

“Bet You I Will!”

Risk or Experimental Behavior During Adolescence?

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A large and growing body of literature has focused on the relationship between the health of adolescents and the notion of risk. Various expressions such as “psychosocial risk,” “risk taking,” and “problem behavior” have been used to delineate this relationship.¹⁻⁴ Interest in risk behavior stems from evidence that most deaths and a substantial amount of adolescent morbidity are related to behavioral and psychosocial characteristics more than to acquired illness or inherited traits. Traffic injuries, suicide, and interpersonal violence are the leading causes of death among adolescents in the United States as well as in many European countries.^{5,6}

However, the concepts of risk behavior and risk-taking behavior, so often combined with the word “adolescent,” should be used more cautiously. Indeed, most of the behaviors considered risk-oriented are essentially developmental in nature²; risk taking is a fact of life.^{7,8} The term “risk” should be reserved for situations where the type of circumstances, the nature of interactions with others, and the particular moment in the adolescent’s development create the conditions for a problem behavior. Other behaviors occurring in different environmental and personal conditions should be considered experimental and approached as such by researchers and clinicians. This perspective on risk behaviors comprises 2 major aspects: epidemiological and methodological on the one hand, sociological and conceptual on the other hand.

EPIDEMIOLOGICAL AND METHODOLOGICAL ISSUES

Risk Factors, Risk Behaviors, or Risky Situations?

From their interpretations of epidemiological research papers, clinicians may get the impression that teenagers who have

identifiable risk factors are automatically risk-behavior participants; conversely, clinicians may erroneously assume that teenagers who do not have these risk factors are not going to be involved with risk behaviors. This is not the case: risk factors and risk behaviors are 2 distinct aspects of the general concept of risk, and one cannot generalize from population-level data to the individual.²

Despite Jessor’s² efforts to promote a qualified and multicomponent definition of risk, much of the research on adolescents’ health behaviors persistently explores a single risk behavior, often as a model, investigating objective as well as subjective or perceptual characteristics. Medical journals on adolescent health are overflowing with articles written from this perspective, exploring the use of cannabis or nonuse of condoms at a given moment in a given population. While such an approach may have been useful in developing and refining discrete preventive strategies for defined populations, there is a risk of generalizing from a population profile to an individual profile. Such a reductionist approach dismisses the fact that adolescents are rapidly changing and that what is true at one point of their lives is not necessarily true 1 week or 6 months later. Very often, risk behaviors arise more because of situations that bring new, unexpected challenges to an inexperienced youngster than because of characteristics inherent in the individual.

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Focusing on risk-enhancing situations rather than on risk behaviors has the advantage that it stresses the influence of environmental factors on health. For example, research has shown migrant youth to be more “at risk” than their indigenous peers. Implicit in those data is that the cause of the migrants’ being at risk lies within them (perhaps something that made them leave their native land in the first place) rather than in the host society, while the host society may subtly or overtly be creating a hostile environment. Similar observations can be made for ethnic minorities, youth with disabilities, and other socially marginalized young people.

Does Clustering Correspond to Any Reality?

Whether so-called risk behaviors are viewed as discrete events or conceived of as clustering is important because evaluative measures will be driven by that conceptual model. Many empirical studies conducted in North America tend to support the perspective that behaviors cluster.^{9,10} Data suggest, however, that where behaviors cluster, it is health-compromising behaviors in particular (eg, illicit substance abuse or heavy drinking), rather than health-promoting behaviors (eg, use of seat belt or regular exercise), that cluster. As far as sexual behavior is concerned, the results are even less indicative of its clustering with other behaviors.¹¹⁻¹³ Thus, the concept of clustering seems inappropriate when it is used to describe all the subtleties of most adolescents’ lives. Moreover, reducing adolescents’ conduct to clusters of harmful behaviors promotes a negative image of their lifestyle. This negative perspective neglects protective factors and beneficial behaviors that may exist independently or may be correlated with potentially dangerous behaviors.

In addition, studies carried out among ethnic minorities in North America have suggested that the definition of risk behaviors and the associations among specific activities may change from one youth culture to another.^{14,15} Results of research in other countries around the world also suggest that the risk-behavior syndrome theory may be in some ways culturally specific and, thus, more related to cultural determinants than to the personal status of the adolescent.¹⁶⁻¹⁹

SOCIOLOGICAL AND CONCEPTUAL ISSUES

Are Adolescents the Only Ones Who Take Risks?

An important drawback of focusing on risk taking when discussing adolescents’ health is the implication that only teenagers, not adults, take risks. Two surveys conducted in France and in Switzerland recently have focused on the issue of blood alcohol level in injured drivers.^{20,21} Both surveys show that the percentages of persons exhibiting detectable levels of alcohol in their blood on arrival in the emergency department are lower among teenagers and young adults than among older people.

The Swiss Federal Office of Public Health has been assessing the influence of the Swiss national campaign against acquired immunodeficiency syndrome for almost 10 years.²² Each time a survey was conducted—in 1987, 1990, 1992, and 1995—the rates of respondents reporting the use of a condom with a casual partner were higher among teenagers than among adults. By being so

focused on risks taken by teenagers, adults often fail to acknowledge their own behaviors!

Youth Must Have Its Fling

Too often, adults, especially health professionals, hold a static view of adolescents’ health. They seem to forget that most hazardous behaviors diminish over time without having the anticipated negative effect.²³ One example is substance abuse. Several longitudinal surveys (eg, Chen and Kandel,²⁴ a 19-year longitudinal study in New York) have addressed the outcome of substance abuse among adolescents. Chen and Kandel’s study shows a steady rise in adolescent drug use until approximately the ages of 18 to 22 years (depending on the drug), when it plateaus and subsequently begins to decline. Simply stated, much of adolescent drug use is time limited. For example, according to Chen and Kandel,²⁴ “by ages 34 to 35, only 25.3% of male users and 14.3% of female users were still using marijuana within the past year, compared with 51.0% of male users and 35.2% of female users during the period of highest usage from ages 19 to 24.” Conversely, these percentages show that a very high proportion ($\approx 75\%$ of the men and 85% of the women) of the young adults defined as “marijuana users” did not use marijuana during the preceding year.

Another implication of these findings is that there may be no aftereffects of these kinds of behaviors for most individuals who adopt them only once during their adolescence.

Health Imperialism

As causes of morbidity and mortality in the second decade of life have shifted from infectious to behavioral origins, so too have our conceptualizations of health and illness. Specifically, behaviors that historically have been illegal (eg, public drunkenness) or immoral (eg, sexual abuse) are now considered to reflect ill health, and lifestyle has become as central to our view of pathology as are microbes. When one’s behavior does not conform to social norms and then illness results (eg, lung cancer in a smoker), public perception is that the individual caused his or her illness,²⁵ ignoring or deflecting societal responsibilities.

For adolescents this contradiction is especially problematic and hypocritical. In the hypersexual world of music, television, and advertising in which youth live and in a world filled with drugs for every mood and difficulty adults may experience (eg, the current selective serotonin reuptake inhibitor and melatonin crazes)—we demand abstinence from adolescents. And when they fail to heed our warnings and morbidity results, we hold responsible their risk-taking behavior (which we view as a pathologic condition) rather than the social environment in which we live. Our language is one of victim-blaming rather than one reflecting collective responsibility.

Additionally, the perception of events and behaviors among teenagers and adults may not be the same. Where health professionals see only irresponsibility and unnecessary risk, adolescents experience intense pleasures and challenging gambles that lead to increased self-knowledge and to the feeling of being real and special. If health professionals are to be effective in working with young people, we must try to understand these percep-

tions and not simply dismiss them as invalid or distracted. From the perspective of young people, risk-taking behaviors are just fun and a vehicle for discovery. They also represent a way to structure their own identity.

IMPLICATIONS

The concept of risk during adolescence, while useful, has some significant limitations: it focuses too much on teenagers and places too much emphasis on the individual's responsibility for health, ignoring the collective responsibility of promoting dangerous behaviors; it represents a negative concept and, thus, implies a negative definition of health influencing the way health care professionals work with adolescents; and too often it is viewed as a static concept (eg, one is a risk taker or not), dismissing the fact that risk is an essential part of life and an important aspect of the maturational process.

In the search for a more appropriate term than risk-taking behaviors, some authors^{26,27} have proposed to use other terms such as "conduite d'essai" or "experimental behavior" for behaviors common during adolescence (eg, having sex, drinking alcohol, trying cannabis, engaging in physically dangerous activities, or driving too fast). We are proposing, much more than a simple change in terminology, a shift of conceptual framework, a change in the attitudes toward adolescents' behaviors.

This approach has several implications. Clinicians should avoid labeling behaviors as risky. Rather, they should try to understand, on an individual level, the role, the meaning, the motives, and the potential consequences of these behaviors for the teenager. Each adolescent health behavior should be considered in the light of its level of risk for negative consequences. Indicators of a worse prognostic can be looked for in the adolescents' material and human environment, as well as in their mental health: poverty, physical or psychological violence, loneliness, hopelessness, or suicidal ideations. Resiliency factors could also be investigated, to evaluate the probability that an experimental behavior may not persist; feeling connected to a caring adult is one of the most powerful of these protective factors. Other ameliorative factors exist and should be explored further.²⁸

Future research should target the positive determining factors and health-enhancing, long-term consequences of experimental behaviors. The developmental consequences should be considered for those who do not participate in these behaviors. Preventive programs should place less emphasis on risks and more emphasis on the consequences—negative and positive—of one's conduct. Programs should strive to increase the margin of safety within which experimental behaviors occur. Rather than preventing behaviors, youth-focused interventions should strive to enhance healthy development of young people by creating skills and options.

Central to this discussion lies the concept of choice: humans are born with the ability—and sometimes the freedom—to choose. Our ultimate duty, as health professionals and educators, is to offer our young patients an opportunity to think and talk about their choices, to become aware of the value of their body and health, to develop a sense of the respect they owe to themselves and to others, and to discover the role they want to play in our society and our world.²⁹⁻³¹

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REFERENCES

1. Millstein SG, Irwin CE, Adler NE, Cohn LD, Kegeles SM, Dolcini MM. Health-risk behaviors and health concerns among young adolescents. *Pediatrics*. 1992;89:422-428.
2. Jessor R. Risk behavior in adolescence: a psychosocial framework for understanding and action. *J Adolesc Health*. 1991;12:597-605.
3. Donovan JE, Jessor R, Costa FM. Syndrome of problem behavior in adolescence: a replication. *J Consult Clin Psychol*. 1980;56:762-765.
4. Irwin CE. The theoretical concept of at-risk adolescents. In: Braverman PK, Strasburger VC, eds. *Adolescent Medicine: State of the Art Reviews*. Philadelphia, Pa: Hanley & Belfus Inc; 1990:1-14.
5. Guyer B, Strobino DM, Ventura SJ, Singh GK. Annual summary of vital statistics, 1994. *Pediatrics*. 1995;96:1029-1039.
6. Kaminsky M, Bouvier-Colle MH, Blondel B. *Mortalité des jeunes dans les pays de la Communauté Européenne*. Paris, France: INSERM; 1991.
7. Keeney RL. Decisions about life-threatening risks. *N Engl J Med*. 1994;331:193-196.
8. Lupton D. Taming uncertainty: risk discourse and diagnostic testing. In: *The Imperative of Health, Public Health and the Regulated Body*. London, England: Sage Publs Ltd; 1995:77-105.
9. Donovan JE, Jessor R. Structure of problem behavior in adolescence and young adulthood. *J Consult Clin Psychol*. 1985;53:890-904.
10. Jessor R. Problem-behavior theory, psychosocial development, and adolescent problem drinking. *Br J Addict*. 1987;82:435-446.
11. Mott FL, Haurin RJ. Linkages between sexual activity and alcohol and drug use among American adolescents. *Fam Plann Perspect*. 1988;20:128-136.
12. Raskin-White H, Johnson V. Risk taking as a predictor of adolescent sexual activity and use of contraception. *J Adolesc Res*. 1988;3:317-331.
13. Senf JH, Price CQ. Young adults, alcohol and condom use: what is the connection? *J Adolesc Health*. 1994;15:238-244.
14. Arredondo R, Streit K, Springer N, et al. Ethnic and cultural factors in substance abuse: diagnosis, treatment, and prevention. *Adolesc Med*. 1993;4:263-276.
15. Stanton B, Romer D, Ricardo I, et al. Early initiation of sex and its lack of association with risk behaviors among adolescent African-Americans. *Pediatrics*. 1993;92:13-19.
16. Choquet M, Manfredi R. Sexual intercourse, contraception, and risk-taking behavior among unselected French adolescents aged 11-20 years. *J Adolesc Health*. 1992;13:623-630.
17. Grube JW, Morgan M. The structure of problem behaviours among Irish adolescents. *Br J Addict*. 1990;85:667-675.
18. Kandel DB, Adler I, Sudit M. The epidemiology of adolescent drug use in France and Israel. *Am J Public Health*. 1981;71:256-265.
19. Wada K, Fukui S. Prevalence of tobacco smoking among junior high school students in Japan and background lifestyle of smokers. *Addiction*. 1994;89:331-343.
20. Haut comite d'étude et d'information sur l'alcoolisme. *Alcool et accidents*. Paris, France: Centre des Enfants Internationale; 1985.
21. Michiels W, La Harpe, R. Les ivresses dans le trafic à Genève: distribution et détection. *Soz Praventivmed*. 1996;41:19-27.
22. Dubois-Arber F, Jeannin A, Meystre-Agostoni G, Spencer B, Moreau-Gruet F, Paccaud F. *Evaluation of the AIDS Prevention Strategy in Switzerland Mandated by the Federal Office of Public Health: Fifth Assessment Report 1993-1995*. Lausanne, Switzerland: Institut Universitaire de Médecine Sociale et Préventive; 1996. Cah Rech Doc IU MSP, No. 120b.
23. Dinman BD. The reality and acceptance of risk. *JAMA*. 1980;244:1226-1228.
24. Chen K, Kandel DB. The natural history of drug use from adolescence to the mid-thirties in a general population sample. *Am J Public Health*. 1995;85:41-47.
25. Fitzgerald FT. The tyranny of health. *N Engl J Med*. 1994;331:196-198.
26. Tomkiewicz S. Les conduites de risque et d'essai. *Neuropsychiatr Enf*. 1989;261-264.
27. Manciaux M, Jeanneret O. Les accidents atteignant les enfants et les adolescents: de la connaissance épidémiologique à l'action préventive. *Rev Epidemiol*. 1983;31:12-23.
28. Werner E. The children of Kauai: resiliency and recovery in adolescence and adulthood. *J Adolesc Health*. 1992;13:262-268.
29. Rassial JJ. Remarques sur le risque. *Santé Publique*. 1992;4:23-25.
30. Deschamps JP. L'adolescent et la prévention: au delà des cloisonnements. In: Choquet M, Dressen C, eds. *Adolescence Plurielle*. Paris, France: Edition du CIE; 1993:139-152.
31. Tursz A, Souteyrand Y, Salmi R. *Adolescence et Risque*. Paris, France: Syros; 1993.