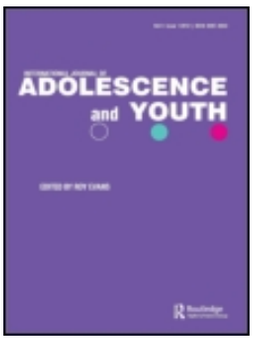

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Risk Behavior in Adolescence
The relationship between developmental and health problems

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DEVELOPMENTAL TASKS IN ADOLESCENCE

The socialization process of adolescents can be viewed as "successful" when they manage to cope with a multitude of developmental tasks and thus combine the requirements of individuation and integration with each other. They are confronted with the challenge of how to handle rapid changes in their bodies, emotions, ways of thinking and drives, while simultaneously adjusting to sociocultural requirements and acquiring socioeconomic qualifications (Hurrelmann, 2004). If they do not succeed in doing so, or only to insufficient extent, it is possible for their *developmental tasks to run into problems* that prejudice the further development of their personality and health (Dryfoss, 1990; Elliot, 1993; Irwin and Millstein, 1992).

Whether the socialization process succeeds or not depends on whether the developmental tasks specific to adolescence are coped with. The support potential of adolescents' social environment and individual resources play a mediating role in this connection (Havighurst, 1952).

One of the developmental tasks confronted by the young is to acquire mental and social competence in various fields that can serve as a basis of individuation and as a precondition for social integration. They have to acquire cognitive, motivational, social and practical competences for the *four central developmental tasks:*

- performance in school and the acquisition of occupational qualifications;
- skills needed to establish ties with others of the same age;

- competence in respect to exploitation of the consumer-goods market;
- skills required to implement their own "political" interests.

Problems arise in the course of the individuation and integration process when, due to inadequate personal or social resources, the abilities and skills expected and called for by the social environment temporarily or lastingly fail to materialize in one or more of these areas. That applies just as much to persistent failure in school as to rejection by an age group, not keeping up in the field of expensive consumer goods, and social isolation in the public realm. In this case the actions available to an adolescent are not up to the respectively established institutional or age-related standards. If this "non-fit" of social demands and subjective skills cannot be compensated for by appropriate personal or social strategies, it is possible to expect considerable individual stress and strain capable of *disturbing the further individuation and integration process* (Jessor, 2001; Jessor and Jessor, 1977; Schulenberg, Maggs and Hurrelmann, 1997).

Alone a lack of or inadequate competence in one of these areas, like performance at school or on the job, can considerably impair the overall coordination of developmental tasks. Failure at school can result in rejection by one's friends and social isolation. A developmental task left unmastered is usually a poor precondition for the mastering of another: a "backlog of problems" resulting from multiple, unmastered developmental tasks that clash with each other is a load factor. A favorable course is taken, by contrast, when the tasks encountered at school, in the formation of partnerships, orientation of leisure-time activities and political participation can be lined up by adolescents in a sequence that harmonizes with their coping skills (Hurrelmann, 1998; 2000).

THE DEVELOPMENT OF COPING SKILLS IN ADOLESCENCE

In the adolescence phase people develop fixed patterns in the way they cope with their developmental tasks, patterns that are anchored in their personality structure and reflect to a certain extent the "history" of how they have dealt with their internal and external reality to date. A favorable pattern is the active *accessing of a problem constellation through the alert perception of one's internal and external reality*, i.e. of one's physical, mental and socioecological surroundings, with subsequent recourse to a flexible but structured reaction. This attitude is open to new impressions and simultaneously

permits recourse to proven rules for the classification and evaluation of events. Imprecise perceptions and subsequent evasive, passive reactions to problem constellations have proved to be unfavorable (Seiffge-Krenke, 1998).

From the point of view of socialization theory the molding of problem-handling skills is a decisive factor in determining whether the problem constellation posed by developmental tasks can be successfully coped with or not:

- *Appropriate coping is* a guarantee that, despite difficult problem constellations, no harm will come to one's physical and psychosocial state and no symptoms of social deviation will arise. The chances they have to build the competence required to cope with developmental tasks and keep the extent of "crises" small right from the start are good in the case of those adolescents who have had an active and openminded temperament ever since early childhood and who develop a great ability to learn so that they can turn crises and strain into productive challenges for the strengthening and stabilization of their personality. The *ability to organize their personality "on their own" is* high.
- Inappropriate coping can lead to problem behavior. Adolescents with inappropriate coping skills are left only with a defensive, passive or evasive reaction to problematic situations engendered by developmental challenges. Strategies designed to analyze situations, search for information, influence troublesome conditions, change one's behavior and harmonize one's feelings and expectations are only weakly developed in the case of these youth. Their resources are inadequate to the job of warding off social and health harms. Their self-organization skill is low (Silbereisen and Todt, 2001) (Figure 1).

Inappropriate coping makes it impossible to effectively deal with problem constellations arising from developmental tasks (like, for instance, premature or delayed sexual maturity, persistent failure in school, rejection by those in one's age group and excessive debts caused by too much consumer spending) and from related *crises in the individuation and integration process.* It is possible for a situation to arise in which excessive demands are temporarily or lastingly made on the ability to act, which is reflected in abnormal and unhealthy development with various symptoms of disorders. The discrepancy between developmental demands on the one hand and coping skills on the other results in "unfit" solutions which, in terms of the way they are manifested and their consequences for the social environment, are unacceptable and unproductive for

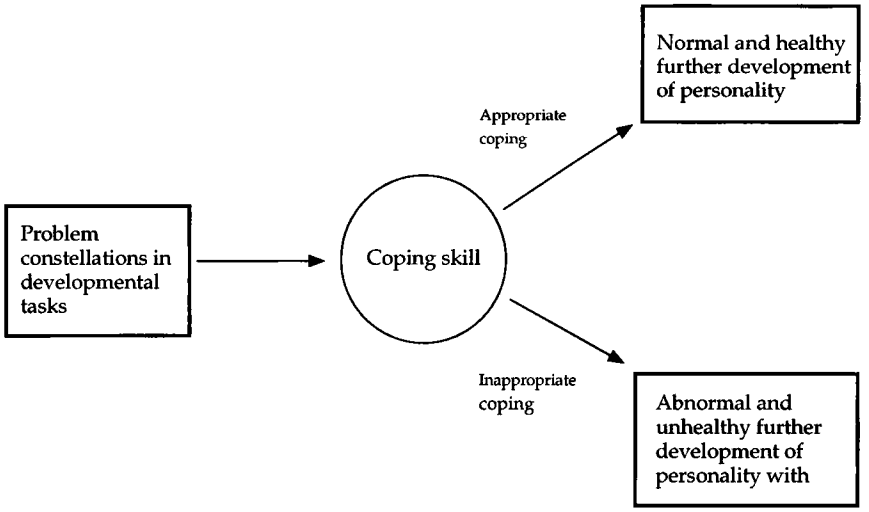

Figure 1. Developmental tasks and appropriate or inappropriate ways of coping with them

the development of a person's personality and health. The unfit solutions can take on a variety of forms of problem and risk behavior (Steptoe et al., 1994).

TYPES AND CATEGORIES OF RISK BEHAVIOR

The concept of "risk behavior" applies to specific forms of inappropriate problem handling. Risk behavior is understood to be behavior with undesirable consequences that go hand in hand with a probability of harm or loss (Cairns and Cairns, 1994). In this connection the concept of unsafeness is a fundamental characteristic inherent in risk behavior. Risk behavior can accordingly be understood as a type of action influenced by unsafeness, with the possibility of harm to one's life and/or the environment, behavior that can thus run counter to productive development in terms of individuation and integration (Raithel, 2001; 2004).

The spectrum of risk behavior can be differentiated on the basis of characteristic forms of harm: risk behavior involving one's health/body, delinquency (in respect to legal norms), finances and ecology can be identified as a prototypical form. Forms of risk behavior can be distinguished between by way of the specific form of unsafeness and/or possible type of harm, the damage resulting from ecological

TABLE 1

Synopsis of the types of risk behavior (Raithel, 2001, p.17)

Types of risk behavior	Unsafeness and/or possible harm	Main behavioral areas of action
Health-related risk behavior	Threat to life, accidents, injury, illness, death	Diet, road traffic, noise, sexuality, violence, sports, hygiene, alcohol, tobacco, illegal drugs, suicide, tests of courage.
Delinquent risk behavior	Sanctions, penal measures	Road traffic, illegal drugs, (sexual) violence, property crime, tests of courage.
Financial risk behavior	Financial obligations, debts, impoundment	Substance abuse, gambling, electronic shopping, compulsive buying
Ecological risk behavior	Pollution, destruction	Road traffic, recreational sports, garbage removal.

risk behavior being directed against the environment, while in the case of the other forms it is directed against the actor (Table 1).

The dimension-specific unsafeness posed by a health risk is to be found in physical and mental harm as well as in threats to life that can manifest themselves in the form of injury, sickness and death. The unsafeness of delinquent risk is to be found in "getting caught" and thus in the application of sanctions resulting from violation of the law. Financial risk refers in terms of its potential unsafeness to economic harm, for example in the form of debts. Ecological risk is the danger of destruction, inherent for example in the form of air, earth and groundwater pollution.

The individual types of behavior usually cannot be genuinely assigned to one single type:

- In road-traffic behavior, for instance, it is possible for all four risk dimensions to come to bear. An accident stands par excellence for a health risk that poses an evident threat to one's life; if one is to blame for the accident, that also has legal consequences.

- The financial damage is twofold: for one, part of the material damage will have to be borne and, for another, a fine will also have to be paid for inappropriate behavior.
- An ecological risk in the case of motorized traffic occurs mainly in the consumption of fossil fuels and in exhaust gases.
- From the risk point of view the use of legal and illegal drugs is likewise multidimensional: in the foreground there is the health threat; next to that there is also a legal risk involved with the use of illegal drugs, and there is a not inconsiderable financial risk when it comes to buying them.
- The use of force also has a number of risk dimensions: in first place is the delinquent act, which can be directed not only against persons but also against property. The health risks entailed by violence against persons cannot be underestimated either, and, indirectly, the use of force, whether against persons or property, entails additional financial expenditures for the material/personal injury as well as a possible fine if legal sanctions are applied.
- Gambling, drug use, excessive consumption or also "compulsive buying" (Lange, 1997) can also be identified as a field of behavior entailing financial risks. The personal lines of credit often available to adolescents easily tempt them to spend excessive amounts of money and enter into long-term obligations that then – often unexpectedly and to their surprise – break their budgets. But it is often none other than adolescents from poor economic circumstances who get into financially risky situations because they want to get their share of the market, such situations very quickly leading to debts and financial crises. But delinquent behavior also has a financial risk dimension, namely when it entails legal sanctions (fines).

The behavioral fields cited make it clear that many types of risk behavior bear the seeds of varied and thus multiple risks.

TWO PROFILES OF RISK BEHAVIOR

Taking the risk-specific connation and the quality of the risk as the basis, it is possible to distinguish between two subtypes of adolescent risk behavior as substance-related (use of alcohol, tobacco, medication and drugs) and explicitly risk-connotative activities (e.g. subway/elevated-train surfing, risky tests of courage) (Raithel, 2001).

Substance-specific risk behavior depends to large extent on psychosocial stress and strain, and on problem-laden situations in

school and the family. This is less so with explicitly risk-connotative activities (Raithel, 2001). Their functionality – these types of risk behavior are mainly indulged in by boys (usually with emphasis on the body) (Yates, 1992; Igra and Irwin, 1996) - is particularly anchored in a sex-specific development of identity. Risk-connotative behavior is explicity connected to tests of courage.

Tests of courage can be distinguished as follows (Raithel, 2003):

- *Tests of courage involving injury/pain:* jumping/heights, balancing, climbing, traffic, animals, selfinjury, victimization;
- *Tests of courage that run the risk of sanctions:* violations of the law, violating conventions, trespassing on premises or in rooms;
- *Tests of courage involving uncertainties:* darkness, drugs;
- *Tests of courage involving shame/revulsion and social fears:* sexual/erotic interaction, food, violating personal-appearance conventions.

Substance-related risk behavior is not seen as a risk by adolescents because they cannot sense or anticipate the direct consequences for the health. In contrast, in the case of extreme or explicit risk-taking behavior the risk relationship and possible harm are evident to the young and they are aware thereof. Here, a high degree of self-efficacy plays a decisive role, for, in expressing his or her behavior the adolescent has to be convinced that he or she will succeed and/or overcome the challenge – so the actor has to proceed from a subjective notion of invulnerability.

One of the main functions of explicitly risk-connotative activities (risk-taking behavior) is to be found in qualitative integration that leads to acceptance by a clique or firmly established group (e.g. when tests of courage are involved). So integration in a group by way of a test of courage is, in qualitative terms, usually quite significant and remains relatively unique. Likewise, overcoming one's fears, exercising will-power, self-affirmation and masculine self-presentation are an important function of reckless undertakings, like for instance risky tests of courage (Raithel, 2001).

RISK BEHAVIOR OF RELEVANCE TO HEALTH

A special accent falls on the range of behavior relevant to health. Health is clearly more than the lack of illness. That is, in addition to surviving it also encompasses thriving. Increasingly, it is becoming recognized that the distinction between physical and mental health is often artificial and sometimes misleading. Consistent with the

World Health Organization's conception of health, Hurrelmann (1990) defines *health* as the objective and subjective state of well-being that is present when the physical, physiological, and social development of a person are in harmony with his or her own possibilities, goals, and prevailing living conditions. Just as the process of working through developmental transitions is shaped by biological, personal, and sociocultural influences, health and well-being are influenced by these factors as well. This definition is sufficiently broad to recognize the diversity of approaches to health extant in the adolescent development field.

The term *health risk* refers to any threat to one's immediate or future health and well-being. Health risk constitutes a broad category that can include both health risk factors (e.g., poverty, role strain, social isolation, hostile temperament) and health risk behaviors (e.g., substance abuse, violence, sedentary lifestyle or habits, unprotected sexual intercourse, poor eating habits). As a rule, health risk factors and behaviors are being recirocally related (e.g., a past risk behavior becomes a risk factor for future risk behavior)

Usually it is not the behavior as such that is important but the specific dose of the respective behavior.

- In the field of diet, for instance, it is not just a matter of the quality resulting from physiological conversion of the energy and

TABLE 2

Range of behavior relevant to health (Raithel, 2004, p. 37)

Health-risk behavior	Health behavior
High-calorie diet	Highly nutritious diet
Restrictive vs. excessive dietary behavior	Meals taken on a regular basis
	Dental hygiene
Lack of exercise	Exercise/sports
Risky sports	Adequate sleep
Unprotected exposure to the sun	Protected sunbathing
Substance use/abuse	"Moderate" consumption of alcohol
Unprotected sex	Mental hygiene/stress avoidance
Risky behavior in traffic	Medical checkups
Explicitly risk-connotative	
Explicitly Connotative activities	
Listenin to loud music	

nutrients ingested but also, above all, a matter of behavior-related quantity. Thus, regular meals promote health, while both restrictive and excessive types of dietary behavior have to be classified as health risks (Kolip, 1995).

- In the field of exercise, regular physical activity (e.g. sports) promotes health, whereas a lack of exercise accompanied by a high-calorie diet is the main reason for many "civilization diseases". On the other hand, excessive sports activities are damaging to the health from a physiological point of view.
- As for sun-related behavior, the sun may be revered as the "source of life" – exposure to the sun leads to the formation of vitamin D and in the case of many people enhances their feeling of well-being (long deprivation can even lead to depression) - but thanks to the carcinogenic effect of ultraviolet rays sunlight has increasingly dangerous drawbacks (Eid, 2003).
- Substance use is generally considered to be a health risk, although recent cardiologic studies attribute beneficial effects to moderate alcohol consumption (a glass of red wine per day). Adequate sleep (Belloc and Breslow, 1972), dental hygiene (Honkala et al., 2000) and general hygienic behavior as well as mental hygiene, stress avoidance and also recourse to medical and psychosocial facilities (Palentien, 1995) continue to be beneficial to one's health.
- Unprotected sex is considered to be a health risk from the point of view of unwanted pregnancy and contagious venereal diseases, above all AIDS. Explicitly risk-connotative activities like, for example, risky tests of courage and reckless behavior or sensation-seeking (Ruch/Zuckerman, 2001), listening to loud music as well as risky passive and active behavior in road traffic are still a danger to the health.

DELINQUENT RISK BEHAVIOR

The diverse individual legal offences can be assigned to different criminological areas. Battery (harming someone with or without a weapon), robbery or mugging (taking something with force), extortion and purse theft are considered to be forms of delinquent violence (Table 3).

Delinquent behavior, as a form of risk behavior, is characterized by the specific uncertainty of "getting caught" and the imposition of sanctions as a form of harm. A subgroup of delinquent risk behavior primarily observed in research and in public is "violence-affinitive risk behavior" (Ulbrich-Herrmann, 1998) the emphasis being on bodily harm in this case.

TABLE 3

Fields of delinquent behavior

Types of delinquent behavior			
Violent delinquency	Property delinquency	Traffic delinquency	Further delinquency
Bodily harm	Property damage	Violation of traffic regulations	Illegal drugs
Robbery/ mugging	Illegal spraying	Inadequate traffic safety	Dealing/ fencing
Extortion	Theft		Counterfeiting
Purse theft	Burglary		Computer crime

The range covered by the notion of violence per se extends, however, from a narrow defmition of bodily harm to verbal and mental violence, all the way to structural violence. Violence in the narrower sense is defined as a destructive physical act directed against persons (or things) that is performed against the will of the person affected (Ulbrich-Herrmann, 1998, 58). Violence-affinitive risk behavior is to be understood as a seeking type of behavior. Situations capable of leading to violence are consciously sought out, provoked or artificially brought on by adolesceVts for the sake of the risk. So they create situations in which they can be the victim or perpetrator of violence. They run the risk of failure, discovery and harm to themselves.

While delinquent behavior falls into the group comprised of conflict-oriented, mainly "outwardly" directed problem-handling methods, problematic consumer behavior and addictive buying belong to the "inwardly" directed, withdrawal-oriented forms (Lange, 1997; Palentien, 1995). That applies above -all when the consumption is motivated by "compensatory" factors. Purchases or consumption that is supposed to compensate for deficits arising from a failure to solve quite different problems is designated as such today. The ware is not (or not primarily) bought for the sake of its utility value but for the sake of the satisfaction the buyer gets from the purchase act itself and, simultaneously, in the expectation that the satisfaction might provide compensation for the frustration evoked by the unmastered problem.

The field of gambling (lotteries, betting on sports/horses,

TABLE 4

Financial risk behavior (Raithel, 2004, p. 47)

Gambling, betting	Consumer behavior	
	Buying patterns	Contract utilization
Lottery	Direct purchases	Cell phones
Gambling casinos	Orders/online purchases	Telephones
Slot machines	Brokerage	Credit
Sports bets		Internet
Private games of chance		Credit
		Leasing

gambling in casinos, slot machines), for one, and consumer behavior, for another, can be subsumed under financial risk behavior, it being possible to subdivide the second into buying behavior (direct purchases or ordering of legal and illegal goods, cash vs. credit payments) and contractual obligations/utilization (e.g. cellular phones, telephone, Internet, leasing, credit) (Table 4).

THEORETICAL EXPLANATIONS OF RISK BEHAVIOR

During adolescence, developmental transitions and risk behavior are closely linked. There have been important changes in the nature of developmental transitions during adolescence over the past several decades, changes that may have increased the possibility of accompanying health risks (Dryfoos, 1990). In particular, the timing and patterns of developmental transitions associated with the transformation from childhood to adulthood have become more diverse and thus less certain. For example, several important social trends have made the transition to adulthood more variable and potentially more difficult, including changes in the order, timing, and patterns of interpersonal relationships (e.g., cohabitation, parenthood); increased duration of vocational training; difficulty entering uncertain labor markets; and increased pluralism of societal norms and values (Hurrelmann, 1984). At the same time, however, it is essential to recognize that the increased diversity in the timing and patterns of developmental transitions may well contribute to more fulfilling options and thus serve to promote health and well-being.

In most of the theoretical models, developmental transitions are vi wed as temporally and even as causally preceding risk behavior (Schulenberg, Maggs and Hurrelmann, 1997, 9–13). This behavior is viewed as a result of experiencing developmental transitions. To the extent that develop ental transitions contribute to stress that exceeds current coping capabilities, health and well-being are likely to suffer, and (health) risk behaviors (e.g., substance use) may be used as an alternative way of coping. Across the life span, it is the rare developmental transition that does not contribute to stress, but in many cases, coping capacities are not overwhelmed and health is not adversely affected. Nevertheless, given the major and multiple transitions that occur during adolescence, existing coping strategies may have difficulty in keeping up with the stress. This is consistent with Coleman's focal theory (1918), which states that decrements in well-being during adolescence result not from hormoneinduced storm and stress, but instead from the multiple and simultaneous transitions that occur in a relatively short period of time. Furthermore, if it were possible to distribute the transitions more evenly over time, decrements in well-being would be less likely to occur.

Risk behaviors in adolescence also can be viewed as important components of negotiating a developmental transition. The idea that a certain amount of adolescent and young adult risk taking is normative is supported by the high prevalence rates and by evidence that it often accompanies healthy personality development (Silbereisen, Eyferth and Rudinger, 1986). Risk taking and even deviance can serve constructive as well as destructive functions in adolescents' health and development (Jessor and Jessor, 1977). For example, risk taking appears to be an important aspect of negotiating greater autonomy from parents (Irwin and Millstein, 1992). On the other hand, such autonomy-seeking behavior could be detrimental to one's health – for example, if it contributes to noncompliance with behavioral regimes prescribed to manage chronic illnesses. Alcohol use and binge drinking during the transition to college may help adolescents achieve valued social goals, such as making friends in a new environment. At the same time, however, binge drinking could be quite destructive in terms of one's safety and short- and long-term health and well-being.

FUNCTIONS OF RISK BEHAVIOR

Summing up, the main instrumental function of risk behavior lies in the "mastering" of developmental tasks and other challenges.

TABLE 5

Developmental tasks and functions of substance use (Silbereisen and Noack, 1998).

Developmental tasks	Functions of substance use
Knowing who one is and what one wants; identity	• expression of personal style • search for limit-breaking, consciousness – expanding experience and adventures
Development of friendships; establishment of intimate relationships	• easier access to peer groups • excessive/ritualized behavior • establishment of contacts with peers of the opposite sex
Becoming independent/ separation from parents	• demonstrating independence from • conscious violation of parental controls • conscious violation of parental controls
Shaping/planning life	• sharing in subculture lifestyles • having fun and enjoying
Developing one's own system of values	• intentional violation of standards • expression of social protest
Developmental problems	• surrogate goals • regulation of stress and emotions

The function is actively employed by young people to meet the specific demands of their phase of life and is considered to be an attempt to confront life's everyday problems and challenges. So a transition related social function can be accorded to risk behavior. Table 5 shows the developmental function of risk behavior taking substance use as an example.

As the examples above demonstrate, risk behavior can be linked to a wealth of instrumental and expressive connotations:

1) As facilitation of acceptance by and *integration* in a clique, for *stabilization* of an acquired social position and as an expression of *identification* with the adolescent subculture (conformity with peer norms going hand in hand therewith). The pursuance of

different risk behaviors assures acceptance of group members by the age group and thus membership in the group.

2) As a means of (role-specific) *self-portrayal* and a way to confer attributes on one's personal identity (development of a concept of self). Extreme risks set a person off from his or her contemporaries and make "admirers" pay attention.
3) As a *symbol of opposition* to demonstrate a break with and resistance to conventional norms and parental/societal value notions. Risk behavior makes it possible to draw a line separating the actor from adult society and the behavioral standards demanded by society. At the same time, it serves to differentiate the actor from concrete adults.
4) As a *symbol of autonomy* when crossing the line to adult status or as a *symbol of maturity* it demonstrates a gradual increase in independence and a claim to the rights and behavior of adults. The instrumentalization of risky forms of behavior works as a symbolic (adult) act. This becomes especially clear in the case of tobacco and/or alcohol consumption.
5) As a form of *egocentrism* or as a pronounced *narcissistic phenomenon* (e.g. the danger to third persons is not reflected on when risky behavior in road traffic is involved). The narcissism phenomenon among adolescents must not be viewed as a disorder but looked at from the point of view of its functionality for the social separation, orientation and identity-finding process. The young see only what is personal, the uniqueness of the way they perceive the world, because they are constantly preoccupied with themselves during the separation process and the social expansion of their realm that entails.
6) As an excessive pattern risky behavior makes it possible to experience and try out *individual degrees of freedom* (feeling of independence) and to gain control over situations and oneself. It also serves as a *counterpoint* to the routine of normal life. Risk behavior is indulged in for enjoyment, fun and the pleasure of experimentation.
7) As a *relief-providing, compensatory or surrogate act* aimed at coping with a lack of status, developmental problems, frustrations, failures, real and anticipated fears. Risky practices likewise help to *fee* from the fate of having to become an adult, and thus reasonable.

INTEGRATIVE MODEL OF RISK BEHAVIOR

For further research it will be helpful to subdivide into three variants the consequences entailed by inappropriate forms of coping with

problem constellations usually attributable to inadequate personal and social resources. They take on *externalizing, internalizing* or *evasive* forms (Figure 2).

- The pressure exerted by the problems confronting youth can be directed "outward" to the social environment of the family, school, workplace, circle of friends and the public (externalizing variant). In the social realm that includes social and political protest, participation in illegal groupings, antisocial behavior, criminal behavior and violence. In the field of health, aggression toward other people is a symptom of inadequate skills to cope with problem constellations. The unpleasant consequences of badly damaged self-esteem are, to a certain extent, *shifted to the outside world* in the case of the externalized variant because one is unwilling or unable to confront them with the core of one's personality.
- The pressure exerted by problems can be directed "inward" to one's psyche and body (internalizing variant). In the social realm this variant is expressed by withdrawal and isolation, a lack of interest in public events and a lack of engagement; in health terms it can manifest itself in psychosomatic disorders and depressive moods, up to and including attempts at suicide. These forms of behavior are symptomatic of a lack of coping skills, a situation that is reacted to with helplessness because *one sees oneself as responsible for the same but without any knowledge of a path to a solution.*
- The handling of problems can take a direction other than outward or inward (evasive variant). This "getting out of the way" is expressed in the social realm by nonconformist types of behavior and fickle, capricious social relationship patterns; and in the field of health by addictive behavior (the use of legal and illegal drugs, eating disorders, compulsive consumption or gambling). These types of behavior are a combination of inwardly and outwardly oriented variants, they have aggressive and autoaggressive features and are symptomatic of *fleeing from and evading arduous "work on oneself"* as well as "work on one's situation in life" that could point to a way out of the problem constellation.

In terms of their subjective logic, all three variants represent a respectively conclusive and psychosocially plausible solution to stress situations and problem constellations. In every case, however, this "solution" is only a *pseudosolution,* for the actual initial problems and their causes are not treated with rigor. Instead of confronting unpleasant, difficult and painful work on one's personality, one evades it, puts the blame on others or withdraws into isolation.

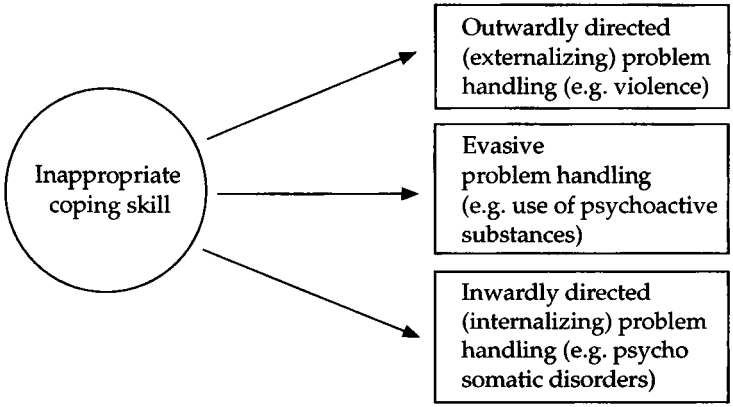

Figure 2. Forms taken by the consequences of inappropriate coping

In the long run, that results in negative dynamics for all further development of one's personality.

DEVELOPMENTAL TRANSITION OF ADOLESCENCE: HEALTH PROMOTION IMPLICATIONS

As the preceding chapters have shown, the passage toward adult roles, relationships, and responsibilites involves fundamental changes in every domain of life. Experiences and decisions during the adolescent years have the potential to build character and competence, develop skills for coping with life's challenges, and enhance health and well-being. At the same time, normative and nonnormative developmental transitions expose adolescents to many challenges and hazards that may jeopardize their optimal development and health. The goal of health promotion therefore is to support and enhance an optimal development (Millstein, Petersen and Nightingale, 1993).

Many health problems of adulthood have their origin in behavioral patterns that are formed during adolescence, such as smoking, exercise, and eating habits. Furthermore, adolescence is a time when coping styles begin to consolidate. Habits and lifestyles formed during these years are likely to continue throughout life. In addition, during adolescence and young adulthood, many consequential life decisions are made concerning educational attainment, occupational choices, relationship and family formation, and lifestyle options, making adolescence an important formative period likely to yield long-term benefits of health-promoting efforts.

Clearly, it is not subjectively attractive or rewarding to behave in an objectively healthy way in every situation. In adolescence, as in adulthood, behaviors that may compromise well-being are an integral and pleasureable part of personal lifestyles. Risky behaviors such as smoking, drinking, and sexual activity can fulfill certain essential functions for adolescents such as identity exploration, coping with stress, gaining admission to or acceptance by certain peer groups, opposing adult authority, or indicating a transition to a more mature status (Hurrelmann, 1990; Irwin and Millstein, 1992; Jessor, 1984; Rutter, 1995).

From the developmental perspective taken in this paper, health promotion should involve attempts to support, alter, or redirect developmental processes that are already in motion. That is, the goal is not only to alter current attitudes and behaviors, but also to have an enduring impact on developmental trajectories. The term developmental intervention has been used to describe such efforts, which may target any aspect of individuals (e.g., biochemical, cognitive, social) or their environments, and may take place at any point, or across several points, in the life span.

Effective developmental interventions should not be individual centered. Recent approachs have largely focused on individual behavior while ignoring or downplaying ecological and social living conditions as prerequisites of healthy development (Hurrelmann, 1990). Focusing exclusively on behavioral dimensions tends to put all of the adaptional burden on individuals; however, experience has shown that health promotion can be successful only if it is embedded in a structural context that takes into account the dependency of individual growth on environmental conditions and that aims at improving the living conditions of adolescents and their families. Although changing individual behavior is a fundamental goal of most programs, it is also important to aim to effect change in other domains, including social norms and structures.

REFERENCES

Belloc, N.B./Breslow, L. (1972). Relationship of physical health status and health prices. *Preventive Medicine*, **9**, 469–481.

Cairns, R.B. & Cairns, B.D. (1994). *Lifelines and risks: Pathways of youth in our time.* Cambridge University Press; New York.

Coleman, J. (1978). Current contradictions in adolescent theory. *Journal of Youth and Adolescence*, **7**, 1–11.

Dryfoos, J.G. (1990). *Adolescents at Risk: Prevalence and prevention.* Oxford University Press; New York.

Eid, P. (2003). Kritische Sonnenexposition. In *Psychologische Gesundheitsförderung. Diagnostik und Prävention* (M. Jerusalem & H. Weber, eds.) pp. 321–338. Hogrefe; Göttingen.

Elliott, D. (1993). Health-enhancing and health-compromising lifestyles. In *Promoting the health of adolescents: New directions for the twenty-first century* pp. 119–145. Oxford University Press; New York.

Havighurst, R. (1952). *Developmental tasks and education*. McKay; New York.

Honkala et al. (2000). A case study in oral health promotion. In: The Evidence of Health Promotion Effectiveness. A report for the European Commission by the International Union for Health Promotion and Education. Brussels.

Hurrelmann, K. (1984). Societal and organizational factors of stress on students in school. *European Journal of Teacher Education*, **7**, 181–190.

Hurrelmann, K. (1990). Health Promotion for Adolescents. Prevention and Corrective Strategies Against Problem Behavior. *Journal of Adolescence*, **13**, 231–250.

Hurrelmann, K. (1998). *Human Development and Health*. Springer; New York.

Hurrelmann, K. (2000). *Gesundheitssoziologie*. Juventa; Weinheim.

Hurrelmann, K. (2004). *Lebensphase Jugend*. Juventa; Weinheim.

Igra, V. & Irwin, C.E., (1996). Theories of adolescent risk-taking behavior. In *Handbook on adolescent health risk behavior*. (R.J. DiClemente, W.B. Hansen, L.E. Ponton) pp. 35–51. Plenum Press; New York.

Irwin, C.E., Jr. & Millstein, S.G. (1992). Risk-taking behaviors an biopsychosocial development during adolescence. In *Emotion, cognition, health and development in children and adolescents* (E. J. Susman, L.V. Feagans & W.J. Ray, eds) pp. 75–102. Erlbaum; Hillsdale, N.J.

Jessor, R. (2001). *Problem-Behaviour Theory*. In *Risikoverhaltensweisen Jugendlicher. Formen, Erklärungen und Prävention* (J. Raithel, ed.) pp. 61–78. Leske + Budrich; Opladen.

Jessor, R. & Jessor, S.L. (1977). *Problem behavior and psychosocial development: A longitudinal study of youth*. Academic Press; New York.

Kolip, P. (1997). *Geschlecht und Gesundheit im Jugendalter. Die Konstruktion von Geschlechtlichkeit über somatische Kulturen*. Leske + Budrich; Opladen.

Lange, E. (1997). *Jugendkonsum im Wandel*. Leske + Budrich; Opladen.

Millstein, S.G., Petersen, A.C. & Nightingale., E.O. (eds.) (1993). *Promoting the health of adolescents: New directions for the twenty-first century*. Oxford University Press; New York.

Palentien, C. (1995). Die Inanspruchnahme medizinischer und psychosozialer Versorgungseinrichtungen von Kindern und Jugendlichen. In *Gesundheitsversorgung von Kindern und Jugendlichen. Ein Praxishandbuch* (W. Settertobulte, C. Palentien & K. Hurrelman, eds.) pp. 153–168. Asanger; Heidelberg.

Raithel, J. (2001). Risikoverhaltensweisen Jugendlicher – Ein Überblick. In *Risikoverhaltensweisen Jugendlicher. Formen, Erklärungen und Prävention* (J. Raithel, ed.) pp. 11–29. Leske + Budrich; Opladen.

Raithel, J. (2003). Mutproben im Übergang vom Kindes- ins Jugendalter. Befunde zu Verbreitung, Formen und Motiven. *Zeitschrift für Pädagogik*, **49**, 657–674.

Raithel, J. (2004). *Jugendliches Risikoverhalten. Eine Einführung*. Wiesbaden; VS.

Ruch, W. & Zuckerman, M. (2001): Sensation Seeking and Adolescence. In: Risikoverhaltensweisen Jugendlicher. Formen, Erklärungen and Pravention. (J. Raithel, ed.) pp. 97–110. Leske + Budrich; Opladen.

Rutter, M. (Ed.), (1995). *Psychosocial disturbances in young people: Challenges for prevention*. Cambridge University Press; New York.

Schulenberg, J., Maggs, J. & Hurrelmann, K. (1997) (Eds). *Health Risks and Developmental Transitions During Adolescence*. Cambridge University Press; New York.

Seiffge-Krenke, I. (1998): *Adolescent's Health.* Erlbaum; London.
Silbereisen, R.K., Eyferth, K. & Rudinger, G. (Eds.) (1986). *Development as action in context: Problem behavior and normal youth development.* Springer-Verlag; New York.
Silbereisen, R.K. & Noack, P. (1988). On the constructive role of problem behavior in adolescence. In *Persons in context: Developmental processes* (N. Bolger, A. Caspi, G. Downey & M. Moorehouse, eds) pp. 152–180. Cambridge University Press; Cambridge.
Silbereisen, R.K. & Todt, E. (1994). *Adolescence in context.* Springer; New York.
Steptoe, A. Wardle, J. Vinck, J. Fuomisto, M. Holte, A. & Wichstrom, L. (1994). Personality and attitudinal correlates of healthy and unhealthy lifestyles in young adults. *Psychology and Health,* **9**, 331–341.
Ulbrich-Herrmann, M. (1998). *Lebensstile Jugendlicher and Gewalt. Eine Typologie zur mehrdimensionalen Erklärung eines sozialen Problems.* Lit; Münster.
Yates, F. (1992) (Ed.). *Risk-Taking Behavior.* Wiley; Chichester & New York.