in understanding health and health-risk behaviors of these youngsters because their daily work brings them face to face with adolescents' health problems. Adolescence is a time when major morbidities are not generally related to diseases such as heart disease and cancer, which strike disproportionately at older adults. Rather, the morbidities and mortalities of adolescence are usually related to adolescents' social behaviors. Today's adolescents face incredible challenges related to the economy, education, crime, and changing family structure (Bronfenbrenner, McClelland, Wethington, Macu, & Ceci, 1996). Most of the social morbidities and mortalities that account for illness, injury, and death in adolescents are behavioral responses to these challenges. Whether we are talking about physical, emotional, spiritual, or social health, it is the behavior of adolescents, how they act and interact from day to day, that puts them at risk for adverse outcomes in any of these dimensions. Given the complexity of health issues facing today's youth, understanding what accounts for differences in those who engage in behaviors that increase or decrease their risk for poor health outcomes during adolescence is the focus of professionals in a variety of disciplines. As social scientists from many disciplines, it is our responsibility to create the knowledge that can help our youth face these challenges in healthier ways. Researchers have shown that adolescents are concerned about their health and about how their behavior can adversely affect their health (Halpern-Felsher & Cauffman, 2001).

Adolescent Mortalities

There has been a gradual decline in the mortality rates for adolescents since the early 1980s. At present, unintentional injuries account for the largest number of deaths in persons 10 to 24 years old, both in the United States and in many other countries of the world (Call et al., 2002). Preliminary findings for 2001 were that

unintentional injuries were still the leading cause of death in Americans between 5 and 24 years old. This represented a rate of 6.8 deaths per 100,000 among 5- to 14-year-olds and 34.7 deaths per 100,000 population among 15- to 24-year-olds. Homicide accounted for 12.8 deaths per 100,000 and suicide for 9.6 deaths per 100,000 among 15-to 24-year-olds (Arias & Smith, 2003). More specifically, 78% of deaths among persons aged 15–19 years were from motor vehicle accidents and claimed the lives of almost two males for every female. Compared with other racial/ethnic groups, non-Hispanic Alaskan Natives and American Indians had the highest mortality rate from motor vehicle accidents (Ozer et al., 2003). From 2001 to 2002, the number of crashes involving drivers between the ages of 16 and 20 years decreased from 1,666,000 to 1,638,000, but fatalities increased from 7,627 to 7,738 (National Highway Traffic Safety Administration [NHTSA], 2003). The NHTSA noted that more than one in four fatalities was related to drinking and driving. Other deaths resulted from the failure to use seat belts in cars and helmets while riding bicycles (NHTSA, 2001; Ozer et al., 2003).

Unintentional Injury

According to the Centers for Disease Control and Prevention (CDC, 2003a), the leading causes of death for persons 10 to 24 years old were (a) motor vehicle crashes (31%), (b) homicide (15%), (c) suicide (12%), (d) other injuries (12%), (e) HIV infection (1%), and (f) other causes (29%). Data from the total United States sample of the 2001 Youth Risk Behavior Surveillance (CDC, 2003a) suggested that these deaths resulted from the prevalence of the following listed behaviors. Of the adolescents surveyed:

- 47% had drunk alcohol in the past month
- 33% had been in a physical fight within the past year
- 31% had, in the past month, ridden with a driver who was drinking
- 30% reported episodic heavy drinking in the past month
- 17% had carried a weapon during the past month
- 14% rarely or never used seat belts

Adolescents between 15 and 19 years old are more likely than younger children to die from injuries from firearms or motor vehicle accidents. Both of these mortalities were greater among males than females. Both Hispanic and African American males were more likely than other adolescents to die from firearm injuries, and African American males were much more likely to die from a firearm injury than from one sustained in a motor vehicle accident (CDC, 2003b).

Homicide

Overall, among 10- to 24-year-olds, homicide is the second leading cause of death and is the leading cause among non-Hispanic African American males of the same ages. Homicide rates among 15- to 19-year-olds peaked in the 1990s and have continued to decline steadily since 1994 (Ozer et al., 2003).

Suicide

In the year 2000, 4294 adolescents between the ages of 10 and 24 years succeeded in committing suicide. Females commit suicide at rates much lower than that of males, and Alaskan Native and Native American males have the highest rates of all adolescents. Although males are more likely to succeed in committing suicide, adolescent females are more likely to attempt suicide than their male peers (Ozer et al., 2003).

Adolescent Morbidities

Adolescents growing up in the 21st century are not likely to experience many of the common childhood diseases that often resulted in health complications during adolescence in their parents' and grandparents' time. For example, antibiotics and sophisticated diagnostic tests have reduced the threats of death and permanent disability from diseases such as polio and scarlet fever that took their toll on previous generations of children and adolescents.

Many of the causes of adolescent mortalities result in injuries rather than death. For example, many unintentional and intentional injuries, as well as suicide attempts, fortunately do not result in death. Nevertheless, adolescents experience serious and sometimes disabling injuries in addition to various acute and chronic diseases and illnesses.

Unintentional and Intentional Injuries

A study of injuries occurring in the Los Angeles Unified School District, the second largest school district in the United States, was done to determine the incidence of injuries related to violent behaviors among the

nearly 700,000 students enrolled. In 1997, the rate of injuries that occurred and were reported at school for elementary, middle, and high school students was 1.74 injuries per 100 students per year. Of these, 77.2% were unintentional and 16.8% were intentional. The final 6.0% of injuries were of unknown intent. Students in elementary schools reported the most injuries, but the highest rate of 2.22 per 100 students was among those in high school. Among all grade levels, males were more likely than females to sustain both unintentional and intentional injuries. Again, the highest rate was among males in high school, with a rate of 2.8 per 100 students. The most common cause of injury was falls, which accounted for more than 40% of unintentional injuries in all grades. Many of these falls were related to sports activities. The second most common type of injury was collision or being struck by an object (Limbos & Peek-Asa, 2003).

Attempted Suicide

In addition to the alarming number of adolescents who successfully commit suicide, an untold number attempt suicide each year. Surveys of students enrolled in public high schools indicate attempted suicide rates ranging from 7.3% (Thatcher, Reininger, & Drance, 2002) to 19.3% (CDC, 2000).

Significant risk factors include being female (DuRant & Smith, 2002), feeling intimidated, using cocaine and alcohol, dieting and bulimic behaviors, and experiences of sexual and physical abuse (Thatcher et al., 2002).

Sexually Transmitted Infections and Diseases

The prevalence of sexually transmitted infections and diseases among adolescents is staggering. Inconsistent use of condoms and high-risk social environments increase the probability of developing a sexually transmitted disease (STD) (Capaldi, Stoolmiller, Clark, & Owen, 2002; Niccolai, Ethier, Kershaw, Lewis, & Ickovics, 2003). Seven of the most common STDs are summarized in Table 1.2.

Table 1.2 Sexually Transmitted Diseases Prevalent Among Adolescents

Disease	*Prevalence in Adolescents*	*Complications*
Chlamydia trachomatis	Highest among 12- to 19-year-old females	Cervicitis and PID in women; torsion of spermatic cord in males

Gonorrhea	Highest in 15- to 24-year-olds	PID and infected Bartholin's gland in women; prostatitis in males
Hepatitis B	15% of cases are in 15- to 19-year-olds	Chronic liver disease and hepatocellular carcinoma
Herpes genitalis	Highest among 30-year-olds 6% of 12- to 19-year-olds	Encephalitis, meningitis, neonatal infections, psychological distress
Human immunodeficiency virus	20% of cases in 20- to 29-year-olds, contracted 7–10 years earlier	Pulmonary tuberculosis, bacterial pneumonia, cervical cancer, AIDS
Human papillomavirus	15%–20% female adolescents	Cancer of vulva and cervix
Syphilis	Highest rate in 20- to 30-year-olds	Meningitis, congenital syphilis

SOURCE: Data taken from Neinstein (2002).
NOTE: PID indicates pelvic inflammatory disease.

Chronic Diseases

Chronic health conditions are defined as having three characteristics: (a) they have a biological, psychological, or cognitive basis; (b) the condition has lasted or is expected to last at least 12 months; and (3) the individual with the condition experiences functional limitations that require reliance on compensatory assistance, such as medication, diet, personal assistance, and medical technology. Using these criteria, it is estimated that 14.8% to 18% of children up to 17 years old have a chronic health condition or disease. The most common chronic diseases of adolescents are arthritis, asthma, diabetes mellitus, epilepsy, and heart disease (Coupey, Neinstein, & Zeltzer, 2002). Other prevalent chronic diseases include cystic fibrosis, disabling conditions associated with congenital anomalies, eating disorders, and mental illness. Many adolescents who have such conditions experience stigma and marginalization, making the transitions of this developmental stage more challenging. As a consequence of these experiences, these youth are at risk for depression and other psychosocial problems (DiNapoli & Murphy, 2002). Although some children outgrow some of these conditions, others experience sleep disturbances, school absences, and restrictions in physical and social activity (Yeatts & Shy, 2001) as well as long-term complications (Donaghue et al., 2003).

Disabling Conditions

A number of physical, cognitive, and psychological conditions render adolescents unable to fully participate in activities that are normative for their peers. Congenital anomalies such as spina bifida, a defect of the spinal membranes and nerves, may be accompanied by limited mobility, severe orthopedic problems, or paralysis (Sawin, Brei, Buran, & Fastenau, 2002). Certain genetic anomalies, such as Turner syndrome, an abnormality with 45 chromosomes and one X chromosome, are accompanied by stigmata and sexual infantilism that may be socially and psychologically disabling to some adolescents.

Eating Disorders

The incidence of eating disorders is greatest among female adolescents between the ages of 13 and 18 years. Both males and females are influenced by media exposure to dieting and thin role models (Labre, 2002; Utter, Neumark-Sztainer, Wall, & Story, 2003). Males and females across various races and ethnicities engage in smoking cigarettes to control or lose weight (Fulkerson & French, 2003). Long-term consequences of smoking include stunted growth (Lantzouni, Frank, Golden, & Shenker, 2002), cardiac arrhythmias (Eidem, Cetta, Webb, Graham, & Jay, 2001; Galetta et al., 2003), osteopenia, menstrual irregularities, infertility, and high-risk pregnancies (Elford & Spence, 2002). Obesity is fast becoming a chronic disease among youth and is strongly related to the development of cardiovascular disorders in adulthood (Sinaiko, Donahue, Jacobs, & Prineas, 1999).

Mental Illness and Psychosocial Distress

Mental illness and psychosocial distress are significant problems for many adolescents. The stress associated with multiple changes that occur in adolescence, complications of chronic diseases, and anxiety about performance expectations in school and social arenas are but a few of the factors that contribute to this situation. Children who have experienced behavioral and learning problems, such as those typical of attention deficit hyperactivity disorder (ADHD), may continue to experience these problems in adolescence. Mood disorders such as major depression, substance-induced mood disorder, and manic episodes may manifest first in adolescence (American Psychiatric Association, 1994). Symptoms of mental illness such as anxiety and

depression are often found associated with eating disorders and engaging in health-risk behaviors such as having multiple sexual partners, using substances such as alcohol and illicit drugs, and frequent fighting. Researchers have shown that children and adolescents who are exposed to violence are prone to post-traumatic stress disorder, depression, and behavioral problems, as well as desensitization to violence (Garbarino, Bradshaw, & Vorrasi, 2002).

Many youth who show signs of mental illness or psychosocial distress are at risk for school drop-out and attempted suicide (Brooks, Harris, Thrall, & Woods, 2002; Eggert, Thompson, Randell, & Pike, 2002). Expanded school programs to provide a full array of mental health prevention and intervention programs are being developed to meet a growing demand for services for the nation's adolescents (Weist et al., 2003).

Skin Disorders

A large number of adolescents experience skin disorders that affect their health and well-being. Acne vulgaris occurs to some degree in approximately 85% of all adolescents. The condition results from increased oil production in the glands of the face, shoulders, chest, upper arms, and neck. The oil glands become plugged with oils and bacteria grow, forming papules of inflammation, better known as pimples. Scarring can occur. Males tend to have a more severe condition than females (Pakula & Neinstein, 2002). In addition to this common skin disorder, about 30% of adolescents spend numerous hours in the sun without protection from ultraviolet rays. Another 10% use indoor tanning sun lamps or beds (Cokkinides, O'Connell, Thun, & Weinstock, 2002). Consequently, a substantial number experience sunburns that may be the precursors of neoplasms in adulthood (Cokkinides et al., 2001).

Adolescent Access to and Use of Health-Care Resources

Although adolescents in general are healthy, they still have multiple needs for health-care resources. They need preventive services, such as those associated with preventing unplanned pregnancy and sexually transmitted diseases. They also need the preventive resources of immunizations against infectious diseases. Many could benefit from screening for physical and mental health problems, such as depression and substance abuse (Brindis, Park, Ozer, & Irwin, 2002). Adolescents also need treatment for any number of illnesses, dis-

eases, and injuries.

The Medical Expenditure Panel Survey collects data on health-care use and expenditures from a nationally representative sample (Elixhauser et al., 2002). In the first 6 months of 2000, more children in the 15- to 17-year-old age range were uninsured than children under the age of 4 years. Among 10-to 14-year-olds, 67.7% had private insurance, 17.9% had public insurance, and 14.4% had no insurance at all. In this age group, 62.6% had visited a physician's office, 5.5% had had outpatient visits at a hospital, 8.9% had visited the emergency department of a hospital, and 53% had had dental visits. For these early adolescents, hospitalizations occurred primarily for injury and poisoning. Mental disorders accounted for 15.5% of hospital stays among this age group. Among the 15- to 17-year-olds, 68.4% had private insurance, 15% had public insurance, and 16.6% had no insurance at all. In this age group, 60.6% had visited a physician's office, 5.7% had had outpatient visits at a hospital, 11.1% had visited the emergency department of a hospital, and 49.9% had had dental visits. Among these older adolescents, 36.6% of hospitalizations were related to pregnancy and childbirth, 13.9% were due to injury and poisoning, and 14.5% were for mental disorders (Elixhauser et al., 2002). In terms of cost, health care for adolescents was lower than that for adults. However, expenditures for adolescents with disabilities and functional impairments were disproportionately high, whereas expenditures for adolescents living in poverty and those who were African American were disproportionately low (Newacheck, Wong, Galbraith, & Hung, 2003).

For adolescents, two major constraints of the external environment are socioeconomic status and health-care providers and services that are not adolescent-friendly. Those living at or near the 100% poverty line have few resources to exchange for regular health care, including insurance. In 2001, the mean age of children living in families with incomes below 200% of poverty was 9.4 years (+5.4). Of these, 48.3% were male, 24.9% were African American, and 24.3% were Hispanic. Of these children and adolescents, 74.4% perceived themselves to be in excellent or very good health, whereas only 6% considered themselves to be in fair health. For children under 19 years old, 16.1% of those living below 200% of poverty were uninsured, compared to 20.0% of those living below 100% of poverty (Cunningham, Hadley, & Reschovsky, 2002).

A secondary analysis of three national data sets (National Ambulatory Medical Care Survey, Comprehensive Adolescent Health Services Survey, and National Hospital Ambulatory Medical Care Survey) was done to identify health-care use by adolescent males. In sites for specialized adolescent care, such as school-based health centers and community or health department programs, males made fewer visits than females. In other sites, however, younger males (i.e., those younger than 16 years old) made visits in almost equal proportions

to those made by females (Marcell, Klein, Fischer, Allan, & Kokotailo, 2002).

Seeking routine health-care services may not be viewed as an important use of time by adolescents, who may see themselves as invulnerable to the threat of disease or injury. As they gain increased independence from their parents, adolescents are less likely to be taken for routine health-care examinations than they were at younger ages. In addition to a general reluctance to seek routine health-care services, an expanding number of adolescents are without health-care insurance, making visits for acute health problems even more challenging.

Many adolescents experience financial and other environmental barriers to health care. Many adolescents fail to seek care not because they have no insurance but because they cannot pay the copayment requirements. Moreover, many preventive services are not fully covered by private insurance plans. Environmental barriers include laws common in many states that require notification of parents and lack of confidentiality when parents are notified of an adolescent's visit or when a youth is afraid to file an insurance claim because his or her parents will learn about the visit. Other barriers are structural and include the location of clinics at an inconvenient distance or location, business hours that coincide with school, lack of transportation, and the lack of an appealing waiting area. Adolescents also find that many health-care providers lack sensitivity to the culture of adolescence (Oberg, Hogan, Bertrand, & Juve, 2002) and to the cultures of racial and ethnic minority groups (Villarruel & Rodriguez, 2003). In a study of 847 male and 1126 female adolescents, Fortenberry and colleagues (2002) found that stigma and shame were barriers to seeking care for suspected STDs.

In an exploratory study of 18 female Mexican American adolescents 10 to 16 years old, Rew (1997) found two themes in seeking care for prevention of illness and in managing health-care problems. Themes derived from focus groups were primarily differences in using formal versus informal resources for health information and health care. More specifically, these adolescent females described seeking formal help from physicians and health clinics for problems such as respiratory infections and gastrointestinal problems. They also described using informal resources such as mothers, friends, or other female relatives for information and help with their concerns related to pubertal development and reproduction. In another study of 693 female adolescents (12 to 20 years old, mean age = 14.96 ± 1.83), the majority of participants reported using informal sources more frequently than formal sources of care. Hispanic and European American participants were more likely than African American, Asian American, or Native American participants to seek help from peers [$F(4) = 5.52$, $p < .0001$], whereas African American females were more likely to seek help from parents (Rew, Resnick, & Blum, 1997).

Access to Reproductive Health Services. American adolescents are less able to access convenient and youth-friendly reproductive health services than their peers in other countries. Some of the limitations are related to adolescents' lack of insurance. Other barriers are structural, such as lack of confidentiality and the need for parental consent. Of the 50 states, only 27 and the District of Columbia have statutes or policies that allow adolescents to give their own consent to obtain contraceptives (Hock-Long, Herceg-Baron, Cassidy, & Whittaker, 2003).

Access to Mental Health Services. It is estimated that more than 50% of adolescents will need mental health services during the transition to adulthood. Schools provide the primary entry point to these services because of students' learning and behavioral problems or substance use (Farmer, Burns, Phillips, Angold, & Costello, 2003). However, schools are not adequately equipped with specialized personnel to address the multiple mental health needs of today's youth.

Access to Health Resources by Gender and Ethnicity. There is mounting evidence of health disparities in America that are related to both gender and ethnicity. Using data from the 1987 National Medical Expenditure Survey (NMES), Bartman, Moy, and D'Angelo (1997) studied access to ambulatory care in a sample of 3102 adolescents between the ages of 11 and 17 years. They found that compared to Whites, African Americans and Hispanics were significantly less likely to have received care in a physician's office ($p < .001$). Similarly, Lieu, Newacheck, and McManus (1993) analyzed data from the 1988 National Health Interview Survey of adolescents ($N = 7465$) and found that Hispanics were less likely to seek care for routine and acute care than Whites and African Americans.

The health status of adolescents is closely related to behaviors. As noted earlier, these behaviors have been identified by many different terms, including problem behaviors, risk-taking behaviors, deviant behaviors, risky behaviors, and health-risk behaviors. Research findings are often difficult to compare because of the variation in terms used. Whenever possible in this book, behaviors that are associated with increasing an adolescent's chances of experiencing an adverse health outcome (morbidity or mortality) will be referred to as health-risk behaviors unless a study using a different term is being cited.

Adolescent Health-Risk Behavior

The concept of *risk* is central to our understanding of adolescent health behaviors. The term comes from the

discipline of epidemiology, where it refers to the probability of loss, injury, illness, or disability (Lescohier & Gallagher, 1996). Risk-taking behavior is considered by some to be a normal part of adolescent development. Experimentation with breaking the rules (e.g., skipping school without parental permission, coming home later than one's curfew) represents an adolescent's willful decision to engage in an activity with a degree of risk of being caught and being punished. Experimentation with sexual behavior, smoking, and alcohol use, however, represents an adolescent's willful decision to engage in activities with associated risks of health- or life-threatening outcomes. These latter behaviors are designated as health-risk behaviors because they threaten the development, health, and well-being of adolescents. As adolescents gain more independence and begin to experiment with new behaviors, some of these behaviors place them at risk for potentially negative health consequences (Green, 1999), whereas other health-risk behaviors may improve their healthy growth and development. In general, health-risk behaviors in youth increase the likelihood that an adolescent will experience one or more of the major morbidities or mortalities, because such behaviors have been found to cluster or covary, and these associations increase with age (Lytle, Kelder, Perry, & Klepp, 1995).

Brindis et al. (2002) note that 70% of adolescent mortalities can be accounted for by six categories of risk-taking behaviors. Those categories are (a) unsafe sexual activity, (b) violence, (c) minimal physical activity, (d) poor nutritional habits, (e) alcohol and other drug use, and (f) use of tobacco products. The risk of adverse health outcomes associated with these behaviors increases for those youth who also have chronic physical or mental health problems or disabilities, who are incarcerated, or who are homeless. In fact, many of the national health objectives identified in *Healthy People 2010* specifically target changes in these behaviors for adolescents (U.S. Department of Health and Human Services [USDHHS], 2000).

Adolescents with chronic health conditions increase their vulnerability to adverse health outcomes by engaging in health-risk behaviors. For example, smoking is a stimulus that can trigger asthma, yet adolescents with asthma begin smoking as often as those without this condition (Zbikowski, Klesges, Robinson, & Alfano, 2002). Compared with 16,262 students in regular high schools, youth attending alternative schools *(n* = 8918) were found to have significantly more health-risk behaviors, including unintentional injuries; sexual activity; poor nutritional habits; physical inactivity; and tobacco, alcohol, and other drug use (Grunbaum, Lowry, & Kann, 2001).

Millstein and Halpern-Felsher (2002) distinguish between the terms *risk judgment* and *risk identification*. Risk judgment is an assessment of the magnitude of risk (e.g., how likely is it that I will die from lung cancer if I smoke cigarettes?), whereas risk identification is not an assessment of the magnitude of the risk but rather an

acknowledgment that a specific behavior is associated with some risk for adverse outcomes (e.g., what might happen if I smoke cigarettes?). The related concept of vulnerability focuses on how concerned or anxious the individual is about being at risk for an adverse outcome (e.g., how worried are you that your smoking might lead to a serious health problem such as lung cancer?).

There is some evidence that risk identification increases with age in adolescents (Beyth-Marom, Austin, Fischhoff, Palmgren, & Jacobs-Quadrel, 1993). There is limited evidence that risk judgment also varies inversely with age (Millstein & Halpern-Felsher, 2002). Moreover, researchers have found that an adolescent's perception that a particular behavior carries a risk for unpleasant consequences plays an important part in influencing the youth's behavior. Other factors that influence an adolescent's behavior include the perceived benefits of engaging in that behavior. Adolescents often initiate or continue a specific behavior that is associated with increased risk for adverse health outcomes (e.g., smoking cigarettes) because that behavior is perceived as having great social benefit. In other words, a person may acknowledge that smoking cigarettes will increase the risk of developing lung cancer, but will be willing to start smoking and continue to smoke because she or he perceives that the behavior will make her or him more well liked by peers (Millstein & Halpern-Felsher, 2002).

The ways in which adolescents think about their own vulnerability to specific adverse outcomes are addressed by many theories of health. Theories such as the Health Belief Model (Rosenstock, 1974a, 1974c), social cognitive and self-efficacy theories (Bandura, 1986, 1997), self-regulation theory, the theory of reasoned action (Fishbein & Ajzen, 1975), and the theory of planned behavior (Ajzen, 1985) all contain propositions concerning how individuals' beliefs about consequences and their vulnerability to those consequences affect their behavior (Millstein & Halpern-Felsher, 2002, p. 415).

National Objectives to Improve Adolescent Health

The nation's objectives to improve the health status of the American people are outlined in *Healthy People 2010* (U.S. Department of Health and Human Services, 2000). In addition to the several global goals identified for all citizens (e.g., increasing quality and years of healthy life), many objectives are targeted primarily at adolescents. They include the following:

- Reduce deaths from accidents

- Increase use of safety belts
- Reduce substance abuse and binge drinking
- Reduce marijuana use
- Increase disapproval of smoking
- Increase use of contraceptives that protect against STDs and pregnancy
- Reduce rates of *Chlamydia trachomatis* infections
- Reduce weapon carrying on school properties
- Reduce proportion of those with disabilities who are sad, unhappy, or depressed
- Improve mental health and access to appropriate services
- Promote health associated with diet and weight
- Reduce dental caries
- Increase proportion who receive all vaccinations

These objectives address the major morbidities and mortalities of adolescents. Moreover, they suggest that those concerned about adolescent health should address health promotion activities such as increasing use of safety belts, promoting proper diet and weight, and increasing the number of youth who are immunized against preventable, communicable diseases, as well as focusing on only the more obvious health-risk behaviors.

Organization of the Book

Theories selected for this book are those that are applicable to the current state of actual and potential health concerns for adolescents. They are arranged in a sequence that proceeds from outlining the context of adolescence as a distinct phase of human development to specific models of behavior change that can guide interventions. Chapter 2 begins with an introduction to the purpose of theory and its relationship to scientific inquiry. In this chapter, several strategies for developing and evaluating theories are described. In subsequent chapters, theories about a particular theme or phenomenon of concern are presented. Each of the theories and conceptual models presented is relevant to the six major types of adolescent health-risk behaviors: nutrition, physical activity, sexual activity, alcohol and other drug use, tobacco use, and violence. Every chapter begins with an introductory section, followed by a critical analysis of two or more theories or conceptual models. Each theory or model is presented in terms of criteria for evaluating theory: (a) origins; (b) purpose; (c) meaning; (d) scope, parsimony, and generalizability; (e) logical adequacy; (f) usefulness; and (g) testabil-

ity. Whenever possible, empirical referents for major constructs of each theory or model are also presented, along with psychometric properties of these referents. Each chapter includes examples of related research on adolescent health and health-risk behavior. Each chapter concludes with implications for further study and a chapter summary. At the end of each chapter are two lists: selected Web sites, to be used as a resource for gaining further information about the topic presented in that chapter, and suggestions for additional reading.

Chapter 3 contains an overview of selected developmental theories. Adolescence is conceptualized as a specific phase in the life-span development of the human being. The theories and models presented in this chapter provide the context for understanding the adolescent person and how adolescents change in physical, cognitive, emotional, social, and spiritual dimensions in response to their environment. Developmental theories explain the various ways in which adolescents, over time, are capable of engaging in more complex behaviors that carry an increasing risk for short- and long-term health consequences. Lerner's model of developmental contextualism provides additional insight into the reciprocal nature of human development as a response to the environment in which that development takes place. The chapter concludes with a presentation of the Youth Development Model. Although this model does not have the attributes of a scientific theory, it has been found to be extremely useful in planning and implementing successful programs that address the unique developmental needs of adolescents.

Chapter 4 augments the developmental approach taken in Chapter 3. The focus of this chapter is the development of a sense of self or personal identity. Beginning with William James's differentiation of the subjective from the objective sense of self, the works of Erik Erikson are analyzed with his assertion that development of self-identity was the primary and essential developmental task of adolescence. The work of Erikson's followers, primarily James Marcia, who elaborated on ego-identity status, provides a broader and deeper context for understanding the health and health-risk behaviors of adolescents. Theories that address the development of a sense of self or personal identity relate to the six types of health-risk behaviors because each of these behaviors may become the focus of an identity formation. That is (for example), a female adolescent may form part of her self-image or identity as a smoker from the use of tobacco products, or she may alter her sense of being female owing to her participation in sexual activities.

Chapter 5 addresses theories of stress and coping. The General Adaptation Syndrome described by Hans Selye forms the backdrop against which more recent models of stress and coping are presented. Many of the health-risk behaviors found among adolescents may be conceptualized as adaptive or maladaptive coping responses to perceived stressors. Chapter 6 covers concepts of risk and vulnerability that arise from the

intersection of stress and adolescent development. The problem-behavior theory of Jessor and Jessor is presented as a model for assessing specific health-risk behaviors in this developmental phase of life. This theory and its recent extensions address the health-risk behaviors directly. Chapter 7 consists of conceptualizations of protection and resilience. Viewed as a response to stress, resilience is central to our understanding of health-risk behaviors in young people.

The next three chapters focus specifically on adolescent behaviors and theories of cognitive and behavioral change. Chapter 8 begins with social cognitive theory and addresses the connection between the adolescent's cognitive development and social interactions within the environment. Theories of reasoned action and planned behavior are also included, along with examples of their application in helping adolescents change health-compromising behaviors. Chapter 9 includes a discussion of the Health Belief Model and Pender's Health Promotion Model. These formulations focus specifically on attitudes, beliefs, and behaviors that directly influence health. Moreover, they include strategies to motivate adolescents to engage in behaviors that promote or enhance health status. Chapter 10 addresses theories of decision making and stages of behavioral change. To promote and maintain the health of adolescents, these models contain specific guidelines for developing age- and behavior-appropriate interventions. In particular, the Transtheoretical Model of Behavior Change identifies various stages in the process of making a decision to change a behavior and includes strategies for helping a person sustain the behavioral change.

The final chapter, Chapter 11, contains a description of a variety of qualitative approaches to developing theories of adolescent health and health-risk behavior. Specifically, this chapter includes a description of content analysis and case studies, grounded theory, focus groups, narrative analysis, and participatory action research methodologies. These descriptions are then followed with examples directly related to adolescent health and health-risk behaviors.

Chapter Summary

The current health status of American adolescents is excellent in many ways. However, adolescents are at risk for a variety of social morbidities and mortalities related to health-risk behaviors. A substantial number of adolescents are uninsured and experience financial and environmental barriers to health-care services. Health disparities exist for adolescents who are racial minorities and who live in conditions of poverty. Mental health and physical health services associated with school health clinics may increase access to and use

of health care by many adolescents, but there remains a lack of coordinated care for those who drop out of school or who are marginalized for any number of reasons. The national health objectives provide direction for adolescent health providers and researchers through which they may focus intervention efforts on the major morbidities and mortalities encountered in the second decade of life.

Related Web Sites

American Cancer Society: http://www.cancer.org

American Diabetes Foundation: http://www.diabetes.org

Asthma and Allergy Foundation of America: http://www.aafa.org

Congenital Heart Defects in Children and Adolescents: http://pediatrics.about.com/library/weekly/aa021200.htm

Cystic Fibrosis Foundation: http://www.cff.org

Epilepsy Foundation of America: http://www.efa.org

Federal Interagency Forum on Child and Family Statistics: http://childstats.gov/americaschildren

Future of Children: http://www.futureofchildren.org

Health, United States, 2000, with Adolescent Health Chartbook (Centers for Disease Control and Prevention [CDC]): http://www.cdc.gov/nchs/data/hus/hus00.pdf

Healthy People 2010:http://www.healthypeople.gov

Monitoring the Future Study (Institute for Social Research, University of Michigan): http://monitoringthefuture.org/

National Adolescent Health Information Center: http://youth.ucsf.edu/nahic

National Center for Chronic Disease Prevention and Health Promotion: http://www.cdc.gov/nccdphp

National Health and Nutrition Examination Survey (National Center for Health Statistics, CDC):

http://www.cdc.gov/nchs/nhanes/nhanes.htm

National Longitudinal Study of Adolescent Health (Add Health): http://www.arhp.org/rap/

Planned Parenthood® Federation of America online magazine: http://www.teenwire.com (in Spanish and in English; winner of 2002 Webby Award for Best Health Web Site for adolescents)

Sexually Transmitted Disease Surveillance (CDC): http://www.cdc.gov/std/stats/TOC2000.htm

Statistics from the Insurance Institute for Highway Safety: http://www.iihs.org

United Cerebral Palsy Association: http://www.ucpa.org

Vital and Health Statistics (CDC): http://www.cdc.gov/nchs/nsfg.htm

World Health Organization: http://www.who.int/about/definition/en/

Youth Risk Behavior Survey (CDC): http://www.cdc.gov/nccdphp/dash/yrbs/

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