



KATJA JORONEN

# Adolescents' Subjective Well-being in their Social Contexts



ACADEMIC DISSERTATION

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for public discussion in the auditorium of Tampere School of  
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University of Tampere, Department of Nursing Science  
Finland

Supervised by  
Professor Päivi Åstedt-Kurki  
University of Tampere  
Docent Marja-Terttu Tarkka  
University of Tampere

Reviewed by  
Professor Markku Ojanen  
University of Tampere  
Professor Katri Vehviläinen-Julkunen  
University of Kuopio

Distribution  
Bookshop TAJU  
P.O. Box 617  
33014 University of Tampere  
Finland

Tel. +358 3 215 6055  
Fax +358 3 215 7685  
taju@uta.fi  
www.uta.fi/taju  
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Dedicated to the memory of my beloved mother and nurse, Sirkka

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## List of original publications

The study is based on the following papers, which are referred to in the text by their Roman numerals. In addition, some previously unpublished data are presented.

- I Rask K (maiden name), Åstedt-Kurki P and Laippala P: Adolescent subjective well-being and realised values. Journal of Advanced Nursing 2002, 38, 254-263.
- II Rask K (maiden name), Åstedt-Kurki P, Tarkka M-T and Laippala P: Relationships of adolescent subjective well-being, health behavior and school satisfaction. Journal of School Health 2002, 72, 243-249.
- III Rask K (maiden name), Åstedt-Kurki P, Paavilainen E and Laippala P: Adolescent subjective well-being and family dynamics. Scandinavian Journal of Caring Sciences 2003, 17, 129-138.
- IV Joronen K and Åstedt-Kurki P. Familial contribution to adolescent subjective well-being. International Journal of Nursing Practice. Accepted for publication in May 2004.
- V Joronen K and Åstedt-Kurki P. Adolescents' experiences of familial involvement in their peer relations and school attendance. Primary Health Care Research and Development 2005, 6, 000-000. In print.

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## **Abbreviations**

AHLS	Adolescent Health and Lifestyle Survey
BSW/Y	Berne Questionnaire of Subjective Well-being/Youth form
ENHPS	The European Network of Health Promoting Schools
FDM II	Family Dynamics Measure II
FVSW	Finnish Questionnaire of Adolescent Values and Subjective Well-being
HBSC	Health Behaviour in School-aged Children
QoL	Quality of Life
SHPS	School Health Promotion Survey
SWB	Subjective Well-Being

# 1 Introduction

A great deal of scientific and lay interest in adolescence exists at the moment in Western countries (Cieslik 2003). While adolescent problems and ill-being continuously receive publicity in the media, resources and well-being of adolescents do not seem to be a current topic of interest. (Ryff 1995; Ambert 1997, p. 41; Heaven 2001; Lintonen 2001; Rimpelä 2002) Previous studies in Western countries no doubt revealed a constant upward trend in or at least a considerable presence of adolescent ill-being, such as smoking (Amos 1996; Hill 1998; Rimpelä 2002) and drinking habits (Pedtechenskaya and Sinisalo 1999; Seguire and Chalmers 2000; Office on Smoking and Health; Division of Adolescent and School Health...2000; Lintonen 2001; Rimpelä 2002), drug abuse (Bosch 2000; Luopa et al. 2000), perceived stress (Natvig et al. 1999), psychosomatic symptoms (Krisjánisdóttir G 1997; Natvig et al. 1999; Rimpelä 2002), and mental disorders (Goodman and Capitman 2000; Rimpelä 2002). Similar results were indicated by two Finnish national surveys, i.e. the School Health Promotion Survey (SHPS), conducted every other year since 1977, and the Adolescent Health and Lifestyle Survey (AHLS), carried out every year since 1995 (see e.g. Lintonen 2001). Although most of the previous studies indicated either implicitly or explicitly that the majority of teenagers in developed countries have no or few problems, the focus still remains problem-oriented.

In addition to the interest in adolescent ill-being, there is also an increasing trend to attribute reasons and responsibility for adolescent behaviour and problems. Several study results highlight the importance of a close relationship with parents or a significant adult, and peer relationships as well as school satisfaction for adolescent development and well-being (e.g. Werner 1993; Ohannessian and Lerner 1994; Shucksmith et al. 1995; Treiman and Beck 1996; Natvig et al. 1999; Ahlström et al. 2002; Field et al. 2002; Konu 2002; Rodgers and Rose 2002; Rönkä et al. 2002; Somersalo 2002; Van Wel et al. 2002; Paavonen 2004). Consequently, families of adolescents, in particular parents, and school currently receive attention in the political arena and the media (e.g. Koivusilta et al. 2002; Turunen et al. 2004).

The World Health Organization (1993) has expressed its concern about adolescent well-being and called for interventions in adolescent health issues. The European Network of Health Promoting Schools (ENHPS) supported by the Council of Europe, the European Commission



and the WHO is a strategic programme to integrate the policy and practice of the health promoting school into the wider health and education sectors. More than 40 countries, Finland among them since 1993, in the European Region are members of the ENHPS. (Turunen et al. 2004; <http://www.who.dk/ENHPS>) The Finnish Parliamentary Commission of Social Affairs and Health stated that adolescent well-being and ill-being are mostly influenced by their families and they suggest, for instance, that the Finnish government should pay more attention to achieving a better balance between family and work (StVM 23/2002). There is also a wide variety of Finnish NGOs (non-governmental organisations), which promote the welfare of families. A number of voluntary community projects related to adolescents, families and school have been conducted. One of them is the “Together to good life<sup>®</sup>” (Yhdessä elämään) project which emphasises the responsibility of all parties for children and adolescents and which was recognised as the best European project (EPA’s Alcuin Award) supporting child rearing in 1996. Furthermore, supporting families (under the title “Koti – kasvun paikka”, “Home – a place for growth”) is a central goal of youth work in the Evangelical Lutheran Church from 2003 to 2005 (Holländer et al. 2002).

Subjective well-being (SWB) is one of the major goals and general concerns for most people (Diener 1998). The concept emphasises strengths and resources as well as problems and needs and provides a more comprehensive picture of health than a traditional biomedical approach. SWB is therefore congruent with the perspective of nursing (Meister 1991), as the maintenance and improvement of individuals’ and families’ well-being is one of the main interests in nursing practice (Harmon Hanson and Boyd 1996; Åstedt-Kurki et al. 1999; Paunonen 1999; Pietilä 1999). In nursing science, subjective health and well-being are studied, for instance, in terms of the meaning of health (Häggman-Laitila and Åstedt-Kurki 1992; Lindholm 1997), life-control (Pietilä et al. 1994), empowerment (Pelkonen 1994; Pelkonen and Hakulinen 2002) and resilience (Walsh 1996). Psychological studies have indicated that personality traits exhibit some of the strongest relations with SWB: a happy person is one who is extraverted, optimistic, and worry-free (Diener et al. 1992; Diener et al. 1999). A number of studies have furthermore investigated the relationships between subjective well-being (SWB) and various demographic and societal indicators, such as financial state (Diener et al. 1995; Kainulainen 1998; Schyns 2003), self-rated health status (Okun and George 1984; Kainulainen 1998), life events (Grob 1991; Grob 1995b; Kainulainen 1998; McCullough et al. 2000), family structure and relations (Grossman and Rowat 1995; Shucksmith et al. 1995; Kainulainen 1998) and life goals (Salmela-Aro 1996).

These studies have shown that high income or especially living in a wealthy nation, perceived good health, good family relations and personal goals are associated with SWB (Grob 1991; Diener et al. 1995; Grossman and Rowat 1995; Shucksmith et al. 1995; Salmela-Aro 1996; Suh et al. 1996; Kainulainen 1998; Currie 1999; Inglehart 2000; McCullough et al. 2000; Schyns 2003). However, SWB researchers believe that social indicators alone do not define quality of life (Diener and Suh 1997). People react differently to the same circumstances, and they evaluate conditions based on their unique values and experiences (Diener et al. 1999, p. 277). Diener et al. (1999, p. 284) thus suggest that demographic factors and life events may affect SWB primarily when they facilitate progress toward personal goals.

Recent studies have also indicated that the level of adult and adolescent subjective well-being regardless of the macrosocial context is fairly high (see e.g. Diener and Diener 1996; Kainulainen 1998; Currie 1999; Grob et al. 1999; Berntsson and Köhler 2001; Koivusilta et al. 2002), and self-rated global well-being has temporal stability over periods of years (Suh et al. 1996; Kainulainen 1998). Teenagers are generally satisfied with life, manage their school work, maintain satisfactory relationships with their parents, and prepare themselves for lives as adults (Conger and Petersen 1984; Niemelä et al. 1994; Heaven 2001; Saarela 2002; Van Wel et al. 2002). Several theorists additionally highlight that bad feelings and problems are naturally included in life, and the perception of these therefore indicates a realistic acknowledgement of life and even contributes to life satisfaction (Veenhoven 1991b; Arnett 1999; Sumerlin and Bundrick 2000; Laine and Kangas 2002).

The economic recession and the subsequent economic boom in Finland have caused both societal and cultural changes (Salmi et al. 1996; Nätti et al. 1998; Sauli et al. 2002). These socioeconomic changes and also cultural changes have been reflected in an increasing disregard of traditional authorities, such as parents and teachers (Helve 1996, p.171; Welzel et al. 2001). However, Salmi et al. (1996) and Kinnunen (1996) noted no significant changes in relationships between parents and adolescents during the recession whereas the recession had a clear negative effect on the general well-being of the family. Solantaus (2002) argued that the decrease of parental psychological well-being influenced by the recession led to more behavioural and mental problems of children and adolescents. Järventie (2001) found in her study that 29 % of 7-14 year-olds in two areas of Helsinki suffered from lack of basic care and negative identity and thus were at risk of social exclusion.

Values and behaviour patterns are adopted by interaction and observation (Holopainen and Lehkonen 1994, p. 20; Helve 2002; Pulkkinen 2002). Values thus play an important role in organising the adolescent behaviour-environment system and life decisions for the future (Stattin and Kerr 2001). According to Finnish studies teenagers construct their own value system by selecting and combining aspects from diverse fundamental patterns, such as individualism, humanism and traditional Christianity (Helve 1993; 2002). Little attention has been paid, however, to whether and how the values are realised in the adolescent lives and how the values are related to adolescent SWB.

The purpose of this study was twofold: the first aim was to examine adolescent subjective well-being and the relationships between that and realised values, health behaviour and social contexts in a large adolescent sample. The second aim was to investigate the quality of familial contribution (microsystem) to adolescent SWB and familial involvement in peer relations and school attendance in a small sub-sample. The study is based on an ecological framework as well as on nursing, psychological and family theories, and the focus is on the individual's well-being. Family is viewed as the context for individual growth, development and well-being. The study is part of a national research project concerning the co-operating between school and family.

## **2 Review of the literature**

### **2.1 Adolescent development**

Adolescence has only relatively recently been recognised as a period in human development (Aapola 2003). Historically, the age of 12 or 13 was perceived as a time for the assumption of adult roles and responsibilities. (Sprinthall and Collins 1988) Adolescence is today defined as a distinct period of adjustment or as a journey to adulthood (Nurmi 2001) where a teenager has to face rapid physical, cognitive and social changes (Sprinthall and Collins 1988; Nurmi 1997ab). Adolescence is commonly divided into three periods: early adolescence (12-14 years old), middle adolescence (15-17 years old) and late adolescence (18-22 years old). Early adolescence includes most of the major physical changes of adolescence, such as changes in

sex hormone production and in appearance, and accompanying changes in relationships with parents and peers. During middle adolescence, the focus is on increasing independence and preparation for an adult occupation and for further education and work. (Sroufe et al. 1996; Aalberg and Siimes 1999) The interest of this study is early and middle adolescence.

Adolescence is a time when individuals acquire important new cognitive skills and become more mature in their reasoning and problem-solving abilities. One of the traditional developmentalists, Piaget (1972; see also e.g. Sutherland 1992, pp. 19-24), characterised adolescence as a cognitive developmental phase where a teenager moves from concrete operations to formal operations, i.e. abstractive and systematic thinking. Some other theorists see the cognitive accomplishments of adolescence as logical progressions from the skills of childhood rather than as a certain period or stage of human development. One area of social domain in which the cognitive advances of adolescence have an impact is moral reasoning – the process of thinking and making judgements about the right and good course of action. (Sroufe et al. 1996) The influence of social environments, such as family, peers and school on an individual's development has been investigated by several studies and it has been pointed out that adolescent cognitive development needs both cognitive stimulating interaction and emotional support (Powers et al. 1983; Bronfenbrenner 1986; Sroufe et al. 1996).

Furthermore, Erikson (1968) emphasised adolescence as a crucial period for an individual to discover his or her identity, i.e. who I am and who I will become. According to the cross-cultural study by Ochse and Plug (1986), the psychosocial development of adolescents appeared to be related with well-being. Since Erikson there has been a vast amount of theoretical and empirical work on the psychology of self, such as self-esteem (e.g. Rosenberg 1979), identity formation (Marcia 1980; 1994) and self-definition (e.g. Nurmi 1997b).

The characteristics of normal adolescence differ from a time of storm and stress to a time of plain sailing (e.g. Nurmi 1997a; Arnett 1999; Toivakka 2002). However, several theorists have recently agreed that the course of adolescent development also depends on biological, sociocultural and emotional factors. There are thus individual and cultural variations in the pervasiveness of the existence of conflicts, mood disruptions and risk behaviour during adolescence. (Havighurst 1972; Hindley 1983; Bronfenbrenner and Ceci 1994; Sroufe et al. 1996; Nurmi 1997b; Arnett 1999; Toivakka 2002)

Havighurst (Havighurst et al. 1962; Havighurst 1972; see also Bengtson and Allen 1993) identified developmental tasks of life based on Piagetian and neo-Freudian principles including social contexts of school and family. He defined developmental task as “a task which arises at or about a certain period in the life of an individual, successful achievement of which leads to his happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by the society, and difficulty with later tasks” (Havighurst et al. 1962, p. 2). Havighurst argued that the sources of developmental tasks are physical maturation, socio-cultural pressure and personality.

The developmental tasks of adolescence comprise (1) achieving new and more mature relations with age-mates of both sexes, (2) achieving a masculine or feminine social role, (3) accepting one’s physique and using the body effectively, (4) achieving emotional independence from parents and other adults, (5) preparing for marriage and family life, (6) preparing for an economic career, (7) acquiring a set of values and an ethical system as a guide to behaviour, (8) desiring and achieving socially responsible behaviour (Havighurst 1972). Despite the overall criticism of developmental theories as too deterministic and normative (see e.g. Rodgers and White 1993), developmental tasks remain the elementary descriptive cataloguing of human development, and they can be refined in different ethnic and cultural contexts (Havighurst et al. 1962; Nurmi 1997a).

## 2.2 Adolescent health

### 2.2.1 Adolescent self-rated health and body satisfaction

#### **Self-rated health status and perceived symptoms**

Adolescence appears to be one of the healthiest periods of the life span (Call et al. 2002). For instance, Finnish teenagers value health highly and the majority of them perceive their health status to be quite or very good, although Swedish-speaking schoolchildren exhibited better perceived health than their Finnish-speaking counterparts (Niemelä et al. 1994; Pedtechenskaya and Sinisalo 1999; Currie 1999; Suominen et al. 2000; Välimaa 2000a; Rimpelä 2002; Välimaa 2000b). In 2001, one out of ten Finnish eighth and ninth graders

reported suffering from a physician-diagnosed chronic disease, whereas seven percent reported having asthma, and 19 percent allergic rhinitis or hay fever (<http://www.stakes.fi/kouluterveys/>; Rimpelä 2002).

Recent studies have indicated that self-rated health status is associated with mortality, while a number of studies have claimed that objective physical health correlates only marginally with subjective well-being (Okun and George 1984; Benyamini and Idler 1999; Heistaro 2002). Self-rated health is one of the strongest predictors of SWB (Okun and George 1984; Kainulainen 1998). Furthermore, Finnish adolescent self-rated good health appeared to be associated with perceived good economic situation of the family, non-smoking, and engaging in physical exercise to a considerable extent (Suominen et al. 2000).

A large study by Välimaa (2000a) indicated that Finnish adolescents' self-rated health was associated with factors describing the physical, mental and social dimensions of health. For instance, teenagers who reported their health status to be excellent experienced fewer symptoms, were more satisfied with their bodies and perceived their physical condition to be better compared to adolescents who reported their health status to be less than excellent. Furthermore, Haarasilta (2003) found that chronic illness, such as asthma, and depression co-occur more often than expected by chance in young Finnish people. Her study also showed that adolescents suffering from depression reported poorer self-perceived health than their non-depressed peers.

Finally, adolescents from intact families perceived their health to be excellent more frequently than their counterparts from other family types. The level of urbanization of residence, however, was not associated with perceived health. (Välimaa 2000a; Koivusilta et al. 2002) Further, according to Karvonen and Rimpelä (2002), health status and symptoms were similar in different types of municipality among Finnish adolescents. Välimaa's (2000a) results suggested that adolescent health experiences cannot be examined separately from their social, physical and psychological environment. Koivusilta et al. (2002) found that self-rated poor health was associated with poor school performance and lower level of education among Finnish teenagers.

Although the majority of adolescents report their health status to be good or excellent, previous studies have found a high prevalence of physical symptoms among adolescents in

Western countries (Niemelä et al. 1994; Poikolainen and Kanerva 1995; Spruijt-Metz and Spruijt 1999; Välimaa 2000b; Rimpelä 2002). In particular, various aches and pains seem to be increasing (e.g. Krisjánisdóttir 1997; Rimpelä 2002). In 2001, 40 % of Finnish female eighth and ninth graders (14-16 year olds) suffered from headache at least weekly. Among boys, the prevalence was 23 %. The corresponding prevalence rates for neck or shoulder pain were 35 % (girls) and 19 % (boys). In summary, comparing the age and gender groups, the older (15-16 year-olds/ninth graders) and female adolescents experienced more pain than the younger (12-13 year-olds/seventh graders) and male teenagers (Krisjánisdóttir 1997; Rimpelä 2002). The frequency of symptoms increased with age, especially among girls (e.g. Välimaa 2000a).

### **Body satisfaction**

Havighurst (1972, p. 51) suggested that one of the developmental tasks of adolescence includes accepting one's physique and using the body effectively. He emphasised that teenagers should become tolerant of their bodies and to learn use and protect the body effectively with personal satisfaction.

Body concerns have recently been reported mostly among adolescent girls (Vincent and McCabe 2000; Dunkley et al. 2001). For several decades, a trend has existed in the media toward a smaller ideal female body size, despite increases in the actual body size of young women. Although obesity in Western countries is an increasingly prevalent disorder (WHO 1998), many normal-weight girls also report body dissatisfaction, which is caused by the discrepancy between actual body size and the ideal one (Bergström et al. 2000; Välimaa 2000a; Dunkley et al. 2001). In Välimaa's qualitative study (2001) adolescents equated body size with the identity and personal traits, which reflects the current cultural values and norms.

Recent studies (e.g. Middleman et al. 1998; Gardner et al. 1999; McCabe and Ricciardelli 2001) have also identified body image disturbances among males. A study (McCabe and Ricciardelli 2001) with a large adolescent sample (N=1266) found that females were less satisfied with their bodies and were more likely to adopt strategies to lose weight, whereas males were more likely to adopt strategies to increase weight and muscle tone. The media influences weight and body dissatisfaction, as does feedback from parents, whereas peers appear to be more significant for females (Dunkley et al. 2001; McCabe and Ricciardelli 2001; Hargreaves and Tiggemann 2002). Results reported by Polce-Lynch et al. (2001)

indicated that body image may be a mediator for female adolescents' self-esteem, but not for males. The findings of a nursing study by Sapountzi-Krepia et al. (2001) also showed that adolescents with chronic illness (scoliosis) reported poorer body image in comparison to healthy adolescents, whereas only females with chronic illness experienced lower level of happiness and satisfaction compared to healthy females. Further, Wolman et al.'s (1994) study revealed that body image was a significant predictor of emotional well-being among US adolescents with and without chronic conditions.

### **2.2.2 Adolescent health behaviour**

Health behaviour is regarded as a multidimensional and complex phenomenon and varies in a numbers of ways, including whether the behaviours are risk enhancing or health-promoting and whether or not they have strong cultural determinants (Spear and Kulbok 2001; Steptoe and Wardle 2001.) Risk behaviour is defined as those behaviours that entail the possibility of subjective loss, and it appeared to be part of life for many adolescents (see Igra and Irwin 1996, p. 35). Maggs et al. (1995) pointed out that risk behaviour may involve an element of fun, adventure, or other positive rewards. However, May (1999, p. 211) argues that it is insufficient to claim that there is a "natural" level of risk-taking, because a relatively high proportion of adolescents does not report such behaviours. The results of Brener's and Collins' study (1998) support this claim by indicating that most adolescents under 14 years and 41 % of young people aged 14-17 years did not engage in any of the health-risk behaviours (e.g. smoking, alcohol or drug use).

On the other hand, youth is an extremely important stage of life as far as health is concerned, because many health habits are acquired in adolescence (Westera and Bennett 1994; Pietilä et al. 1995; Paavola et al. 1996; Pietilä 1999; Spear and Kulbok 2001; Call et al. 2002). Pietilä et al.'s (1995) study of Finnish males revealed that health behaviour, such as smoking and physical exercise in adolescence predicted health behaviour in adulthood. Results of a cross-national studies conducted by Tynjälä et al. (1993) found a correlation between poor sleeping habits and frequent substance abuse, lack of physical activity and psychosomatic symptoms. In addition, Paavonen (2004) recently demonstrated an association between poor sleep quality and mental health problems and somatic complaints. Noom et al. (1999) found a complex relationship between individual characteristics, parental and peer relations and adolescent psychosocial adjustment, and they suggested that adolescent problem behaviour is likely to



increase with a combination of high functional autonomy, a negative relationship with father and a positive relationship with peers. Results reported by Maggs et al. (1995) additionally showed an association between increased problem behaviour and negative self-image.

### **Adolescent smoking**

Initiation of smoking generally occurs during adolescence (Paavola et al. 1996; Kawabata et al. 1999; Seguire and Chalmers 2000). According to WHO (1993) the majority of smokers begin before the age of 19 and people who start smoking young find it more difficult to stop. A number of studies have shown that adolescent smoking in Western countries has increased in recent decades (e.g. Hill 1998; Office on Smoking and Health; Division of Adolescent and School Health...2000; Luopa et al. 2002). There is also evidence that female smoking is on the increase and appears to be a leading killer of women in many developed countries (Amos 1996; Light 2000; Seguire and Chalmers 2000; Office on Smoking and Health, Division of Adolescent and School Health...2000; Rimpelä et al. 2002). The proportion of daily smokers among 14 year-olds was well over 10 percent in both Finnish gender groups in 2001 (Hakkarainen 2002).

Recent research suggests that self-esteem is a key variable in understanding adolescent smoking (see e.g. May 1999). For instance, Kawabata et al.'s (1999) study revealed that never smokers reported higher cognitive, family, and global self-esteem, but lower physical self-esteem than ever smokers. However, May (2001) emphasised a more complex vision of self-identity as a means of connecting teenagers' perceptions of themselves with their realised health behaviour. The results of a cross-cultural study (Hanson 1999) found an association between beliefs about smoking and smoking habits among teenage women with low socioeconomic status. For instance, those adolescents who believed smoking was enjoyable were more likely to smoke. There is also increasing evidence that social factors such as peer smoking and within-group processes may be more important than personal factors like self-esteem in adolescent smoking (Paavola et al. 1996; Glendinning and Inglis 1999; Wiegersma et al. 2000). Further, findings reported by Zullig et al. (2001) revealed that smoking among high school students was significantly associated with reduced life satisfaction measured as satisfaction with family, friends, self and living environment.

Adolescent smoking has also been claimed to be associated with non-intact family (Ahlström et al. 2002), low socioeconomic status (Dishion et al. 1999), full-time employment (Siqueira

et al. 2000), stress (Siqueira et al. 2000) and school problems (Simons-Morton et al. 1999). Significant associations have also been demonstrated with lower self-perceived health (Suominen et al. 2000; Haarasilta 2003) and ill-being, such as depressive symptoms (Escobedo et al. 1998; Patton et al. 1999; Goodman and Capitman 2000; Haarasilta 2003), emotional distress and rebelliousness, deviance and family problems (Orlando et al. 2001). On the basis of the longitudinal study (N=2961), Orlando et al. (2001) described a mechanism of relationship between smoking and distress and suggested that emotional distress, such as anxiety and absence of positive affect, led to increased smoking from grade 10 to grade 12, whereas smoking at grade 12 led to increased emotional distress in young adulthood.

Jones and Heaven (1998) identified low levels of family control, peer approval, negative attitude to school and low levels of school attendance as predictors of tobacco use among Australian adolescents. Ahlström et al. (2002) suggested that parental approval, lack of parental control, poor father-adolescent relationship, increased purchasing power, and smoking of older sibling increased the risk for smoking among Finnish adolescents.

### **Adolescent drinking patterns and drug abuse**

One of the most common types of risk-taking behaviour among adolescents in the Western world is drinking alcohol (Abalbjarnardottir 2002). Alcohol consumption carries the image of adult status, probably because most adults drink alcohol without sanction whereas drinking by adolescents is forbidden (Galambos et al. 1999). There is an increasing trend towards adolescent alcohol drinking in Western countries (Pedtechenskaya and Sinisalo 1999; Lintonen et al. 2000a, Sutherland and Shepherd 2001). A similar trend has been shown in general alcohol consumption in Finland (Ahlström and Mustonen 2002; Österberg 2002). Lintonen et al. (2000a) found that Finnish adolescents' drinking patterns have changed towards drinking to get drunk since the second half of the 1980s. Similar trends have also been reported in Swedish and Danish studies (see Lintonen 2001, pp. 26-27). Drinking to get drunk is part of the traditional Finnish alcohol culture pattern and adolescent drinking can be understood as socialization to this pattern (Hakkarainen 2002, p. 175).

According to the Adolescent Health and Lifestyle Survey, the proportion of recurring drinking in 1999 among 14-year old Finnish boys was 20 % compared to 22 % among girls. The age-adjusted prevalence of monthly drunkenness among 14-year-olds in 1999, however, was 10 % for boys and 15 % for girls. (Lintonen et al. 2001) The increase of drinking to get

drunk during the 1990s was most pronounced among 14-year-old girls and in 1999: they reported significantly more monthly drunkenness than boys. The results of the increasing trend in female drinking have also been reported in other studies (e.g. Light 2000; Lintonen 2001). In early 2000, however, the drunkenness appeared to have slightly decreased among Finnish adolescents (Rimpelä et al. 2002; Rimpelä et al. 2003).

Two important factors, i.e. increased purchasing power and earlier biological maturation appeared to be strongly related to Finnish adolescent drunkenness at the moment (Lintonen et al. 2000b). Galambos et al. (1999) additionally found that Canadian adolescents who felt older relative to their same-age peers reported more substance abuse than those feeling the same or younger than peers. Furthermore, the results of a large Icelandic study revealed an association between adolescent psychosocial immaturity (incl. egocentricity) and heavy alcohol drinking (Abalbjarnardottir 2002). Other risk behaviours seemed to be related to drinking patterns as well, among them smoking (Feldman et al. 1999; Lintonen et al 2001), drug abuse (Rodondi et al. 2000), drinking and driving (Feldman et al. 1999) and suicidal behaviour (Rossow et al. 1999; Borowsky et al. 2001). A recent study (Haarasilta 2003) also revealed an association between frequent drunkenness and depression among Finnish adolescents and young adults. Winter (2004) found that adolescent abstinence was influenced by religiousness, the drinking habits of parents, and regional factors. Family influences on the consumption of alcohol were more pronounced in Central and Northern Finland than in Southern Finland.

Research evidence also emphasises the association between drunkenness and social and environmental factors such as lack of parental control (Shucksmith et al. 1997; Hämäläinen 1999; Lintonen et al. 2001; Ahlström et al. 2002; Kouvonen and Lintonen 2002) or extremes therein (Shucksmith et al. 1997), adolescent intensive part-time working (more than 10 hours per week) (Kouvonen and Lintonen 2002), dating (Lintonen 2001) as well as resistance to school (Treiman and Beck 1996). According to Jones and Heaven (1998), Australian adolescent alcohol consumption was predicted by peer models, parental approval and low levels of family support. Ahlström et al. (2002) found that in addition to parental approval and low level of parental control, poor father-adolescent relationship and heavy drinking of older siblings were associated with adolescent drunkenness. Additionally, Hämäläinen (1999) found parents' use and abuse of, and attitude towards intoxicants correlated with those of their adolescent children. Lieb et al. (2002) discovered more detailed that parental alcohol

consumption disorders predicted escalation of alcohol consumption and development of alcohol use disorders in offspring.

The findings of the study by Barber et al. (1998) revealed significant gender differences in predictors of alcohol drinking: peer pressure was the most significant predictor for adolescent males, whereas in addition to this intrapersonal disorders were associated with female drinking. A national representative Finnish study (Mäkelä and Mustonen 2000) indicated that men (15-69 years) tended to perceive more hedonic benefits from drinking such as being funnier and getting closer to the opposite sex while women perceived more functional benefits such as sorting out interpersonal problems. In addition, younger drinkers reported more both positive and negative consequences of alcohol but health problems related to drinking were more common among older people.

Although alcohol use remains the number one psychoactive substance, there is an increasing involvement with illegal drugs among adolescents in Western countries in the 1990s (Bosch 2000; Luopa et al. 2000; Lintonen 2001; Hakkarainen and Tigerstedt 2002; Murto 2002). According to the School Health Promotion Survey, about eight per cent of Finnish adolescents from the eighth and ninth grades had experimented with drugs in 1998 and 1999 (Luopa et al. 2000). The majority (95 %) of Finnish teenagers took a critical attitude toward drug use in 2002 (Saarela 2002).

Research findings have shown that smoking and alcohol consumption were related to cannabis use (e.g. Luopa et al. 2000; McGee and Williams 2000), and both alcohol and drug abuse were associated positively with adolescents' somatic symptoms, such as fatigue, nightmares and headache (Poikolainen and Kanerva 1995) and lack of life satisfaction (Zullig et al. 2001) as well as problems with parents (Topolski et al. 2001). Kouvonen and Lintonen (2002) claimed an association between intensive part-time working and frequent drug abuse. Low levels of family control (Jones and Heaven 1998; Luopa et al. 2000; Ahlström et al. 2002) and support as well as peer modelling (Jones and Heaven 1998) have been identified as significant predictors of drug abuse. The results of White et al.'s (1998) longitudinal study on the outcomes of drug abuse suggested that adolescent drug abuse was related to lower likelihood of being married as well as to higher levels of both alcohol and drug dependence in adulthood.

## **Physical exercise**

One aspect identified as representing health enhancing behaviours is physical exercise. Across several studies, positive correlations have been indicated between high levels of physical activities and perceived good health status (Mahon 1994; Suominen et al. 2000), higher education (Krick and Sobal 1990), higher levels of perceived family affluence (Currie 1999), psychosocial and behavioural conventionality (such as absence of problem drinking and being religious) among adolescents (Donovan et al. 1991). Field et al.'s (2001) study revealed that high school students with a high level of exercise had better relationships with their parents, were less depressed, abused drugs less frequently and did better at school than those with a low level of exercise. Haarasilta (2003) recently found an association between low frequency of physical exercise and adolescent depression. Ylén and Ojanen (1999) suggested as a possible explanation for the positive impact of physical exercise that activity mediates increased locus control and self-esteem.

According to the School Health Promotion Survey (see e.g. Konu et al. 2002b), 78 % of Finnish female eighth and ninth graders and 82 % of males of same age engaged in leisure exercise at least weekly in 1998 and 1999. Välimaa (2000a) found an association between self-rated excellent health and perceived good physical condition among Finnish adolescents.

## **2.3 Subjective well-being and health**

Life satisfaction or subjective well-being (SWB) appears to be one of the major goals of most people, and asking a person how she or he feels as a way of starting a daily interaction is almost universal in Western countries (Grob 1998; Diener 1998). Consequently, nursing science as well as positive psychology have increasingly emphasised the importance of the promotion of health and well-being, and the prevention of illnesses and ill-being in addition to the treatment of established diseases and disorders (e.g. Spector 1996; Åstedt-Kurki et al. 1999; Ojanen 2000; McCullough et al. 2000; Seligman 2002). Recent cross-cultural studies indicated that the majority of people are satisfied with their lives (e.g. Diener and Diener 1995; Diener and Diener 1996; Grob 1998; Kainulainen 1998; Grob et al. 1999). Kainulainen (1998) and Berntsson and Köhler (2001) found that not even the major economic recession in

the 1990s in Nordic countries significantly affected level of life satisfaction among adults, adolescents and children.

The literature on *subjective well-being* presents a diverse array of definitions (Diener 1984; Veenhoven 1991a; 1991b). SWB has been conceptualized for instance as *psychological well-being* (PWB) (Ryff 1995; Ojanen 2000) or the balance between negative and positive affect (Bradburn 1969), *happiness* (Veenhoven 1991a) and intertwined components of *satisfaction and ill-being* (Grob 1991; Grob et al. 1991). According to Keyes, Shmotkin and Ryff (2002) psychological well-being entails perception of engagement with existential challenges in life. Ryff (1995) and co-workers constructed six key dimensions of psychological well-being: self acceptance, positive relations with other people, autonomy, environmental mastery, purpose in life, and personal growth. The features were derived by integrating different elements from the guiding theories in developmental psychology (e.g. Erikson), clinical psychology (e.g. Maslow) and mental health (e.g. Jadoha). Key et al. (2002) distinguished between SWB and PWB, and they suggested that these approaches are conceptually related but empirically distinct.

Definition of health is also shifting from viewing health in terms of survival or lack of illness to a broader definition of well-being (e.g. Kannas 1994; McDowell and Newell 1996). One of the most significant and used definitions is that by WHO (1958, p. 459), who declared health as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity”. In nursing science, health has been defined in terms of perceived well-being (Åstedt-Kurki 1992; Okkonen 2004), health motives (Lindholm 1997) or resources of life or empowerment (Pelkonen 1994; Pelkonen and Hakulinen 2002).

The concept quality of life (QoL) can be taken as a synonym or tied in closely with the concept of SWB. In psychology and sociology, it is defined as the overall evaluation of an individual's life condition, on both objective and subjective dimensions (see e.g. Gullone and Cummins 1999; Cummins 2000; Heikkilä and Kautto 2002). The relationship between objective and subjective well-being or quality of life has been debated in the 1990s (Cummins 2000). Cummins (2000) reviewed several SWB studies and argued that objective and subjective indicators of SWB are generally fairly independent, but their degree of dependency increases when the objective conditions of living are very poor (see e.g. Diener et al. 1993). In medicine, the concept of quality of life is understood as *health-related* quality of life and

refers to the subjective impact of disease and its treatment on the well-being of an individual (Fayers and Machin 2000, p. 4; Fairclough 2002, p. 2; Kattainen 2004).

Positive psychology as well as the present study determines subjective well-being as individuals' affective and cognitive evaluations of their lives (Diener 2000). SWB as a cognitive experience refers to a situation where an individual compares the actual state to an ideal and expected one, and a positive perception or no discrepancy between existing and aspired states results in satisfaction and joy (Higgins 1987; Grob 1995b). SWB combines both the frequency and intensity of pleasant emotions and the absence of ill-being and considers both momentary and long-term levels of affect and satisfaction. (Grob 1995b; Diener 1998; Grob et al. 1998) Veenhoven (1991a) pointed out that happiness in the sense of life-satisfaction depends not only on the comparison but also the gratification of bio-psychological needs. Diener (1998, p. 313) emphasises that SWB is not a complete definition of well-being as well-being includes additional characteristics, such as contact with reality and self-efficacy. Although SWB is not sufficient for mental health, it is nevertheless a significant aspect of well-being which grants importance to the respondents' own views of their lives and which also empowers lay persons rather than leaving judgements about their well-being solely to the professionals.

### **2.3.1 Adolescent subjective well-being**

#### **Satisfaction and ill-being**

Following the works of Bradburn (1969), Diener et al. (e.g. Diener, 1984), Headey et al. (1984) and Grob et al. (1991), Grob with his colleagues (1991; 1999) differentiated between two intertwined components of adolescent SWB: satisfaction (*Zufriedenheit*) and ill-being (*Negative Befindlichkeit*). These aspects of SWB consist of both the cognitive and emotional sides of well-being as well a set of accomplishing normative and age-specific developmental tasks, non-normative developmental tasks (such as a death or severe illness in the family or divorce) and important life events, appropriate coping styles, adequate social support, the personal conviction that one is in control regarding significant life domains, meaningful purposes in life and future perspectives and a fit between personal aspirations and the social and cultural context (see e.g. Havighurst 1972; Folkman et al. 1986; Bronfenbrenner 1986; Nurmi 1997ab; Grob et al. 1999, pp. 116-117). In addition, SWB refers to achieving and

successful handling of personal and divergent goals imposed by authority, attaining socially defined values, adapting to one's social environment, satisfaction of everyday needs, participating in interesting activities, positive evaluation of daily events, meaningful use of time, good health and accepting oneself. (Havighurst 1972; Grob et al. 1991; 1999, pp. 116-117) Thus, adolescent satisfaction comprises a positive attitude toward life, self-esteem, joy of life and absence of depressive mood (Grob et al. 1991). Headey et al. (1984) suggested that a positive sense of well-being appeared to depend on a wider range of personality variables, extraversion and optimism as well as personal competence and supportive social network.

Adolescent ill-being refers on the one hand to recent or present problems and worries in everyday life, such as with parents, friends, money, health, growing up, and on the other hand to somatic complaints, such as unusual fatigue, physical pain, sleep disorders or poor appetite. (Grob et al. 1991) On the basis of a cross-cultural study in 14 countries, Schwartz and Melech (2000) also suggested that worry concerning the welfare of the self or extensions of the self is a component of subjective well-being. Several theorists emphasised that problems and worries are naturally included in life, and the perception of those therefore indicates a realistic acknowledgement of life and even contribute to life satisfaction (Headey et al. 1984; Veenhoven 1991b; Arnett 1999; Sumerlin and Bundrick 2000; Laine and Kangas 2002). Headey et al. (1984) concluded on the basis of their study that a sense of ill-being results quite largely from a low sense of personal competence and from unfavourable socio-economic and family circumstances.

### **Knowledge and activities related to SWB**

Åstedt-Kurki (1992) studied the health and well-being of the residents of a municipality in Finland by phenomenological-hermeneutical methods, and differentiated knowledge and activities as characteristics of well-being. Knowledge is defined as knowledge of one's own health status, health problems and personal abilities to control and improve well-being and as the possibilities of receiving help in life's difficulties if needed. Results further reported by Häggman-Laitila and Åstedt-Kurki (1995) identified health knowledge as institutional and individual health knowledge experienced by Finnish adults. *Institutional* knowledge consisted of knowledge about health as normalcy, knowledge about proper health care, knowledge about factors causing illness, knowledge about diseases observed in oneself and knowledge about obtaining help. *Individual* health knowledge referred to knowledge about being healthy



and well, knowledge about how produce well-being and how to deal with ill-being, and knowledge about ill-being.

Activities represent a variety of life habits, self-care and activities in order to maintain or improve one's SWB. This does not mean a rigid adherence to the norms of present health education, but to living in a purposeful way from the individual's perspective. (Åstedt-Kurki 1992; Åstedt-Kurki et al. 2002) Activities also refer to health behaviour as discussed in Chapter 2.2.2.

### **2.3.2 Factors related to SWB**

Psychological studies have revealed that personality, i.e. especially extraversion (Diener et al. 1992), lack of neuroticism (Okun and George 1984; Pavot et al. 1996), and self-rated health (Okun and George 1984) appear to be major determinants of long-term, subjective well-being among adults. In addition, a recent study demonstrated that positive daily events were significantly related to adolescent satisfaction (McCullough et al. 2000). A similar pattern was found in Grob's (1991; 1995b) studies concerning adults' and teenagers' SWB and significant life events.

Results emerging from cross-national adolescent SWB studies have reported that adolescents reporting better SWB, also reported less strain, more personal control, less emotion-oriented and more problem-oriented coping strategies. In addition, notable differences in the relationship between SWB and sociocultural context and economic situation emerged: teenagers from Eastern and Central Europe (i.e. the former socialist countries) whose economies were much weaker than those of Western countries, felt in general worse than those from Western countries. (Grob 1998; Currie 1999; Grob et al. 1999) These results confirm the findings of similar studies among adults (e.g. Diener and Diener 1995; Diener et al. 1995, Schyns 2003) that income has an effect on SWB. Schyns (2003) in her cross-national longitudinal study found that at the level of individuals, income is positively, but only weakly, related to life satisfaction. Further, she found that at the national level, wealthier nations are on average happier nations. Moreover, this country effect on individual life satisfaction was stronger than the effect of individual income.

Demographic variables such as age and gender, however, appeared not to be strongly related to SWB among adults. According to the World Value Survey (N=57, 000 from 41 nations), women tended to report greater unpleasant affect than men whereas both gender groups experienced similar levels of pleasant affect and life satisfaction. In the same survey, age had no effect on life satisfaction. (see e.g. Lucas and Gohm 2000; Diener 2002) Similar findings among adolescents were obtained by Huebner and Dew (1996), who found no significant correlations between age (14 to 19 year-olds) and SWB in adolescence. A number of studies, however, indicated that there are differences between genders and age groups among adolescents. Simeoni et al. (2001) found that French girls (11-17 year-olds) assessed higher scores on the friend domain but lower scores on psychological well-being domain and overall health-related quality of life scale. Further, their study revealed that older adolescents had higher scores than younger ones for dimensions dealing with relations with friends but lower scores on relations with parents and psychological distress. Ryff (1995) found that women of all ages consistently rate themselves higher on positive relations with others than men do.

## 2.4 Adolescents in social contexts

Bronfenbrenner (1977; 1988) and Bronfenbrenner and Ceci (1994) incorporated the biological and environmental components of human development and proposed an ecological model. Their three propositions of human development are (1) human development takes place in through processes of interaction between an active human organism and the persons, objects, and symbols in its immediate environment, so-called proximal processes (e.g. parent-child activities), (2) the form, power, content, and direction of the proximal processes affecting development vary systematically as a joint function of the characteristics of the developing person, of the environment – both immediate and more remote – in which the processes take place, and of the nature of the developmental outcomes under consideration, (3) proximal processes serve as a mechanism for actualizing genetic potential for effective psychological development, but their power to do so is also differentiated systematically as a joint function of the same three stipulated in proposition 2 (Bronfenbrenner and Ceci 1994, p. 572). In summary, Bronfenbrenner and Ceci distinguished the interaction and environment conceptually and differentiated the immediate setting in which activities can take place, and the broader context in which the immediate setting is embedded (Bronfenbrenner and Ceci 1994, p. 572).

Bronfenbrenner (1977; 1988) borrowed from Brim (see Bretherton 1993, p. 286) four organisational concepts that describe the structure of the ecological environment within which development comes about. He defined the ecological environment as a set of nested structures, each contained within the next. According to Bronfenbrenner (1977; 1988, p. 32-40) *microsystem* refers to immediate region of person-environment interaction (proximal processes), within which direct manipulation and face-to-face communication are possible, such as home and classroom. Bronfenbrenner (1989, p. 227) later emphasised that microsystem contains other persons with distinctive characteristics of temperament, personality, and systems of belief. The *mesosystem* includes several microsystems and comprises the linkages and processes taking place between two or more settings containing the developing person, such as interaction between home and school. The *exosystem* encompasses the linkage and processes occurring between two or more settings, at least one of which does not ordinarily contain the developing person, but in which events take place that influence processes within the immediate setting that does contain that person. One example of the exosystem of an adolescent is the parents' workplace. Finally, micro-, meso- and exosystems are embedded in the *macrosystem*, defined as an overarching pattern of ideology and organisation of the social institutions common to a particular culture or subculture. It includes the belief systems, laws, resources, hazards, lifestyles, life course options, and patterns of social interchange that affect individuals through a variety of internal and external processes. It may be said that the macrosystem is, in part, inside the individual. In Bronfenbrenner's model, interactions are multidirectional, so that the systems influence each other, as well as the individual, and the individual also exerts influence on the various systems in which he or she participates. (Bronfenbrenner 1977; 1988, pp. 32-40; 1989; Bretherton 1993).

In addition, Bronfenbrenner (1986) proposed another system, the *chronosystem*, for examining the influence on the person's development of changes and continuities over time in the environments in which s/he lives. These changes may include both normative transitions, such as secondary school entry and nonnormative transitions, such as a death or severe illness in the family. Although Bronfenbrenner's model is not a model of family process *per se*, it provides a framework for looking at ways in which intrafamilial processes are influenced by extrafamilial conditions and environments (Bibolz and Sontag 1993). Some of the human

ecology theorists, such as Bibolz and Sontag (1993) agreed that family ecosystems are a subset of human ecosystems, and thus can be described with systems concepts.

### **2.4.1 Adolescent in the family**

Despite the increasing significance of peers in adolescence, the family remains a critical context for a teenager (Schickedanz et al. 1994; Sroufe et al. 1996; Noack et al. 1999; Pietilä 1999; Pulkkinen 2002). Family may serve as an important protective or risk factor for children (Hawley and DeHaan 1996; Meltaus and Pietilä 1998). It plays a key role in adolescents' individuation and identity formation by providing a forum to explore new roles and values. Most adolescents want to maintain intimacy and connection with their families at the same time as they search for increased autonomy and independence. (Schickedanz et al. 1994; Sroufe et al. 1996; Noack et al. 1999; Pietilä 1999) Intimacy with mother and father was found to be the most important predictor of adolescent psychosocial adjustment (Richardson and McCabe 2001). Earlier findings reported by Poikolainen and Kanerva 1995 supported the latter by indicating that increased absence of a parent from home was related to adolescent somatic symptoms among males, whereas increased number of arguments between parents was associated with somatic symptoms among females. Parental support has been suggested to have a significant effect on adolescent self-rated health as well (Vilhjalmsson 1994; Suominen et al. 2000). Furthermore, a number of studies (e.g. Allen et al. 1994; Noom et al. 1999) suggest that autonomy and relatedness in an adolescent's family are linked to a range of positive outcomes, such as self-esteem.

Family dynamics changes dramatically as a child passes through adolescence. It is thus not only the teenager who is developing but also the family. (Schickedanz et al. 1994; Sroufe et al. 1996; Noack et al. 1999) Research evidence found that families with adolescents experienced higher levels of interfamily strain and stressors and lower levels of well-being than do childless families (Olson 1993). Dissatisfaction with family life as a whole increased from the age of 11 to 15 (Bergman and Scott 2001). According to previous studies, adolescents perceived lower levels of family cohesion (Ohannesian and Lerber 1995), communication in the family significantly less open and more problematic than their parents did (Barnes and Olson 1985). Olson et al. (1989) argued that the high level of intrafamily stress during adolescence may be due to this natural disagreement between parental and

adolescent perceptions. Consequently adolescent research is focused not only on family dynamics but also on parental styles (Shucksmith et al. 1995).

### **Parenting styles with adolescents**

Parenting practice is a basic factor of the parent-adolescent relationship. A number of studies have examined the correlations between various parenting styles and adolescent outcomes (Olson et al. 1989; Baumrind 1991; Ambert 1997; Fletcher et al. 1999; Rönkä and Poikkeus 2000) and parental style has also been claimed to be associated with adolescent SWB (Petito and Cummins 2000; Rönkä and Poikkeus 2000; Kinnunen et al. 2001).

Baumrind (1978; 1991) and Maccoby and Martin (1983) identified four types of parenting that differ on the basis of commitment and balance of demandingness and responsiveness. These types include authoritative, authoritarian, permissive, and neglectful parenting styles whose operational definitions differ somewhat depending on the social context, developmental period and method of assessment, but share certain essential features. *Authoritative* parents are both demanding and responsive. They are assertive but not intrusive or restrictive and their disciplinary measures are supportive rather than punitive. *Authoritarian* parents are extremely demanding and directive but not responsive. They expect their orders to be obeyed without explanation and they monitor their adolescents' activities without being involved in them. *Permissive* parents, in turn, are more responsive than they are demanding. They often avoid confrontation and allow their adolescents to behave autonomously and independently. *Neglectful* parents are neither responsive nor demanding. They do not monitor adolescents' behaviour or support their self-regulation. In addition to these extreme patterns of parenting Baumrind (1991) also identified *democratic* and "good enough" parents in her study. Democratic parents are high on the responsiveness and average on the demandingness dimension. A "good enough" pattern includes moderate scores on both control and responsiveness. (see Figure 1.)

Baumrind (1978; 1991) suggested that an authoritative parenting style is the ideal child-rearing pattern contributing to self-reliance and self-control. She found later that authoritative parents who are very demanding and highly responsive were successful in protecting their adolescents from problem substance use in California, US, but she stressed that adolescent development was facilitated by both authoritative and democratic parenting. Baumrind (1991) highlighted the socio-ecological view of adolescent development (see Bronfenbrenner 1986;

1988) and argued that the emphasis of parenting styles is dependent on social circumstances, such as instability or stability.

		<b>Control</b>		
		Low control	Average	High control
<b>Responsiveness</b>	High	Permissive	Democratic	Authoritative
	Average		“Good enough”	
	Low	Neglecting		Authoritarian

Figure 1. Parenting styles (adapted from Baumrind 1978; 1991 and Maccoby & Martin 1983)

Several studies have been conducted on the relationships of these parenting styles and adolescent outcomes. Shucksmith et al. (1995) observed that authoritative parenting style was associated with fewer symptoms of psychological distress among teenagers, whilst neglectful parenting was associated with raised level of psychological stress. Similarly, Rönkä and Poikkeus (2000) suggested that warm parenting with high involvement and autonomy granting was related to fewer depressive symptoms among Finnish adolescents. Fletcher et al. (1999) reported in more detail that adolescents with one authoritative and one non-authoritative parent were observed to experience more psychological and somatic symptoms of distress than their counterparts from homes with two authoritative parents. Shek (1999) found relative to maternal parenting characteristics, that paternal parenting exerted a stronger influence on adolescent psychological well-being, and the impact was stronger on females in a Chinese context. Aunola et al. (2000) recently found that authoritative parenting was associated with adolescent adaptive achievement strategies, such as low levels of passivity and failure expectations in a Swedish sample. The study by Kinnunen et al. (2001) investigated the relationships between parenting practice, characteristics of parental work and adolescent well-being and they indicated an association between parental warmth and acceptance perceived by adolescents, and adolescent school satisfaction and low level of alcohol use. Further they found that parental involvement was related to school satisfaction, low level of aggressiveness and alcohol consumption. After regression analysis, Kinnunen et

al. (2001) suggested that the negative work experiences of parents reflected on decreased parenting practice (warmth and acceptance) which increased adolescent depression.

Shucksmith et al. (1997) found that an unsupportive family environment with extremes of parental control was associated with raised level of alcohol consumption in adolescence. Hämäläinen (1999) claimed that teenagers who felt that their parents' practices and personal characteristics were positive also reported least use of intoxicants. Consistently, Levamo (2001) showed that adolescents in families with exaggerated parental control used drugs more often than those in families without extreme control. Fallon and Bowles (2001) proposed a relationship between adolescent problems with family and high degree of conflicts and low degree of democratic parenting.

## **2.4.2 Family dynamics**

### **Barnhill's healthy family system model**

Barnhill (1979) proposed a system-theoretical model of health family cycle which includes eight bipolar dimensions: (1) individuation versus enmeshment, (2) mutuality versus isolation, (3) flexibility versus rigidity, (4) stability versus disorganisation, (5) clear communication versus unclear communication, (6) role reciprocity versus role conflict, (7) clear perception versus distorted perception, and (8) clear generational boundaries versus breached generational boundaries. The dimensions are closely linked as four themes of healthy family functioning, i.e. the theme of *identity processes* consist of (1) individuation - enmeshment and (2) mutuality - isolation; (II) the theme of *change* includes (3) flexibility - rigidity and (4) stability - disorganisation; (III) *information processing* comprises (5) clear - unclear or distorted perception and (6) clear - unclear or distorted communication; and (IV) the theme of *role structuring* refers to (7) role reciprocity - role conflict and (8) clear - breached generational boundaries. (Figure 2.)

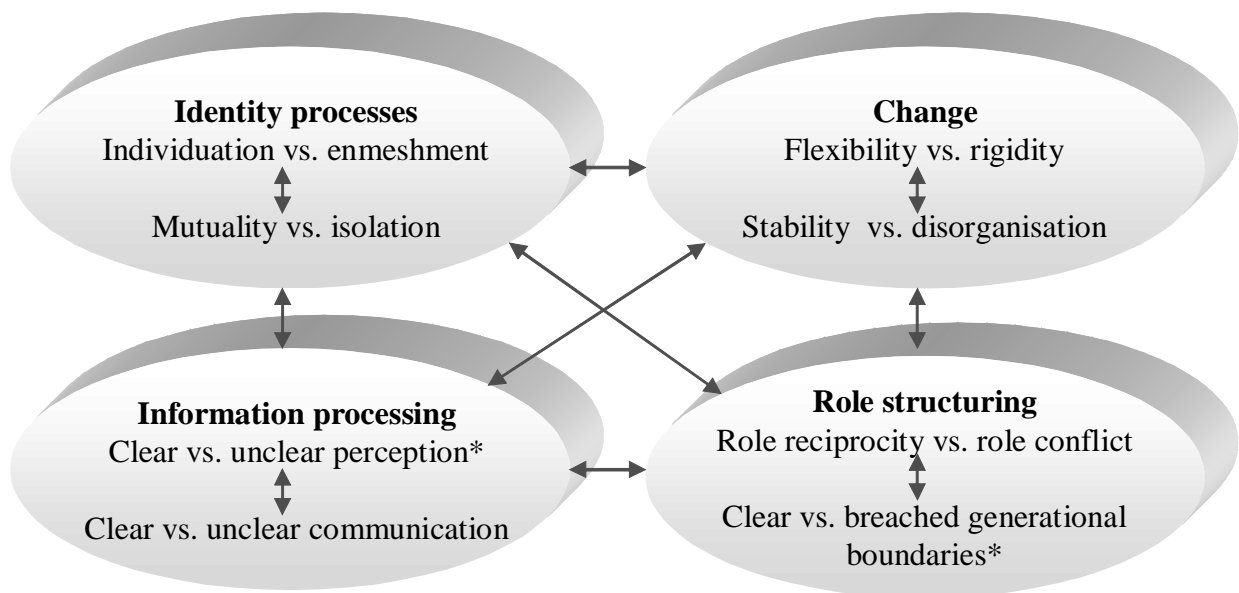


Figure 2. Model of health family cycle (adapted from Barnhill 1979)

\*Dimensions eliminated in this study

This study used a modification of the model developed by nursing researchers (Lasky et al. 1985), in which the dimensions of perception and generational boundaries were eliminated because of the difficulty of measuring them. According to Barnhill (1979), a healthy family system is one which allows the full development of all members and yet remains a functional whole. Further, all aspects are interrelated and any aspect can be taken as a beginning of intervention, hence by improving functioning in one or more areas the family may improve its functioning in other areas. In a period of change, such as during adolescence, the family has to modify its behaviour in order to achieve a new balance (Barnhill 1979).

An earlier study by Mills and Grasmick (1992) revealed that satisfaction with family has a positive effect on psychological well-being among adults, especially among women. However, family systems research mostly focuses on aspects of family dysfunction, such as alcoholism (Steinglass et al. 1987) and domestic violence (Asen et al. 1989; Paavilainen 1998). In terms of adolescent research, the impact of various aspects of family dynamics on adolescent problem-behaviour, somatic symptoms as well as on healthy outcomes has been assessed in several studies.

(1) Individuation has been characterised as the intrapsychic process by which an individual comes to see the self as separate and distinct within one's relational context (Karpel 1976, p.



66; Bartle and Anderson 1991). Adolescent individuation is influenced primarily by family interaction, particularly between parents and children (Bartle and Anderson 1991). Enmeshment refers to poorly delineated boundaries of self and symbiosis in the family (Barnhill 1979). Barber and Buehler (1996) found an association between family enmeshment and youth problems, such as anxious and depressive affect. Resilience researchers, such as Walsh (1996), criticised the family functioning theories for underestimating family diversity and the effect of life events and cultural context on families. Walsh (1996) argued that family therapists characterize highly cohesive families as enmeshed although their processes may be workable, or even necessary in a particular situation such as when a family member falls ill.

(2) Barnhill (1979) emphasizes that mutuality, i.e. a sense of emotional closeness, is only possible between individuals with clearly defined identities. Isolation is defined as disengagement or alienation from other family members (Barnhill 1979). According to Barnhill (1979, p. 97) mutuality appears to be a central factor representing cohesion in the family. Olson et al. (1983) similarly used the concept of family cohesion defined as the emotional bonding between family members. Research findings showed that low level of familial cohesion has been related to higher level of adolescent depressive mood and negative thoughts (Aydin and Öztütüncü 2001) and problem behaviours (Barber and Buehler 1994). In terms of positive outcomes, Baldwin and Hoffmann (2002) suggested that being a teenage member of a cohesive family is associated with increased self-esteem over time. Further, findings reported by Wolman et al. (1994) emphasised the strong association between family connectedness and adolescent emotional well-being. Meltaus and Pietilä (1998) additionally found that a mutual understanding between parents and adolescents supported adolescents' choices concerning health habits.

Previous studies (e.g. Bartle and Sabatelli 1989; Noom et al. 1999) have emphasised the importance of both autonomy and attachment for psychological adjustment in adolescence. The developmental challenge for the family is thus to find a balance between individuation and connectedness (Worden 1991).

(3) Family flexibility refers to the capacity to be adjustable in response to diverse situations and to the process of change (Barnhill 1979). Olson et al's (1983) concept of adaptability relates closely to flexibility. In a rigid family, the relationships are inflexible and fail to facilitate functional changes related to problems or developmental needs (Barnhill 1979;

Olson et al. 1983; Olson 1993). Some studies (e.g. Hollis 1996; Carris et al. 1998; Garber et al. 1998) have revealed a positive relationship between family dysfunction, especially rigidity, and youth suicidal symptoms. Carris et al. (1998), however, suggested that family rigidity affects suicidal ideation or symptoms indirectly, through its effect on the problem-solving deficits of the adolescent.

(4) Stability is characterized as security and consistency in family interactions. Family stability provides regularity in daily family time and routines which decrease the need for decision making each time tasks arise (Barnhill 1979; Henry 1994). Although adolescents seek for autonomy within the family they also need a base of security and stability at home (Conger and Petersen 1984). Findings reported by Henry (1994) found a strong correlation between family stability and adolescent family life satisfaction. Disorganisation, in contrast, refers to lack of stability and predictability in family relations (Barnhill 1979).

(5) Barnhill (1979) defines clear communication as a clear and successful exchange of information between family members and it is regarded as a central feature of good family functioning (Barnes and Olson 1985). Barnes and Olson (1985) proposed that communication is a facilitating process in developing family cohesion and adaptability. In terms of positive familial effects, Jackson et al. (1998) and Huang (1999) indicated a positive association between open and conversation-oriented family communication and adolescent self-esteem, sociability and aspects of coping. Unclear communication is defined by Barnhill (1979) as paradoxical communication or confusing exchanges of feelings and ideas. Recent studies also showed that increased arguments between parents and adolescents (Stewart and McKenry 1994) were associated with higher level of adolescent depressive mood and negative thoughts. Sweeting and West (1995) found an association between poor relationship and conflict with parent(s) and lower self-esteem and poorer psychological well-being.

(6) According to Barnhill (1979), role reciprocity refers to behaviour patterns in which an individual complements the role of a role partner. Role expectations and practices vary from one family to another. Olson's (1993) concept of flexibility includes the change in a family's leadership, roles and rules. For instance, in a single-parent family, the adult assumes the roles of both parents or shares them with an adolescent child. Role conflict arises when no shared role expectations exist and the behavioural patterns between family members fail to complement each other (Barnhill 1979; Friedman 1997).

### **2.4.3 Adolescent peer relations**

Friends and peers become increasingly important to adolescents and they spend more time with them. Peer relationships change in a number of ways during adolescence. (Giordano et al. 1993; Sroufe et al. 1996; Rönkä et al. 2002) According to Sroufe et al. (1996), increased intimacy with and commitment to friends appear in early to middle adolescence. Several study findings (e.g. Conger and Petersen 1984; Ohannessian and Lerner 1994; Poikkeus 1995; Meeus et al. 2002) emphasise the importance of peer relations for the developmental tasks of adolescence. Laible and her colleagues (2000) showed that both parent and peer attachment served adolescent adjustment, such as increasing sympathy and absence of depression. On the basis of their study, they even suggested that peer attachment may be more influential on teen adjustment than parental attachment. However, Dekovic and Meeus (1997) emphasised the balance between developing an active pattern of interactions with peers and remaining close to parents. Maxwell (2002) and Buysse (1997) indicated that peers have a strong impact on adolescent behaviour and may offer protection in some risk behaviour, such as alcohol consumption. According to Ellenbogen and Chamberland (1997), females tend to be more attached to their friends, less likely to be rejected by their classmates, and less open to negative influence by them.

Recent studies have showed that close family relations (Field and Lang 1995; Dekovic and Meeus 1997; Madden-Derdich et al. 2002) predict adolescent intimate same-sex peer relations. Additionally, marital quality perceived by adolescents predicted prosocial behaviour and attachment security to friends (Markiewicz et al. 2001). On the other hand, Ohannessian and Lerner (1994) suggested that peer support protected from the harmful developmental effects of maladaptive family functioning. They suggested that adolescents who were dissatisfied with their family environments at the beginning of the school year were less likely to be depressed or anxious at the end of school year if they reported high level of peer support. Findings reported by Noack et al. (2001) suggest that peer relations were affected by parental separation only to a minor extent. The study by Ellenbogen and Chamberland (1997) furthermore showed that students at-risk had more dropout friends, more working friends, fewer school friends and fewer same-sex friends. Further, Maggs et al. (1995) and Engles and Bogt (2001) found a positive association between risk behaviours and quality of peer relations. Engles and Bogt (2001, p. 689) explained the relations by the fact that adolescents

who are involved in risk behaviour are more integrated into a peer network, which in turn affects feeling of attachment, support and acceptance in a positive way. Ladd (1992) illustrated three ways in which family interactions may affect adolescent peer relations: (1) *discipline styles* that promote various types of behaviours in the child, (2) *parent-child interactions* whose quality affects the development of emotional regulation processes, and (3) *parental behaviors* that teach or fail to teach children aspect of social competencies (see also Szydrowski 1999).

#### **2.4.4 Adolescent school satisfaction**

School has a major influence on adolescent development and most adolescents in developed countries complete their school education (Heaven 2001). School can be described as a workplace of pupils, teachers and staff working in the school (see Savolainen 2000). In addition, school can strengthen social and cultural capital, especially among at-risk pupils (Pulkkinen 2002).

Research evidence among adults indicated that e.g. work ability was strongly related to general subjective well-being (Sjögren et al. 2002). The longitudinal study by Pietilä et al. (1994) indicated that poor school performance in adolescence was connected with weak life control including life satisfaction among Finnish young men. Results reported by Koivusilta et al. (2002) confirmed that poor school performance was associated with self-rated poor health, chronic disease, fatigue and increased symptoms among female adolescents, too. Savolainen et al. (1998) further found that adolescent school satisfaction has been related to school atmosphere, cooperation, encouragement, support with problems, school organization and physical environment.

According to the School Health Promotion Survey (see Konu et al. 2002a), Finnish pupils criticized school conditions: the majority of respondents objected to inappropriate ventilation, temperature and desks in the classroom. Nearly half of the Finnish pupils also reported lack of peaceful atmosphere in class. However, these factors appeared to have only a minor impact on pupils' subjective well-being. Konu et al.'s (2002a) results showed that the school context in terms of means for self-fulfilment, such as getting help with problems and finding a personal way to study, was the most important school-related predictor of adolescent subjective well-being measured by Raitasalo's modification of the Beck Depression Inventory.

Earlier studies from the Nordic countries found an association between increased psychosomatic symptoms and school distress (Natvig et al. 1999) as well as failing examinations (Poikolainen and Kanerva 1995). A positive relation was also found between rebelling against school and adolescent problem drinking (Treiman and Beck 1996). A recent study by Somersalo (2002) found an association between poor classroom atmosphere and an increase in emotional and behavioural problems among Finnish sixth graders. Konu et al. (2002b) discovered a positive relation between general subjective well-being and social relationships in school and outside the school, and social cohesion in the family. Results reported by Shek (1997) and Aunola (2001) showed an association between negative family environment and school adjustment problems among Chinese and Swedish teenagers. Previous findings also indicated that positive parental involvement influences students' academic self-concepts (Sanders 1998) and school integration (Shucksmith et al. 1995). Furthermore, recent data have established links between negative daily life events, such as pressure from parents, and school dissatisfaction (Huebner and McCullough 2000).

Research evidence has shown that support from teachers and peers is important for adolescents' well-being and health (Samdal 1998; Natvig et al. 1999). Female teenagers especially identified peers even as the most significant reason for their school satisfaction (Pölkki 2001). Kracke (2002) and Meeus et al. (2002) additionally emphasised the role of peers in adolescent career and school exploration.

## 2.5 Adolescent realised values

One developmental task of adolescence according to Havighurst (1972) is acquiring a set of values and an ethical system as a guide to behaviour. Stattin and Kerr (2001) also argued that values are especially important in adolescence, because this is the time when significant life decisions are being made and adolescent goal settings for the future are based on their values and motives. Adolescents are influenced simultaneously by several value systems, such as parents, peers and school, which reflect the values of a certain era (Hämäläinen 1999). In addition, the media have an impact on the value constructs of adolescent by both maintaining the traditional values and promoting the emergence of new critical values (Helve 1993, p. 71). Findings reported by Stattin and Kerr (2001, p. 22) suggested that adolescent values are

reflected in adolescents' everyday activities and lifestyle and they are related to personality, and have long-term implications for adult life. Laine (1999) in her study found an association between values and value-related behaviour but the appreciation of a certain value was significantly stronger than the realised behaviour related to it (Nurmi 1997b, p. 441) found that not only the goals (which are means of achieving values, see Locke 2002, p. 304), but also how they are concretely pursued in the context of adolescent life, play an important role in personal well-being. Oishi et al. (1999b) moreover indicated that intraindividual changes in life satisfaction were strongly influenced by the degree of success in the domains that individuals valued. For instance, global life satisfaction was greatly affected by social life for individuals high in benevolence values, whereas it was strongly influenced by family life for those high in conformity values. Diener and Suh (2000, p. 4) further suggested that SWB takes people's values into account, and gives a summary of whether their lives fulfill these standards, because individuals' own views of their well-being reflect their values. In this study realised values are defined as adolescent behaviour or action derived from a certain value. The interest of this study is not in perception/appreciation of values but in how these are actualised in adolescent life. For instance, in terms of family relations the question is not "how high I value familial relations" but "how much family is involved in my life".

Rokeach (1970; 1973, p. 5) defined value as "an enduring belief that a specific mode of conduct or end-state existence is personally and socially preferable to an opposite or converse mode of conduct or end-state of existence". Schwartz and Bilsky (1987, p. 551) reviewed several different definitions of values and summarized them into the following definition which is also incorporated in this study: "values are concepts or beliefs about desirable end states or behaviours that transcend specific situations, guide selection or evaluation of behaviour and events, and are ordered by relative importance". Rokeach (1970; 1973) argued that human values can be conceptualized as consisting of a relatively small number of core ideas or cognitions present in every culture. Schwartz and Bilsky (1986) supported the universal types of values but they found cross-cultural differences in the meaning and importance of specific values. In addition, the study by Oishi et al. (1999a) suggested that standards for life satisfaction judgements vary across cultures and such cross-cultural variations are systematically related to salient cultural values. For instance, norms for life satisfaction were more strongly associated with the level of life satisfaction in collectivist nations than in individualist nations (Suh et al. 1998), whereas satisfaction with esteem needs predicted global life satisfaction more strongly among people in individualist nations than

people in collectivist nations (Oishi et al. 1999a). Helve (1993) investigated Finnish adolescents' values and found that teenagers construct their own value system by selecting and combining aspects from diverse fundamental ideologies and belief systems, such as individualism, humanism and traditional Christianity.

Furthermore, Rokeach (1970; 1973) divided values into two categories: terminal values and instrumental values. The former refer to idealized end states of existence and consist of two kinds of terminal values: personal, such as inner harmony, and social values, such as world peace. The latter refer to idealized modes of behaviour and comprise moral values, such as honesty and competence values, such as autonomy. According Rokeach (1973, p. 12), instrumental and terminal values represent two separate yet functionally interconnected systems. On the basis of a phenomenological-hermeneutical study of health, well-being and nursing, Åstedt-Kurki (1992) proposed values to be a manifestation of health and well-being on a more abstract level than everyday experiences. Åstedt-Kurki (1992) arrived at eight core ideas in the Finnish context: (1) human relations, (2) religiousness, (3) equilibrium and aesthetics, (4) peace and safety, (5) work, (6) humour, (7) autonomy, and (8) self-fulfilment. According to Rokeach's (1973) categories, the first four refer to terminal values and the rest refer to instrumental values. Based on data collected from 40 countries (including Finland), Schwartz and Savig (1995) identified 10 universal values, i.e. power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity and security. The adolescent realised values were postulated based on Åstedt-Kurki (1992) and adapted from Schwartz and Savig (1995). After principal component analysis (see Chapter 4.3. and study I) ten values of the present study were identified (Figure 3.).

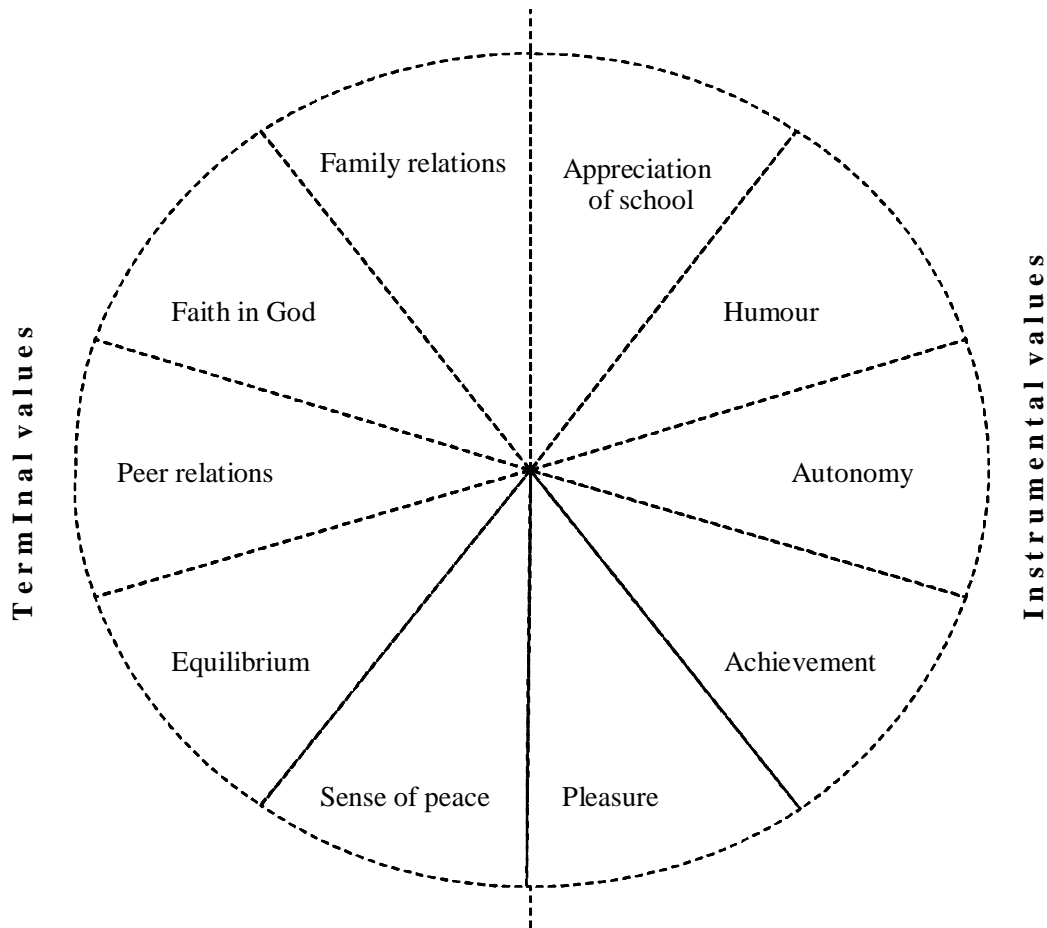


Figure 3: Structure of realised values in this study (adapted from Åstedt-Kurki, 1992, and Schwarz and Savig, 1995)

### 2.5.1 Terminal values

(1) *Human relations* refers to an individual's desire for social contact with other people (Åstedt-Kurki 1992). According to the study by Cohen and Cohen (1996) on adolescent life priorities, adolescents placed a very high priority on having friends and family who love them and are near them. The WHO's cross-national Health Behaviour in School-aged Children (HBSC) survey indicated that Finnish pupils identified parents, siblings and friends as the most significant persons in their lives (Välmaa 1996). Hämäläinen's (1999) study indicated that the majority of Finnish adolescents perceived their parents as highly valued social relationships. A number of studies (e.g. Werner 1993) have found that e.g. self-esteem and self-efficacy were promoted through supportive relationships. Werner (1993) noted that studies of disadvantaged children have found the most significant positive influence to be a close, caring relationship with a significant adult who accepted the child unconditionally.



(2) *Religiousness* comprises *faith in God* who enhances meaning, hope and help in every day life (Åstedt-Kurki 1992). In the psychological literature, religiousness or faith in God has been noted as providing the meaningfulness and coherence which are needed in the development of coping strategies and resilience (see e.g. Antonovsky 1987, p. 104; Blaine and Crocker 1995; Pargament and Mahoney 2002). There is also research evidence that strong religiosity significantly decreases the level of risk taking behaviour, such as smoking and binge drinking among adolescents (e.g. Abbott-Chapman and Denholm 2001; Winter 2004). A similar observation was reported by Baldwin et al. (1990) concerning high-risk families and children. Winter (2004), however, noted that only fairly strong religiousness seemed to reduce the consumption of alcohol among Finnish adolescents, especially in Ostrobothnia.

Hämäläinen (1999) found that more than two out of three of Finnish adolescents reported that their parents did not consider the religious values important in their rearing practices. The results reported by Helve (1993) suggested that only few Finnish adolescents in the late 1980s were actively involved in religious organisations, although they placed greater emphasis on spiritual values than the generation which grew up in the post-war period. Helve (2002) found later that religion became more important in the 1990's for Finnish female teenagers, whereas males were quite indifferent to it.

(3) *Equilibrium and aesthetics* refer to an individual's desire for inner balance and experience of beauty of environment, such as nature (Åstedt-Kurki 1992). Harmony emerges e.g. from stability in society, in relationships, and in the self (Schwartz and Savig 1995). Maslow (1954, p. 97) in his empirical studies identified the human need for aesthetics. He even suggested that some individuals fall sick from ugliness and are cured only by beautiful surroundings. Hämäläinen (1999) found that mothers of Finnish teenagers especially perceived aesthetics as an important upbringing value assessed by adolescents.

(4) *Peace and safety* is one of fundamental needs and values of human beings (Rokeach 1979; Åstedt-Kurki 1992). According to Åstedt-Kurki (1992, p. 57) people highly value experiences of safety and peace. Maslow (1954, p. 87) considered safety to be physical safety, such as feeling safe enough from animals, extremes of temperature, murder as well as economic security, such as a job with tenure and permanence. In this study peace is defined as a world peace (absence of war and conflict) (see e.g. Rokeach 1979).

### **2.5.2 Instrumental values**

(5) *Appreciation of school.* One of the most important extrafamilial environments in adolescence may be school (Cohen and Cohen 1996). Brophy (1999) argued that current research on motivation in education focuses on the achievement situation. He emphasized that education should pay more attention to the value aspects of motivated learning and that new strategies are needed to help pupils come to value what they are learning for its perceived self-relevance and potential life application. Further, Covington (1999) found that college students were more likely to value what they were learning when they were attaining their grade goals, when their studies were of personal interest and when the dominant reasons for learning were task oriented, not self-aggrandising or failure avoidant. (see also Chapter 2.4.2)

(6) *Humour.* A sense of humour is a combination of the ability to appreciate humour and the ability to create humour (Freiheit et al. 1998). The results of Freiheit et al. (1998) indicated that humour appreciation and humour creativity were positively related to self-esteem and negatively related to depression and hopelessness among adolescent psychiatric inpatients and non-clinical high school students. Further, Freiheit et al. (1998) found that humour coping evidenced the strongest relation to symptoms of depressive mood as compared to humour appreciation or humour creativity and they suggested that the deliberate use of humour to deal with stressful problems may be more effective in ameliorating depressive mood than a pure sense of humour. Contrary to these results Kerkkänen (2003) found no association between one's sense of humour and health or well-being among Finnish policemen.

Lefcourt (2002) summarised the recent psychological studies on humour by suggesting that humour can be a positive asset in survival and recovery from illness and loss. It may also help to withstand the debilitating effects of pain and fear associated with threatening or frightening circumstances. In these studies as well as in the present study, humour is defined as a nonhostile, emotion-focused coping strategy. Lefcourt (2002), however, remarked that humour can be characterized as a form of hostility as well. Robinson (1991, pp. 4-5) described humour as a spontaneous, individual and situational phenomenon. Recent nursing studies (e.g. Lowis 1997; Åstedt-Kurki et al. 2001) revealed that humour also provides new perspectives and means of showing and dealing with strong emotion during hospitalization and other life stress situations.

(7) One element of the transition from adolescence to adulthood is defined as the development of *autonomy* (Havighurst 1972). Autonomy refers to an individual's ability to regulate his/her own behaviour (see e.g. Åstedt-Kurki 1992; Noom et al. 1999). According to Sheldon and Bettencourt (2002, p. 35) autonomy and independence are different things. Thus people can feel quite self-determined and autonomous even if they are dependent on someone and behave according to another person's wishes, if they have internalized what they do. The question of autonomy is also culturally related. In Western countries autonomy is much more highly valued than in other countries in the world.

Reis et al. (2000) and Rönkä et al. (2002) demonstrated that autonomy was not only competence and relatedness but also significantly associated with adolescent daily well-being. Further, Noom et al. (1999) found that adolescents' autonomy was positively related to their social competence, academic competence and self-esteem, and negatively related to their depressive thoughts. Noom et al. (2001) differentiated three aspects of adolescent autonomy, i.e. attitudinal, emotional and functional. Attitudinal autonomy refers to "the ability to specify several options, to make a decision, and to define a goal" (p. 578). Emotional autonomy is defined as "a feeling of confidence in one's own choices and goals" (p. 581). Finally, functional autonomy comprises "the ability to develop a strategy to achieve one's goal" (p. 581). Noom et al. (2001) found that attitudinal and emotional autonomy increased from early to middle adolescence, whereas the functional aspect of autonomy appeared to be stable during this period.

(8) *Self-fulfilment* or self-actualization refers to openness to experience (openness to self, to others and to life) and self-reference (adaptation and autonomy) (Åstedt-Kurki 1992; Leclerc et al. 1999). Self-actualization can be viewed as a value or as a need. Maslow (1954) characterised self-actualization as a need and theorized that self-actualization usually required fulfilment of other needs, such as need for food, safety, love and belonging, and self-esteem. He briefly defined self-actualization as "What a man *can* do, he *must* do" (Maslow 1954, p. 91). Maslow (1968, p. 157, 210) emphasised that self-actualization includes positive characteristics, such as ability to love, increased integration and spontaneity but also human problems, such as the conflict, anxiety and sadness. According to Sumerlin and Bundrick (2000), Maslow (1991, see Sumerlin and Bundrick 2000) later questioned the hierarchy of needs and suggested that self-actualization might be attained in spite of satisfying needs rather than because of it. He also posited a connection between happiness and self-actualization.

Recent study results supported this connection (Sumerlin 1997; Sumerlin and Bundrick 2000) and the lack of hierarchy of needs among homeless men (n=146) (Sumerlin and Bundrick 2000). The results of Konu et al. (2002a) moreover indicated that means for self-fulfillment in the school environment were the most important school-related predictors of adolescent subjective well-being.

In the present study, self-fulfilment was identified as a value and divided into two categories: achievement and pleasure. In terms of achievement, several current teenagers experience strong pressure to succeed in what is portrayed as an increasingly competitive world (Sroufe et al. 1996, p. 572). A number of studies has indicated that academic achievement and school performance were effected by parenting practices and the parent-child relationship (Dornbush et al. 1987; Wenzel et al. 1991; Gottfried et al. 1998). Pleasure can be seen as a hedonistic dimension of self-actualization. It has a central role in human life and motivates people in many ways (Warburton 1996, p. 1). In this study pleasure refers to a person's desire for plenty of free time and pleasant experiences.

## 2.6 Summary of the literature

In this study adolescent subjective well-being is defined on the basis of psychological and nursing theories of well-being. It consists of components of satisfaction, ill-being, knowledge and activities related to SWB. Satisfaction refers to aspects of a positive attitude toward life, healthy self-esteem, joy of life, absence of depressive mood. Ill-being includes the aspects of adolescent problems and worries in life and somatic symptoms. Knowledge related to SWB refers to knowledge of health related issues, problems and sources help as well as of personal abilities to improve and control well-being. Activities comprise life habits, self-care and activities in order to maintain or improve one's well-being. (Grob et al. 1991; Åstedt-Kurki 1992; Grob 1998; Grob et al. 1999) Figure 4 presents a summary of relationships related to SWB supported in previous studies, antecedents of adolescent SWB as well as the empirical references of adolescent SWB in this study.

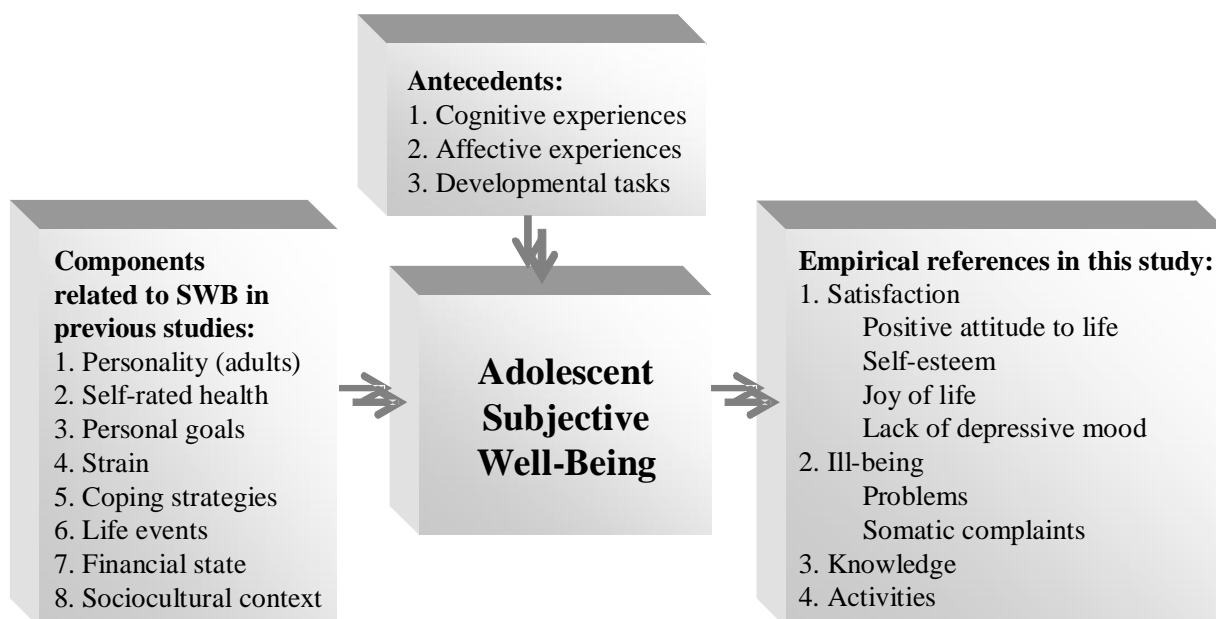


Figure 4. Summary of the antecedents, components and empirical references related to adolescent subjective well-being (SWB)

This study and its concepts can be presented as an ecological model (Figure 5). A broad approach to the prediction of adolescent SWB was proposed by Diener and Grob. An ecological approach (e.g. Bronfenbrenner 1989) to studying the relationships between multivariate factors and adolescent SWB has several advantages. First, using an ecological approach assists in the organisation, selection, and inclusion of constructs related to adolescent life. Second, an ecological model emphasises the influence of proximal interpersonal events, which in turn are affected by contextual factors. For instance, adolescent interactions with family, peers and school may have a direct impact on SWB. Although the ecological model is generated to describe and explain adolescent development it can still be used in cross-sectional settings when the data is gathered from different age groups (see Bronfenbrenner 1986, p. 733). Chronosystem refers to study design that makes possible examining the effects of changes or similarities over time, i.e. in the present study the impact of time (two different age groups). The model is provided as a guide for describing the study on individual's SWB in his/her multiple environments. Additionally, a systemic view of family dynamics shifts the focus from individual traits to interactional processes that must be understood in the ecological and developmental context as well.

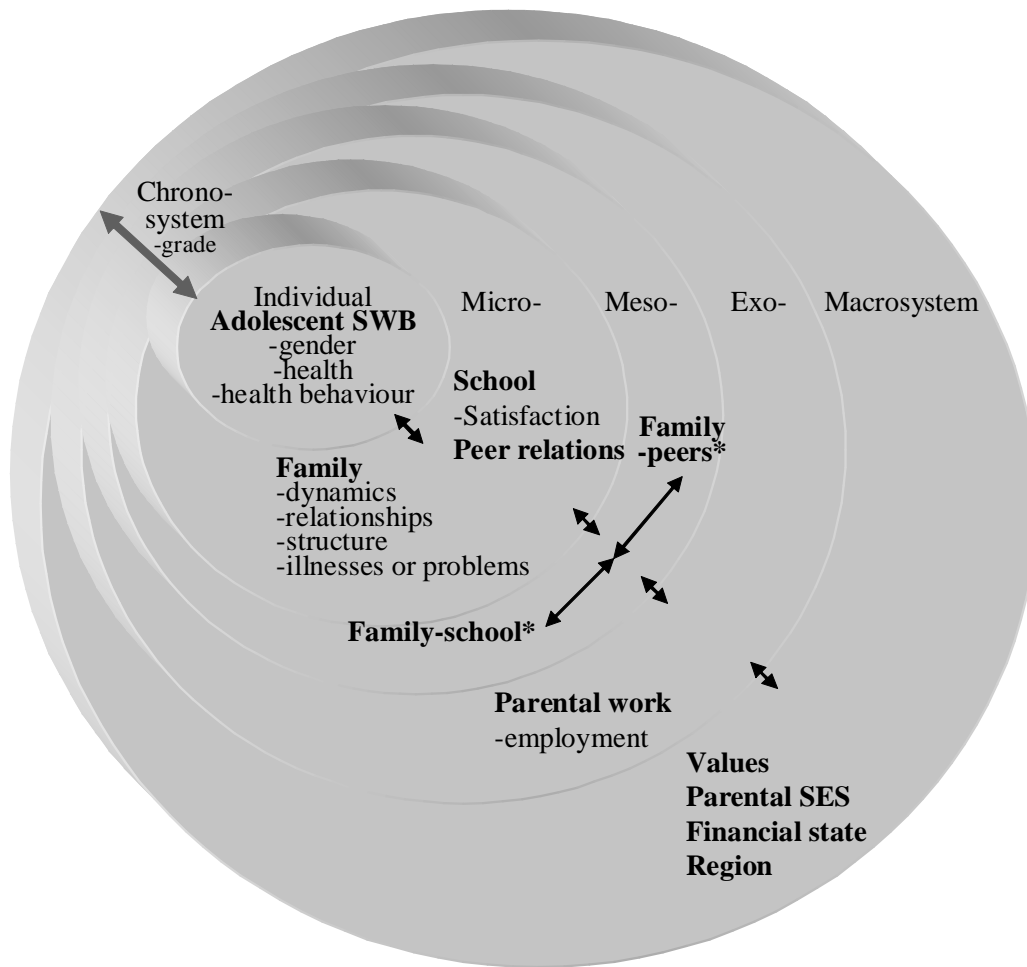


Figure 5. Adolescent ecosystem in this study (adapted from Bronfenbrenner 1989)

\* Familial contribution to adolescent peer relations and school attendance

Family is defined as a psychosocial unit composed of an adolescent and one or both of his or her parents who live together (see Lasky et al. 1985; White et al. 1999). Family dynamics is defined according to family systems theory (Barnhill 1979) and Lasky et al.'s (1985) modification of it. The family dynamics used in this study is composed of four family themes: (1) identity processes, (2) change, (3) information processing and (4) role structuring (Barnhill 1979).

### **3 Aims of the study**

The purpose of this study was twofold: the first purpose was to examine adolescent subjective well-being and the relationships between this and realised values, health behaviour, school satisfaction and family dynamics. The second purpose was to understand more profoundly the familial contribution to adolescent subjective well-being, school attendance and peer relations.

The aims of the study were:

- I            To assess the intensity of adolescent subjective well-being and realised values and the relationships between them (Studies I, II)
  
- II            To examine the relationships among adolescent subjective well-being, health behaviour, and school satisfaction (Study II)
  
- III           To assess adolescent and parental perceptions of family dynamics and the relationships between adolescent subjective well-being and family dynamics (Study III)
  
- IV           To describe the familial contribution to adolescent subjective well-being, peer relations, school attendance (Studies IV, V)
  
- V            To develop an explanatory model of adolescent subjective well-being

## 4 Subjects and methods

### 4.1 Triangulation

In order to explain and understand the complexity of adolescent SWB from an adolescent's perspective, this study took a multiple approach by using multiple triangulation. Triangulation refers to the use of different vantage points and allows elucidation from multiple standpoints, reflecting a commitment to thoroughness, flexibility and differences of experience. Triangulation may assume a variety forms, such as data, investigator, theoretical and method triangulation. (Morse 1991; Tindall 1994, pp. 145-149) In this study, theoretical, data and method triangulation were used. In addition, investigator triangulation was used while developing the instrument and interview themes and writing up the results of the study. Theoretical triangulation comprises multi-theories and recognises the complexity and diversity of realities (Tindall 1994, pp. 148-149). This study was informed by and originated in nursing and health research as well as psychological and family therapy literature. Theoretical triangulation was used in terms of theory testing in order to develop a model of adolescent subjective well-being in social contexts.

Method triangulation entails the use of different methods to collect data (Tindall 1994, p. 147; Bottorff 1997). An appropriate cluster of methods provides different information and at least some assurance that the material is more than a product of the method. Morse (1991, p. 122) suggested that methodological triangulation is a method of obtaining complementary findings that strengthen research results and contribute to theory and knowledge development. In this study quantitative and qualitative methods were combined. The study began by using structured questionnaires filled in by adolescents and one of their parents but continued by using a qualitative approach in terms of adolescent interviews. This sequential type of method triangulation is often used in order to examine unexpected results (see e.g. Morse 1991; Bottorff 1997). In the present study, qualitative data proved useful in the identification of conceptual issues used in quantitative methods. Further, the qualitative data elaborated the meanings of concepts and the relationships between them. In terms of analysis, the data of the present study was analysed using both statistical analyses and qualitative content analysis. (Shih 1998)



## 4.2 Data collection

### **Phase I**

The data were collected by self-report questionnaires from adolescents and one of their parents. The adolescent questionnaire is presented in Appendix 1 and the parental questionnaire in Appendix 2. The adolescent questionnaire consisted of demographic data, Berne Questionnaire of Subjective Well-being (BSW/Y), a Finnish Questionnaire on Adolescent Values and Subjective Well-being (FVSW), Family Dynamics Measure (FDM II) and items concerning relations with family members and friends, school satisfaction and health behaviour. Adolescent questionnaires were administered by the researcher between October and November 2000 in the classroom on a given day. Parental permission and parental questionnaires was gathered ex post facto with a return envelope given to the adolescent informants. The parental questionnaire comprised the Family Dynamics Questionnaire (FDQ), including age, gender, family structure, education, socio-economic status and parent's perception of problems and severe diseases in the family and the Family Dynamics Measure (FDM II). Family structure was measured among both adolescents and one of their parents by asking with whom the respondent was currently living.

### **Phase II**

Semi-structured interviews were conducted between February and May 2001. The researcher telephoned each adolescent and made an appointment. According to participants' wishes, 15 interviews took place in a secluded booth of a restaurant, and four in participants' homes. The interviews varied in length from twenty-five minutes to one and a half hours (mean length 1 hour) and were tape-recorded. Figure 6 describes the samples of the whole study, missing data, data collection methods and in study populations for each of the respective papers.

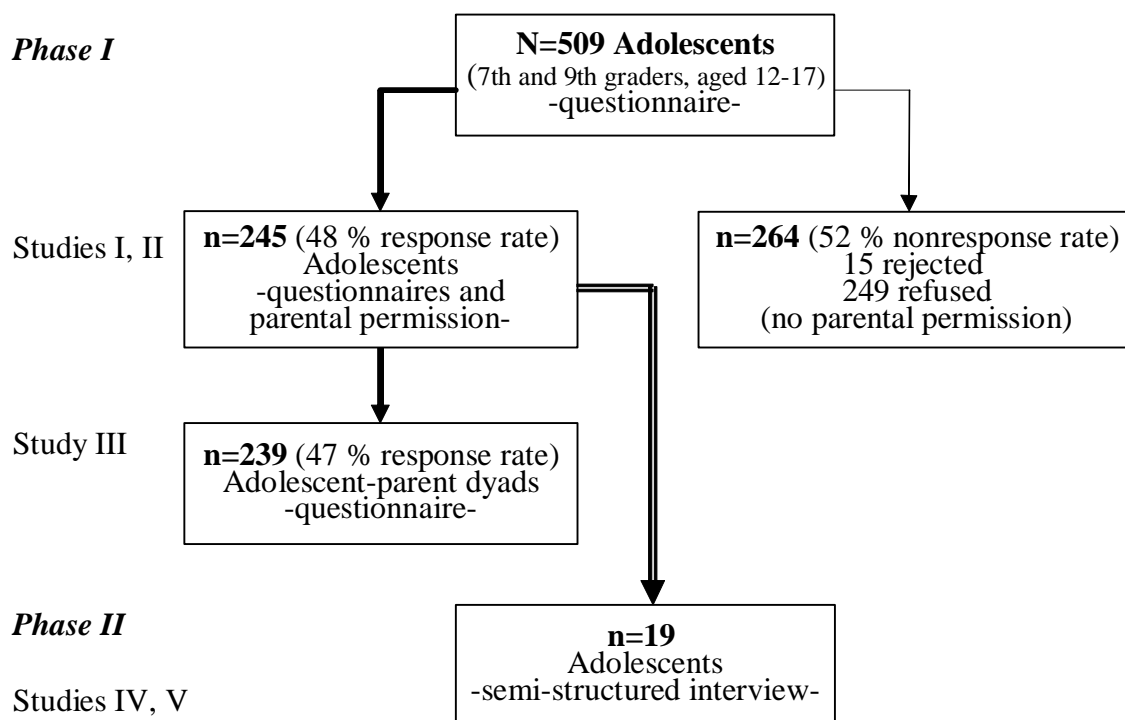


Figure 6. Study samples and data collection methods

#### 4.2.1 Measurements

The data were collected during phase one by structured questionnaires from adolescent and one of their parents.

*Adolescent subjective well-being.* The Berne Questionnaire of Subjective Well-Being (Youth Form) was used to measure adolescent SWB (Grob 1995a). The BSW/Y is a 38-item instrument consisting of two independent scales: satisfaction (22 items) and ill-being (16 items). Satisfaction refers to a positive attitude toward life, self-esteem, joy in life and absence of depressive mood. The ill-being scale comprises sub-scales of problems and somatic complaints. Each item is rated on a five point Likert scale ranging from 1 “totally disagree” to 5 “totally agree”. One statement measuring problems with girl- or boyfriend was not counted as a sum variable of ill-being because 85 % of the respondents were not dating. The instrument was translated from English into Finnish and verified through back-translation. The reliability of the scale measured by Cronbach’s alpha coefficients has been reported to be acceptable in previous studies (Grob et al. 1991; 1999). The instrument was pilot tested in a study with 55 adolescents aged 14-17 in May 2000 and the Cronbach’s alpha

values varied from .68 to .90. In this study, the internal consistency of the scale on the basis of Cronbach's alpha values in different dimensions of SWB varied from .73 to .90, suggesting that the scale was reliable.

*Adolescent realised values, knowledge and activities related to SWB.* The Finnish Questionnaire on Adolescent Values and Subjective Well-being (FVSW) was developed *ad hoc* for this study on the basis on Åstedt-Kurki's (1992) dissertation. The FVSW was used to measure adolescent perceptions of realised values, knowledge and activities related to SWB. It consists of 52 items composing four scales: 1) realised terminal values (26 items), 2) realised instrumental values (18 items), 3) knowledge related to SWB (3 items) and 4) activities related to SWB (5 items). The scales of the measures ranged from strongly disagree (1) to strongly agree (5). The instrument was pilot tested in a study with 55 adolescents aged 14-17 in May 2000 and five items were eliminated because of low internal consistency. In addition, on the basis of the pilot test, five items concerning achievement and pleasure were added to the instrument.

Principal component analyses (with varimax rotation) were conducted for both terminal and instrumental values and the procedures yielded five factors that reflected the eight original values (see Åstedt-Kurki 1992), with eigenvalues exceeding 1.0. The scale of terminal values comprised the factors Safe family, Faith in God, Mutual relationship with friend, Equilibrium and Peace. These five factors explained 29.1 % of the total variance. The scale of instrumental values consisted of items concerning Appreciation of school, Humour, Autonomy, Achievement and Pleasure explaining 24.0 % of the total variance. All factor loadings were above .42, and majority of the loadings were between .61 and .97 which can be considered good to excellent (Tabachnick and Fidell 2001, p. 625). In addition, all factor cross loadings were smaller than .48. The Cronbach's alpha coefficients were .88 for terminal values, .75 for instrumental values, .56 (knowledge) and .73 (activities) (see more in Study I).

*Family dynamics.* Adolescent and parental perceptions of family functioning were measured by the Family Dynamics Measure (FDM II) developed by a group of nursing researchers (Lasky et al. 1985) and revised on the basis of several studies in the U.S.-Nordic Family Project (see e.g. White and Elander 1992; White et al. 1999). The inventory consists of 66 items developed for responses on a 6-point Likert-type scale (1 = strongly disagree, 6 = strongly agree). The FDM II includes six bipolar dimensions of healthy family systems

identified by Barnhill (1979): individuation-enmeshment, mutuality-isolation, flexibility-rigidity, stability-disorganisation, clear communication-distorted communication and role reciprocity-role conflict. In previous studies, the Cronbach's alpha coefficients have been acceptable (Murtonen et al. 1998; Hakulinen et al. 1999). The instrument was pilot tested in a study with 15 adolescents aged 14-17 in May 2000 and no revisions were made on the basis of this. In the present study, since one inter-item correlation for individuation-enmeshment and one for stability-disorganisation were negative, these items were deleted. After that, the internal consistency was moderate as measured by Cronbach's alpha coefficients (.59-.88 for adolescents and .65-.87 for parents, more details see Study III Table 4).

*School Satisfaction.* Adolescent school satisfaction was measured by a total sum variable consisting of three items: "I enjoy schoolwork," "I feel I am able to cope with my schoolwork," and "I am enthusiastic about schoolwork" (Savolainen 2001). Each item is rated on a five-point Likert scale ranging from (1) strongly disagree, to (2) strongly agree. The Cronbach's alpha coefficient of the scale was .77.

*Health Behaviour.* Adolescent health behaviours were measured by asking the frequency of cigarette smoking, lifetime alcohol drinking, beer and cider drinking, drunkenness in the previous three months, drug abuse, and physical activity. Cigarette smoking was measured by frequency from (1) never smoking to (5) daily smoking. Lifetime alcohol drinking was investigated with the question 'Have you ever tried alcohol?' Alternatives for beer and cider drinking were: 'daily', 'a few times a week', 'once a week', 'a few times a month', 'about once in two months', '3-4 times a year', 'once a year', 'I do not drink alcohol'. Drunkenness was elicited using the question: 'How many times have you been really drunk during the last three months?' Physical activity was measured by asking the participants to report the frequency of physical exercise ('weekly or more often' to 'less frequently than once a month or never') and to name the activity.

*Socio-demographics and family relationships.* The socio-demographic characteristics of the adolescents included age, grade, gender, family structure, occupation of the parents, economic situation. Family relationships of adolescents consisted of the items on the parental relationship, mother-adolescent and father-adolescent relationship. The socio-demographics of the parents were obtained with the Family Dynamics Questionnaire (FDQ), including age, gender, family structure, education, social status and parent's perception of problems and

severe diseases in the family. Family structure was measured in both groups by asking with whom the respondent was currently living. The adolescent age was dichotomised indicating whether he or she belonged to the younger group (i.e. 7<sup>th</sup> grade, mean age of 13 years) or to the older group (i.e. 9<sup>th</sup> grade, mean age of 15 years).

*Adolescent self-rated health and weight.* Self-rated health was based on two items asking adolescents to report whether they had a chronic disease or disability, and to rate their health on a five-point scale from excellent (1) to very poor (5). The single-item indicator of self-rated health has been found to be a reliable indicator of overall health and showed an unambiguous association with ill health and its functional consequences (Manderbacka 1998). The perceived weight was measured by one item that asked participants to rate their weight on a three-point scale from too high (1) to too low (3).

#### **4.2.2 Semi-structured interviews**

Adolescent interview themes were based on concepts of adolescent subjective well-being (Åstedt-Kurki 1992; Grob et al. 1999) and family dynamics (Barnhill 1979; Lasky et al. 1985). The interview themes are presented in Appendix 3. Background variables of age, family members and hobbies were included in each interview. The definition of the themes was carefully considered in terms of adolescent cognitive, linguistic and emotional development (Kortesluoma and Hentinen 1995; Dashiff 2001). Consequently, abstract terms were avoided (especially among 7<sup>th</sup> graders), careful explanations about the interview and report were provided, additional time to comprehend and to reflect on the meaning of the questions while refreshments were provided (Dashiff 2001). Alternative questions were formed together by several investigators and these were evaluated by three adolescents (12-15 year-olds).

### **4.3 Samples of the study**

#### **Adolescent sample of Phase I**

The target population of the first phase of this study consisted of 3266 pupils from the 7<sup>th</sup> and 9<sup>th</sup> grades enrolled in community comprehensive schools in a town of southern Finland. The

participants were selected randomly from 13 secondary schools so that there was one 7<sup>th</sup> and one 9<sup>th</sup> grade class taking part in the study from each school. The sample included 509 pupils who were present in class during the day of data collection. The number of incompletely filled or totally empty forms was 15 (3 %) and they were omitted from the analysis. The study sample comprised 245 pupils who received parental permission *ex post facto*, resulting in a response rate of 48 %. The study sample represented eight percent of the target population. Nonrespondent analysis was conducted by background variables of gender, age, school, family structure, religion and parental socioeconomic status. Nonresponse data did not differ from study data in any other variables but parental socio-economic status. The study data had a significantly lower proportion of parents from lower white-collar workers and manual workers than the nonresponse data had (Kruskal-Wallis,  $p < .001$ ). However, the nonresponse data included 54 missing values (22 %) for mothers' occupation and 60 missing values (24 %) for fathers' occupation, which impaired the validity of the results of the Kruskal-Wallis test. (Studies I, II)

### **Parent sample of Phase I**

Second, the target population of the first phase comprised one of the parents of adolescent population ( $n=3266$ ). The parent sample consisted of all the families from the adolescent survey ( $N=509$ ) who were willing to complete the inquiry and to give permission for the adolescent to participate in the study. A total of 239 parents (either the mother or the father of the respondent) filled in the questionnaire and returned it with the parental permission, resulting in a response rate of 47 %. (Study III)

### **Adolescent sample of Phase II**

The sample of Phase II of the study was a subsample of 19 adolescents (12 females and seven males), selected from among 245 pupils participating in Phase I of the study. While questionnaire data were being collected in the classroom, the objectives and the interview process were explained to the pupils. Adolescents who volunteered to participate in Phase II of the study and obtained parental consent were interviewed. (Studies IV, V)

## 4.4 Data analysis

### 4.4.1 Statistical analysis

The statistical analysis was carried out using SPSS/Win 9.0 programme and the significance level for all analyses was set at  $\leq .05$  (Munro 2001). First, frequency distributions were formed in order to identify possible coding errors and to examine the normality of distribution of each variable. The total sum variables of satisfaction and ill-being and school satisfaction formed a normal distribution, whereas the scales for realised values, activities, knowledge and family dynamics as well as subscales of satisfaction and ill-being were not normally distributed. Bivariate data analyses were thus both parametric, i.e. Pearson's product moment correlation coefficient, t-test, ANOVA, and non-parametric tests i.e. chi-square test, the Spearman rank correlation coefficient, Mann-Whitney U, Wilcoxon and Kruskal-Wallis test (Volicer 1984; Munro 2001d).

Second, continuous variables of adolescent subjective well-being, realised values, school satisfaction and family dynamics were determined using the means (SD) or medians ( $Q_{1,3}$ ) of the sum scores of the sub scales (Clark-Carter 1997). In addition, the frequencies for well-being, realised values, school satisfaction and family dynamics were categorised into three classes so that the lowest level included the responses 1 and 2 (strongly disagree/never to disagree/seldom), the medium level included response 3 (neutral/sometimes) and the highest level contained the responses 4 and 5 (agree/often to strongly agree/very often).

Third, to examine the differences between the adolescent gender and grade groups, t-test for continuous variables of SWB and school satisfaction and Mann-Whitney U-test for continuous variables of realised values and family dynamics was conducted. One-way analysis of variance was conducted in order to examine the differences between the three different groups of adolescents (in terms of family types, family relationships, self-rated health, body satisfaction, health behaviour, socio-economic status, perceived financial state and parental employment) for satisfaction and ill-being, and the Kruskal-Wallis test was conducted for realised values and subscales of SWB (Volicer 1984; Munro 2001a,c,e).

Fourth, the inter-correlation among the SWB, school satisfaction, health behaviour and family dynamics was evaluated by Spearman's rank correlation coefficients (Burns and Grove 1997; Clark-Carter 1997). The interpretation of the correlation coefficient was considered according

to Burns and Grove (1997): a correlation coefficient of .3-.5 showed a moderate linear relationship, and above .5 a strong linear relationship. Furthermore, differences between the adolescent and parental perceptions of family dynamics were tested with the paired Wilcoxon signed ranks test. The Mann-Whitney U-test and Kruskal-Wallis test were carried out to examine the differences in family dynamics between genders, grades and family type. (Burns and Grove 1997; Munro 2001c)

Fifth, eight stepwise multiple regression analysis was conducted to examine the associations between the dependent variable of adolescent satisfaction and ill-being and independent variables of realised values, school satisfaction, family dynamics, health, health behaviours, socio-demographics and family relationship. Categorical independent variables were dichotomised, i.e. dummy coded for regression analysis (Munro 2001b). The family type was collapsed into two classes: intact and non-intact (single parent and step family) families. The variables of perception of the parental relationship, mother-adolescent and father-adolescent relationship, financial state and self-rated health were dichotomised into good and moderate or poor. The perceived weight variable was collapsed from three to two categories, with “overweight” and “underweight” being collapsed within “body dissatisfaction” and with “normal” within “body satisfaction.” Frequency of smoking was categorised into nonsmoking and smoking groups. Frequency of drunkenness was identified as lower-intensity or higher-intensity drinkers as follows: higher-intensity drinkers (also defined as problem drinking) reported having been drunk once a month or more and drinkers who did not meet this definition were defined as lower-intensity drinkers. Adolescents who reported drinking beer or cider once a month or more frequently were characterised as regular drinkers, and those who reported drinking less than once a month as “rare”/never drinkers. Adolescents who reported engaging in physical activities once a week or more, were characterised as frequent exercisers, while those who exercised less frequently were classified as nonexercisers.

The first two models included independent variables of realised values (with correlation coefficient of .30 or more), socio-demographics (gender, grade, family type and financial state) and parental relationship (Paper I). Two further regression analyses using the same procedure were conducted with the independent variables of school satisfaction, self-rated health, health behaviours, body satisfaction and sociodemographics separately for girls and boys. Separate models were used due to gender differences among group means and frequencies of independent variables (Paper II). The last two stepwise analyses of regression



were made by using the following independent variables: subscales of family dynamics, family relations and socio-demographics (Study III). The maximum number of predictor variables entered in any regression was 11, which is acceptable according to Marascuilo and Levin (1983, p. 98). They recommend that sample size (N) should be at least 10 times larger than the number of predictor variables (P) ( $N > 10P$ ).

The correlation of Satisfaction scales and Ill-being scales was measured using Spearman's rank correlation coefficient (Appendix 4). The reliability of the BSW/Y, the FVSW, the FDM II and the School Satisfaction Scale were assessed by means of Cronbach's alpha coefficient (Cronbach 1984; Burns and Grove 1997) presented in Appendix 5. Furthermore, the construct validity of the FVSW was evaluated using principal component analysis (Nunnally 1978; Dixon 2001, p. 307). (see Study I)

#### **4.4.2 Inductive content analysis**

The interview data were analysed using inductive content analysis, which is applicable to written and oral communication (Lindkvist 1981; Kyngäs and Vanhanen 1999). This method was chosen because it provides both structural frames and the opportunity to "ask the data" outside the themes as well. An additional data set was provided by the interviewer's research diary, where an interpretive summary of each interview was recorded including the interviewer's personal impressions, the tone of the encounter, and any other reflections (Kortelnuoma and Hentinen 1995).

Inductive content analysis was conducted according to Kyngäs and Vanhanen (1999), and Dey (1993). The analysis was started by reading transcripts and the interviewer's research diary several times in order to obtain a sense of the whole. The unit of analysis was chosen to be phrases and sentences (Studies IV, V). The data were analysed by identifying mainly manifest content, but latent content such as verbal and non-verbal characteristics was also considered by listening to the taped data and by consulting the interviewer's research diary. (Field and Morse 1985; Dey 1993; Burns and Grove 1997; Kyngäs and Vanhanen 1999.)

Next, all expressions concerning each research question were indexed in a table using Microsoft Word. The expressions were indexed so that they could be located in the original text. After that the original expressions were compressed into briefer statements. Next, these

succinct statements were compared with each other and categorised so that expressions with similar content were classified into the same subcategory and named according to its content. Next, the subcategories were abstracted into main categories, separately according to the respective research questions. Finally, the main categories of each subquestion were abstracted into core categories. (Dey 1993; Burns and Grove 1997; Kyngäs and Vanhanen 1999). After the analysis was completed the preliminary categories were reviewed by two interviewees (one girl and one boy). They were met by the researcher and they evaluated the relevance and clarity of the schemes. (Burns and Grove 1997) On the basis of these face-validity meetings, the description of the two categories was expanded.

#### 4.5 Ethical issues and approval

The ethics of research with human participants deals with all parties involved in the study, such as participants and their families and communities, the researcher and the institution where the study is conducted (Sieber 2000). The study plan was approved by the principals of the schools. Permission to use and translate the Berne Questionnaire of Subjective Well-being/Youth form (BSW/Y, Grob 1995a) was received from the author. Written parental permission was gathered because the participants were underage. Permission was received from one of the parents *ex post facto*. Those adolescents for whom permission was not obtained were counted as non-response data.

In terms of participants, Sieber (2000) stressed a need to assess risk, harm and possible benefits to participants the study may affect. Participants' psychological well-being, health, values and dignity need to be preserved (Tindall 1994; Kylmä et al. 2002; Author's note: especially when investigating these issues). Thus, psychological risks and harm, such as embarrassment or increased anxiety, were already considered during the research planning (LaRossa et al. 1981; Lipson 1997; Sieber 2000). Therefore, the self-report questionnaire was chosen to reduce the emotional sensitivity for adolescents by providing physical distance and envelopes for returning questionnaires in the classroom (Dashiff 2001). Adolescents were furthermore informed by the researcher about the study in the classroom and before the interview, and participation was voluntary. Parents were informed about the study in writing with the envelope, including the parental permission and parental questionnaire. During the interview, the interviewer was aware of the importance of the adolescent's freedom to end

participation as a protection against increased risk by asking when sensitive topics emerged whether the interviewee was willing to continue. In terms of benefit to participants, adolescents in the survey were told to how to find the results. Interviewees were offered a snack in a restaurant and told that they would receive the summary of the study results as well as an invitation to the defence of the researcher's dissertation.

Privacy refers to a person's right not to be given information he or she does not want (Folkman 2000, p. 49). The privacy of the participants was ensured in addition to adolescent and parental informed consent by keeping the data matrix and transcripts anonymous (Kvale 1996). Confidentiality refers to agreements with individuals about what may be done with their data, and its primary purpose is to protect privacy (Tindall 1994; Lipson 1999; Folkman 2000). Participants were informed about the methods used in the study and about the anonymous presentation of the data. While writing the research report of the qualitative data the researcher kept in mind that subjects might tell friends, relatives, and some strangers about their participation in the research (LaRossa et al. 1981).

## **5 Results**

### **5.1 Description of the participants**

#### *Phase I*

The 245 adolescents who participated in Phase I and on whom Studies I and II were based, consisted of 125 females (51 %) and 120 males. The youngest adolescent was 12 years old and the oldest 17 years (mean=14.0, SD=1.1). However, 45 percent of the respondents were 13 years old and 44 percent of them were 15 years old. Fifty-one percent of the respondents came from the 7<sup>th</sup> grade. The majority of participants (72 %) lived in a nuclear family with both parents. One out of five adolescents lived in a single-parent family and eight percent in a step family. Both parents were employed in 83 % of the households.

Socio-economic status was based on reported occupation and that of the father (and mother) was as follows: 25 % (16 %) senior white collar worker, 23 % (42 %) lower white collar worker and 41 % (37 %) manual worker. However, 11 % of the adolescents did not report the

occupation of their fathers and five percent of those did not report the occupation of their mother. The economic situation of the family was reported to be good by 61 % of the respondents. Most of the respondents (88 %) were members of the Evangelical-Lutheran Church of Finland whereas 11 (4.5 %) adolescents had no religious affiliation. Nonresponse data did not differ from study data in grade, gender, school, and family type.

Fourteen percent of the adolescents reported having a chronic disease, such as asthma or diabetes. No gender differences occurred in self-rated health or in the prevalence of chronic disease. The majority of the adolescents (89 %) perceived their health status as rather or very good, whereas one out of 10 respondents rated their health as moderate. Twenty percent of the participants perceived their weight as too high and 9 % too low. Girls (29 %) reported more frequently being overweight compared to boys (10 %). Although boys (11 %) rated themselves as underweight more frequently than girls (7 %) body dissatisfaction was more common among girls ( $p=.010$ ).

Out of 245 respondents, those 239 teenagers one of whose parents filled in the FDM II established the sample of adolescent-parent dyads. The socio-demographics of the sample are presented in Study III. In summary, one out of five adolescents had no siblings whereas nearly half of them had one. Eighteen percent of the adolescents perceived the parental relationship to be moderate. Most teenagers reported good adolescent-mother and adolescent-father relationship. Most of the respondent parents (86 %) were mothers and the mean age of the parents was 43.2 (SD 4.7) years. Twenty-two percent of the parents reported suffering from severe illness in the family and one out of four parents reported severe problems in the family, such as unemployment or severe conflicts between parents.

### *Phase II*

The adolescent subsample consisted of 19 adolescents (12 females, 7 males) in grades 7 ( $n=10$ ) and 9 ( $n=9$ ) from nine of the 13 secondary schools participating in the survey. Ten participants lived in a nuclear family, three in a stepfamily, and six in a single-parent family, one of which was with a father. Two interviewees had lost a family member by death. Eight participants had one sibling and eight had two or more, whereas two participants had no siblings. All participants belonged to the Evangelical Lutheran Church. The social-economic status of the parents was as follows: five of the mothers and six of the fathers were senior

white collar workers; five of the mothers and four of the fathers were lower white collar workers; and six of the mothers and fathers were manual workers.

## 5.2 Adolescent subjective well-being

### 5.2.1 Adolescent SWB and realised values

The intensity of adolescent SWB and realised values and the relationships between these and socio-demographics were investigated using BSW/Y and FVSW from the adolescents' point of view (Study I). The mean values of SWB and realised values are presented in Table 1. The majority (66 %) of the adolescents scored high on global satisfaction as well as activities and knowledge related to SWB (mean of 3.5 or more when sum scores were divided by the number of variables). However, one out of ten respondents had low scores on joy in life. In terms of ill-being, adolescents scored higher on problems than somatic complaints. For instance, one out of four reported having problems with money, 14 percent had regularly worried because of school and one out of ten had worried because of parents or friends. Girls and 9<sup>th</sup> graders (14-17 year-olds) experienced ill-being more often than boys, but the global satisfaction was nearly identical in both gender and grade groups.

Most of the adolescents enjoyed a high perception of terminal values concerning social relations and sense of peace. However, only one in four teenagers reported that faith in God had a positive impact on their lives. Girls valued mutuality with friends and faith in God more highly than boys, whereas boys reported a higher degree of equilibrium than girls. Both genders valued family relations similarly. However, 7<sup>th</sup> graders reported a higher degree of safe family relations and faith in God relative to 9<sup>th</sup> graders. In terms of instrumental values, humour was realised most widely among the adolescents. In addition, 66 percent of the respondents enjoyed a high perception of personal autonomy. Schoolwork was perceived to be valuable by 82 % whereas 18 % showed moderate or scant appreciation for school. Boys valued personal autonomy and achievement more highly than girls, whereas girls reported higher degree of school appreciation compared to their male counterparts.

Table 1. Intensity of adolescent SWB and realised values (N=238-245)

<b>Scales and subscales</b>	<b>Mean<sup>1,2</sup> (SD)</b>	<b>Median (Q<sub>1</sub>, Q<sub>2</sub>)<sup>1,2</sup></b>
<b>BSW/Y</b>		
<b>Satisfaction</b> (22 items)	3.78 (0.49)	3.82 (3.50, 4.09)
Positive attitude toward life (seven items)	3.75 (0.56)	3.71 (3.43, 4.14)
Self-esteem (five items)	3.75 (0.66)	3.80 (3.40, 4.20)
Joy of life (five items)	3.40 (0.64)	3.40 (3.00, 3.80)
Lack of depressive mood (five items)	4.24 (0.57)	4.20 (3.80, 4.60)
<b>Ill-being</b> (16 items)		
Problems (seven items)	1.94 (0.53)	1.93 (1.53, 2.27)
Somatic complaints (eight items)	2.15 (0.66)	2.14 (2.14, 2.57)
1.77 (0.59)	1.75 (1.38, 2.13)	
<b>FVSW</b>		
<b>Terminal values</b> (26 items)		
Safe family relations (10 items)	3.81 (0.45)	3.78 (3.50, 4.11)
Faith in God (five items)	4.17 (0.57)	4.20 (3.90, 4.63)
Reciprocal peer relations (six items)	2.61 (1.15)	2.60 (2.00, 3.20)
Equilibrium (three items)	4.07 (0.62)	4.08 (3.83, 4.50)
Sense of peace (two items)	3.55 (0.71)	3.67 (3.00, 4.00)
<b>Instrumental values</b> (18 items)		
Appreciation of school (six items)	4.09 (0.77)	4.00 (3.50, 4.50)
Humour (five items)	3.73 (0.38)	3.72 (3.50, 4.00)
Autonomy (three items)	3.74 (0.61)	3.83 (3.33, 4.12)
Achievement (two items)	3.92 (0.62)	3.80 (3.60, 4.40)
Pleasure (two items)	3.72 (0.60)	3.67 (3.33, 4.00)
<b>Knowledge related to SWB</b> (three items)	3.61 (0.79)	3.50 (3.00, 4.00)
<b>Activities related to SWB</b> (five items)	3.41 (0.77)	3.50 (3.00, 4.00)
3.78 (0.65)	4.00 (3.33, 4.00)	
3.78 (0.62)	3.80 (3.40, 4.20)	

<sup>1</sup>Range 1 (low degree) to 5 (high degree)

<sup>2</sup>The sum variable was divided by the number of variables

Adolescent satisfaction was predicted by safe family relations, a high perception of personal autonomy, equilibrium, appreciation of school and humour as well as self-perceived good financial situation and intact family type ( $R^2 = .76$ ) (Figure 7). Ill-being was associated with a lower level of personal equilibrium, perceived moderate or poor parental relationship, a lower degree of safe family relations, and living in a non-intact family ( $R^2 = .37$ ) (Figure 8).

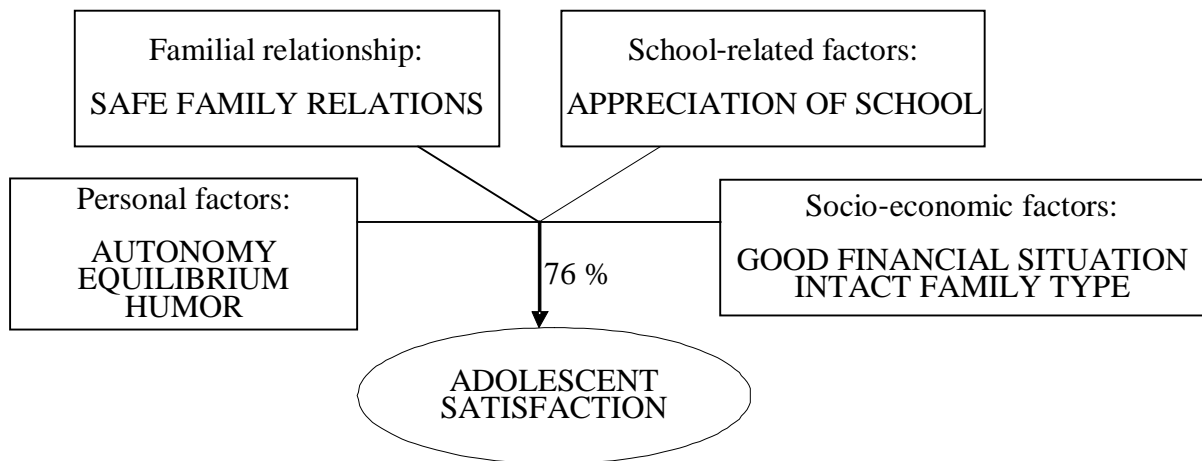


Figure 7. Realised values and socio-economic factors related to adolescent satisfaction ( $R^2=.76$ )

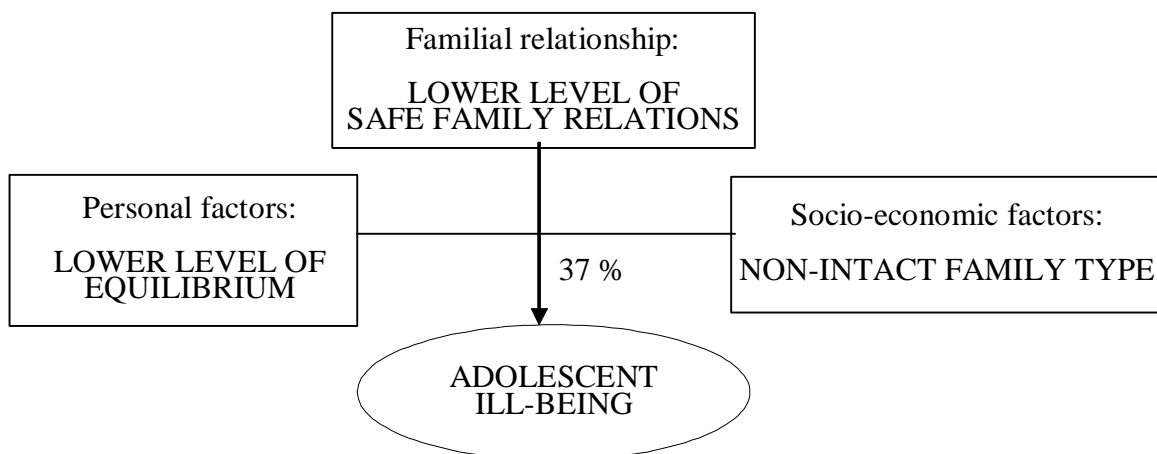


Figure 8. Realised values and socio-economic factors related to adolescent ill-being ( $R^2=.37$ )

### **5.2.2 Adolescent SWB, health behaviour and school satisfaction**

The relationships between adolescent SWB, health-related factors and school satisfaction were investigated using the BSW/Y, two sub scales of the FVSW, variables of health-related factors, and the School Satisfaction Scale (Study II). In terms of health-promoting behaviours, most female and male adolescents engaged in physical activities at least once a week while 11 percent of them did so less than once a month or never. In terms of risk enhancing behaviours, eighteen percent of the respondents were current smokers (smoking several times week) whereas 59 % had never smoked. Girls and 9<sup>th</sup> graders (12-14 year-olds) smoked significantly more often than boys and 7<sup>th</sup> graders (14-17 year-olds). (see Paper II, Table 1) One out of five adolescents had never tried alcohol. Most of these were respondents from the 7<sup>th</sup> grade. One out of five (19 %) teenagers reported drunkenness at least three times in the previous three months while 60 % had not been intoxicated during that time. Heavy alcohol consumption was not related to gender, but boys reported more lifetime drinking than girls. In addition, boys preferred drinking beer to cider and girls preferred drinking cider to beer. Ten 9<sup>th</sup> graders (4 %) had experimented with or taken drugs.

One third of respondents enjoyed school work while 19 % reported low levels of school satisfaction. Seventh graders were considerably more satisfied with school relative to 9<sup>th</sup> graders, but no statistically significant differences occurred in school satisfaction between gender groups.

The most significant predictors for global satisfaction among girls included school satisfaction, body satisfaction and self-rated health ( $R^2 = .50$ ). In addition to these predictors, male satisfaction was explained by low intensity drinking ( $R^2 = .31$ ). In the global ill-being of girls, the variables of school dissatisfaction, high-intensity drinking, and self-rated moderate health explained 34 % of the variance. The most significant associations for global ill-being among boys were body dissatisfaction and regular drinking, explaining merely 14 % of the variance.



## 5.3 Adolescent SWB and family

### **5.3.1 Adolescent SWB and family dynamics**

The relationship between the existence of adolescent SWB and the family dynamics perceived by adolescents and their parents was studied (Study III). Adolescents' assessments of family dynamics ranged from 3.70 to 4.91 (1-6 scale) and those of the parents from 4.08 to 5.27. Thus, both adolescents and their parents generally assessed family dynamics to be quite good. The younger adolescent group reported higher scores on mutuality, stability and role reciprocity compared to the older group, while older adolescents perceived higher level of individuation in the family relative to their younger counterparts. Further, girls reported higher levels of individuation and mutuality compared with boys. Teenagers from intact families reported highest scores on mutuality and role reciprocity, whereas the adolescents from single parent families reported the highest scores on familial flexibility. Adolescents also perceived family dynamics to be significantly poorer than their parents, except for role reciprocity, with which the teenagers were more satisfied than their parents (Figure 9). Comparing mothers and fathers, mothers rated the higher scores in individuality and mutuality, whereas fathers reported higher levels of the role reciprocity. Adolescents' and their parents' perceptions of family dynamics did not correlate with each other.

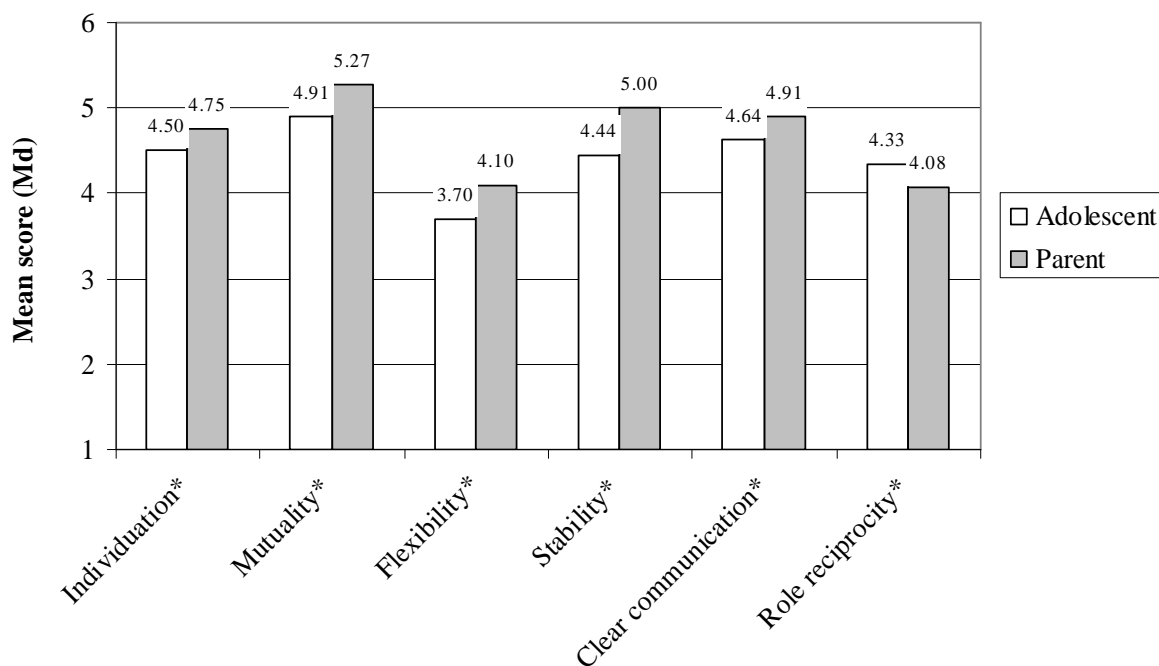


Figure 9. Family dynamics assessed by adolescents (n=218-232) and parents (n=230-236)

\*  $p < .001$  (Wilcoxon signed ranks test)

All dimensions of SWB were positively associated with teenagers' perception of family dynamics, and the most significant correlations were between adolescent global satisfaction and stability, mutuality and clear communication. Additionally, the high level of stability perceived by adolescent respondents was related to low levels of ill-being. Activities and knowledge related to SWB were also associated with stability, mutuality and good communication in the family. Parental perceptions of family dynamics, however, were not associated with the adolescents' SWB. Including the socio-demographics, high level of stability (perceived by adolescents), mutuality (perceived by adolescents), male gender and lack of serious problems in the family (reported by parents) accounted for 61 % of the variance of adolescent satisfaction. In terms of adolescent ill-being, five significant associations emerged: adolescents with low level of stability, being female, serious problems and illness in the family (reported by parents) and moderate or poor parental relationship (assessed by adolescent). These predictors accounted for 45 % of the variance of ill-being.

### **5.3.2 Familial effect on adolescent SWB and familial involvement in adolescent peer relations and school attendance**

The more detailed role of family in adolescent SWB, peer relations and school attendance was studied using adolescents' (n=19) interviews (Studies IV, V). Adolescent satisfaction was consisted of their experience of possessing a comfortable home, a loving atmosphere, open communication, familial involvement, external relations, and a sense of personal significance in the family. Adolescent ill-being was affected by familial hostility, ill-being or death of a family member, and excessive dependency. (see Study IV, Figure 1)

Adolescents described the familial involvement in their peer contacts and school attendance with both negative and positive expressions. However, teenagers did not value positive or negative involvement in terms of good or bad but perceived negative aspects useful or sometimes even necessary for them. Furthermore, the families in this study could not be categorised solely as negative or positive types; rather, each family displayed both negative and positive aspects of familial involvement. Adolescents described positive familial involvement in terms of enablement, continuing conversations, support and taking an active role in adolescent activities. Negative involvement was described as negligence, criticism, restrictiveness, or coercion in the family. (see Paper V, Figure 1)

### **5.4 Summary of the results: Models of adolescent well-being**

On the basis of Studies I, II and III, a summary of explaining models on adolescent SWB was constructed (Figure 10.). In addition to the results of studies by stepwise analyses of regression reported in Studies I, II and III, some further stepwise regression analysis was conducted. In these further analyses, the socio-demographic factors, realised values, school satisfaction, family dynamics, health behaviour and perceived health were considered as distinct models in order to elicit the diversity of the variables and their relations to adolescent SWB. Six sets of variables were entered in the six models pertaining to satisfaction and ill-being, and as the results of the analyses the 12 models are presented in Figure 10.

In the macrosystem, the most profound indicators related to SWB were realised values: strong sense of safe family relations, personal autonomy, equilibrium and appreciation of school, as

a set, explained 73 percent of the variance of satisfaction, whereas weak sense of personal equilibrium and low level of safe family relations explained 30 percent of adolescent problems and somatic symptoms. From the socio-demographic factors only self-rated good financial situation was associated with adolescent satisfaction, explaining 11 percent of variance. Moderate or poor financial state explained nine percent of the variance in adolescent ill-being. Parental employment or unemployment were weak predictors for adolescent subjective well-being.

In the microsystem, school satisfaction was more significantly associated with adolescent satisfaction than with ill-being. It explained 23 percent of the variance of adolescent satisfaction, whereas school dissatisfaction accounted for only six percent of variance in adolescent ill-being. Further, family dynamics as perceived sense of familial stability and mutuality accounted for 54 percent, a substantial portion, of variance in adolescent satisfaction, while the sense of familial disorganisation was the only variable to enter the regression of adolescent ill-being, explaining 28 percent of variance in adolescent ill-being.

On the individual level, health behaviour such as engaging regularly in physical activities explained a mere six percent of the variance in adolescent satisfaction. Predictors for adolescent problems and somatic complaints were smoking and regular (once a month or more) cider drinking with an explanatory percentage of 11. Self-rated good health and body satisfaction accounted for 20 percent of variance in adolescent satisfaction whereas the sense of poor health and body dissatisfaction explained 16 percent of the variance in adolescent ill-being.

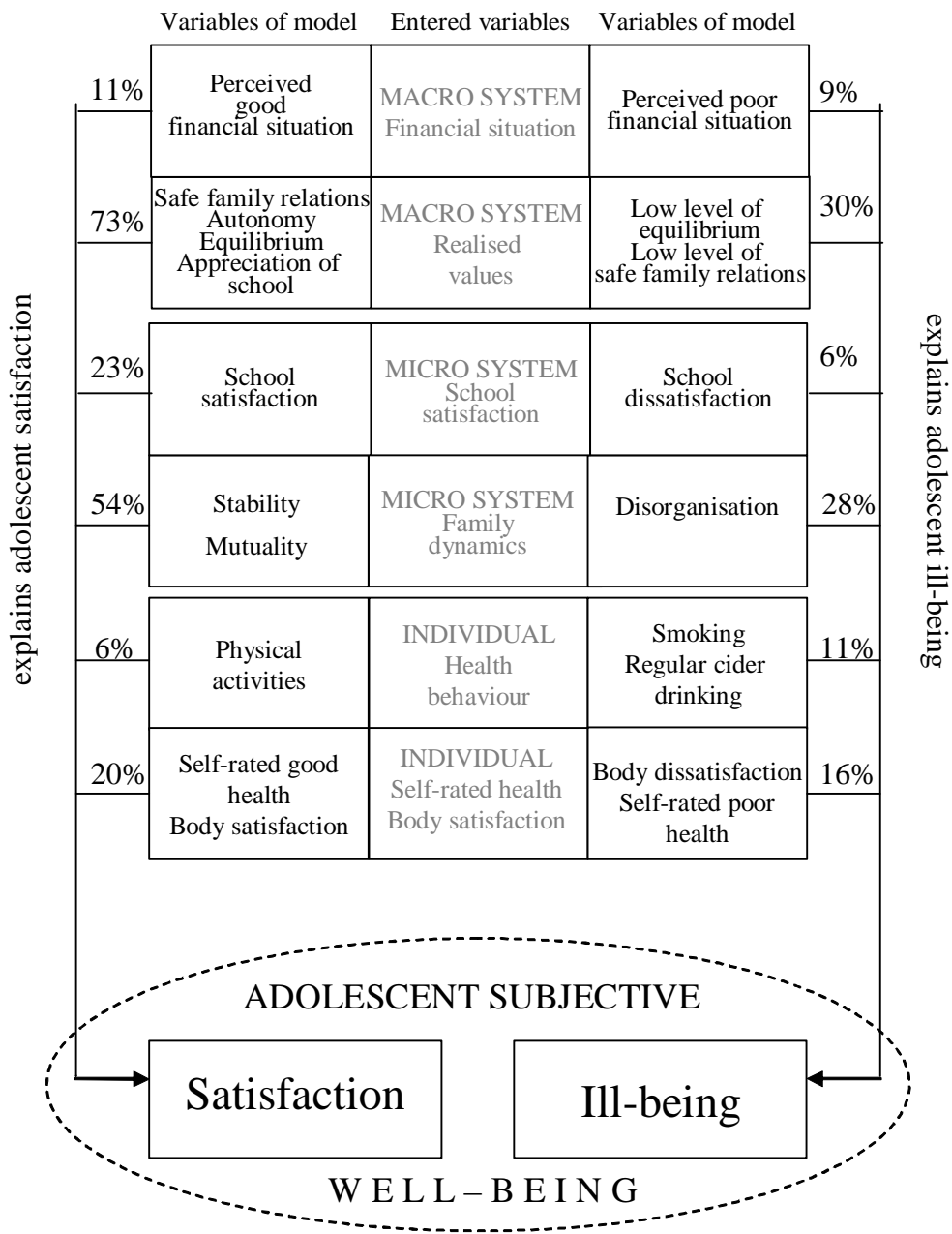


Figure 10. Explanatory models of adolescent subjective well-being (N=239-245)

On the basis of Studies IV and V, a model describing familial contribution to adolescent subjective and social well-being was developed (Figure 11). The family simultaneously produces both satisfaction and ill-being in adolescent life. On the one hand, it creates satisfaction by providing safe frames, a warm atmosphere, support, possibilities for relations outside home and experience of significance. On the other hand, familial conflicts, ill-being and inevitable dependence cause ill-being in teenage life. The family takes both a supportive and controlling attitude to adolescent school attendance and peer relations. Both positive and negative factors are intertwined in adolescent everyday life and they are perceived by teenagers as a natural part of family life.

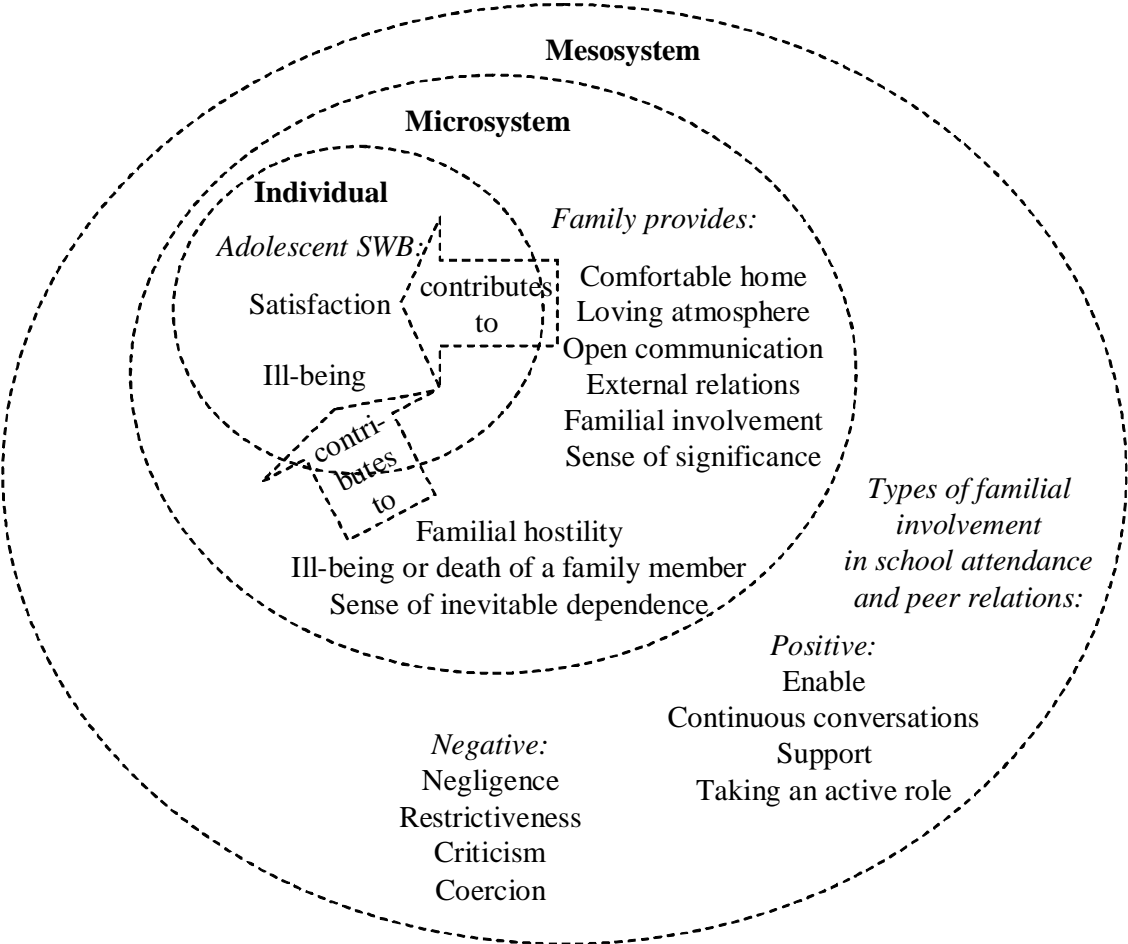


Figure 11. Familial contribution to adolescent subjective and social well-being (N=19)

## 6 Discussion

### 6.1 Validity and reliability of the results

The validity and reliability of this study are discussed separately for the quantitative and qualitative parts.

#### Quantitative research

##### *Sampling and data*

The target population of this study included 3266 pupils from the 7<sup>th</sup> and 9<sup>th</sup> grades enrolled in comprehensive schools in a town in southern Finland. In this study random sampling was used: the respondents were selected randomly from 13 municipal secondary schools so that there was one 7<sup>th</sup> and one 9<sup>th</sup> class participating from each school. The response rate for the questionnaire was 48 % in Phase I (representing eight percent of the target population) and 47 % in Phase II, which can be regarded as acceptable (Diem 2002). It was not possible to conduct a second round of enquiry as the questionnaires were completed anonymously.

The non-response data analysis revealed that the non-response data did not differ from the study data in the background variables of gender, class, school and family type, except in parental socio-economic status. The non-response group had considerably more lower white-collar workers and manual workers than the study data had (Kruskal-Wallis,  $p < .001$  for mothers and fathers). However, the proportions of missing values concerning parental occupation in the non-response data were high (22 % for mothers' and 24 % for fathers' occupation) which impaired the validity of the Kruskal-Wallis test. Because no statistical differences were found between the respondents and non-respondents in terms of gender, class, school and family type, the results can be generalized to the sample and the target population (Diem 2002). Some limitations should still be mentioned. A study by Lintonen et al. (2000a) showed that adolescent drunkenness was likely to be more prevalent among the non-respondents than the respondents. It is thus possible that drunkenness and related ill-being were underestimated in this study.

Quantitative data apply only to adolescents who were present at school when the study was conducted. Adolescents who were absent from school on that day may show different characteristics in terms of their SWB and family dynamics from those who were present. The study was organised by the researcher in the classrooms and every pupil sealed the questionnaire in an envelope, which might have improved the feeling of confidentiality. The questionnaires for parents were given passed on by the adolescents. The parents were expected to fill in a questionnaire independently. It is still possible that the adolescent or the spouse may have influenced the response of the parent participating in the study.

The use of double informants on family dynamics improved the validity of the results. A study using two informants can represent complex pictures of the family, but not the essence of the whole family (Uphold and Strickland 1989; Fisher et al. 1990, 3. art.). In the future, it would also be informative to identify the relationships and dynamics between the adolescent and all the other persons in the household. However, as suggested by Uphold and Strickland (1989), one family member, i.e. the adolescent in this study, is considered as the most appropriate source of data collection when the study is based on ecological theory and the family is viewed as the context for individual development and well-being. The single-informant approach might also enable a family member openly to express feelings and perceptions that would not be divulged if the whole family were interviewed together (Uphold and Strickland 1989).

All data were cross-sectional and self-reports. This is why it only presents associations and gives no explanations. The correlational data are not sufficient to demonstrate causality. Unfortunately, conducting experimental studies on adolescent subjective well-being in real contexts would be difficult and perhaps unethical. One potential way to assess causality is to use prospective designs, which measure baseline levels of well-being at time one and track subsequent changes in well-being as a function of familial and other variables at time two. A further question concerning the correlational analyses is how valid the correlations between different variables in this study are. For instance, Sweeting (2001) argued that when the same individual rates two or more variables, such as in this study parenting and well-being, the risk of correlation between the variables also increases. In terms of self-reports, the results are no doubt subjective (which was actually also the purpose of the study). The reports may still have been affected by social desirability. However, several investigators (see Pavot & Diener 1993, Sandvik et al. 1993, Pavot et al. 1998) have shown that the reliability of different well-



being instruments is good, which encouraged the present author to use self-reports in the assessment of subjective well-being. Furthermore, Pavot et al. (1998) stated that life satisfaction shows a degree of temporal stability.

### *Instruments*

Three instruments were used in this study: the Berne Questionnaire of Subjective Well-being/Youth form (BSW/Y), the Finnish Questionnaire of Adolescent Values and Subjective Well-being (FVSW) and the Family Dynamics Measure II (FDM II). The BSW/Y instrument was developed by Grob (1995) on the basis of the work of several psychologists. Since the instrument was developed in Switzerland and it has been implemented earlier with Finnish samples, its suitability for Finnish culture may be good. In addition, backtranslation of the instrument improved its validity. In this study the internal consistency of BSW/Y varied from 0.73 to 0.90.

The FVSW instrument was developed ad hoc for this research project. The instrument was developed from empirical data collected by Åstedt-Kurki (1992) and pilot tested with 55 adolescents. After the pilot test minor adjustments were made in the FVSW, which were: five items on knowledge related to SWB were eliminated and five items on achievement and pleasure were added. The instrument was composed of 52 items and consists of four scales: realised terminal values (26 items), realised instrumental values (18 items), knowledge (three items) and activities (five items) (see Åstedt-Kurki 1992). Two principal component factor analyses with varimax rotation were conducted concerning the terminal values and the instrumental values. The scale for terminal values comprised five factors: Safe family, Faith in God, Reciprocal relationship with friends, Equilibrium and Peace. The scale of instrumental values also consisted of five factors: Appreciation of school, Humour, Autonomy, Achievement and Pleasure (see more in Study I). Hence, the factor structure clearly suggested the existence of ten dimensions of adolescent realised values and mainly supported the structure of values developed by Åstedt-Kurki (1992). Cronbach's alphas were 0.88 for terminal values, 0.75 for instrumental values, 0.56 for knowledge and 0.74 for activities, with a mean coefficient of 0.73, which can be considered acceptable. Further analysis is needed to investigate the similarities and differences between the concepts of SWB, knowledge and activities related to SWB and realised values. Additionally the scores of knowledge and activities related to SWB could be distinguished from SWB and named health knowledge and positive health behaviour.

The FDM II was developed by a group of nursing researchers (Lasky et al. 1985) and it has been revised on the basis of several studies in the U.S.-Nordic Family Project (White et al. 1999). Additionally, the translation of the instrument has been verified through backtranslation and it has been modified for Finnish culture. The Cronbach's alpha coefficients have been acceptable in several earlier studies (Murtonen et al. 1998; Hakulinen et al. 1999). In this study, the Cronbach's alpha coefficients were good to moderate on all the dimensions: .59-.88 for adolescents and .65-.87 for parents. As one inter-item correlation for individuation-enmeshment and one for stability-disorganisation were negative, these items were deleted.

The use of the FDM II among adolescents has not earlier been reported in peer-reviewed papers. This study thus served as a pilot study for using the FDM II among both adults and adolescents. The findings revealed that it is possible to use the instrument as a data gathering method from families with adolescents if the interpretation is scrutinised from the adolescent point of view, too.

### Qualitative research

Validity refers to whether a study yields a correct answer, while reliability asks whether repeated investigations of the same phenomenon by the same method will yield the same answer (Kvale 1989, p. 79). Kvale (1989, p. 78) suggested that validation in qualitative research involves checking the credibility of knowledge claims, ascertaining the strength of the empirical evidence and the plausibility of the interpretations. In order to gather accurate information about usual familial factors related to adolescent well-being the subjects of this study were non-clinical female and male teenagers from 7<sup>th</sup> and 9<sup>th</sup> grades (aged 12 to 17). The subjects had also participated in the survey, which enabled the control of background variables. The interviewees represented the range of background variables, such as gender, age, family type and parental socio-economic status. The interviews were conducted in a peaceful restaurant or in the adolescent's home, which contributed to the interviewee's sense of security and made it easier to discuss freely.

The interviews were transcribed verbatim by the interviewer, which improved the clarity of the transcripts and made it possible to note the connections of words and the nonverbal

communication. While analysing the data the researcher continually asked the questions as to the what, why, when, where and who of an action (Kvale 1989) and listened to the recorded tapes in order to check the nuances of the interviews. The interrater technique in data analysis would have improved the reliability of the findings.

In order to validate the interview statements the researcher tried to question the nature of the phenomena investigated, i.e. adolescent subjective well-being in the family (Kvale 1989, p. 82). On the basis of the analysis, it was obvious that adolescents emphasised both negative and positive familial factors related to their well-being, peer relations and school attendance. The conceptualising concerning the qualitative data captured a part of the complexity of the social reality adolescents live in. Other methods, such as family interview (Åstedt-Kurki et al. 1996) could be used to understand more comprehensively the nature of familial factors related to adolescent well-being. As mentioned earlier, the family interview, however, may have inhibited adolescents from speaking freely about ill-being emerging from the family. The face-validity of the findings was improved by allowing one female and male interviewee to review the preliminary research results (Burns and Grove 1997).

## 6.2 Overview of findings

### Most adolescents were satisfied and happy

The majority of the adolescents participating in this study were satisfied with their lives. The findings support the claim that people are typically happy rather than neutral (Veenhoven 1991a, Diener and Diener 1996). It is claimed that people overstate their happiness for reasons of social desirability and self-defence. Kainulainen (1998) uses the term “happiness wall”. Veenhoven (see 1991a) found that, although such distortions do occur to a modest extent, these claims are generally untenable. He argued (1991a) that happiness is in fact the normal condition, such as health.

In this study, adolescent boys, however, perceived their self-esteem to be significantly better than did their female counterparts. On the other hand, girls valued human relationships more highly than did boys, which is also reported in other studies (e.g. Ryff 1995). Several earlier studies have indicated that boys attending slightly higher global self-esteem scores (Quatman

and Watson 2001; Baldwin and Hoffmann 2002), girls evaluated human relationships more than boys (Helve 1996; Quatman and Watson 2001) and fluctuations in self-esteem were significantly more dramatic among girls than among boys (Baldwin and Hoffmann 2002). Further, Polce-Lynch et al. (2001) indicated no gender differences in self-esteem among old adolescents (12<sup>th</sup> graders) who attended a single-sex high school. Polce-Lynch et al. (2001) suggested that the girls in the study were afforded a self-esteem enhancing milieu at school and they supported the positive effects of single-sex education for girls. In this study, all the participants attended co-educational schools.

One unexpected result was found in the relationship between adolescent satisfaction and ill-being scales. Grob et al. (1991; 1999) claimed these two aspects of SWB to be independent or weakly dependent, but in this sample there was a moderate correlation ( $r=-.48$ ,  $p<.01$ ) between satisfaction and ill-being (see Appendix 4). The most natural reason may be the fact that happy adolescents did not suffer from ill-being as frequently as their unhappy counterparts. Another explanation is that healthy respondents tend to score high on all scales (see e.g. Sweeting 2001). Especially those teenagers who reported having many problems in life scored lower on satisfaction compared to those who reported having few problems. The weakest correlation was found between somatic complaints and satisfaction ( $r=-.36$ ,  $p<.01$ ), especially in joy of life subscale ( $r=-.14$ ,  $p<.05$ ). The results thus partly support the claim that ill-being is only weakly associated with subjective well-being.

This study also suggested that adolescents were satisfied with their lives to the extent that their values were realised. In more detailed, safe family relations, a strong sense of personal autonomy, equilibrium and humour had a positive connection to adolescent satisfaction, whereas a weak sense of equilibrium and poor family relations predicted higher levels of ill-being among teenagers. The results support the findings of Oishi et al. (1999b), who claimed that intraindividual changes in life satisfaction were strongly influenced by the degree of success in the domains that individuals valued.

Furthermore, the study by Werner (1993) similarly found that e.g. self-esteem (which was one aspect of satisfaction) was promoted through supportive relationships. The present findings seem to confirm the results of the study by Reis et al. (2000) and Rönkä et al. (2002) which indicated that autonomy in addition to competence and relatedness was also significantly associated with adolescent daily well-being. Further, Noom et al. (1999) found similarly that

adolescents' autonomy was positively related to their social competence, academic competence and self-esteem. Teenagers seem to be happy if they feel autonomous, harmonious and simultaneously have good family relations. Thus one of the key dilemmas in adolescence seems to be the balance between autonomy and bonding.

This study generated new knowledge on the essence of realised values related to adolescent SWB. The question of the structure of SWB persists: are realised values predictors of SWB or part of it? For example, Ryff (1995) and Ryff et al. (1995) included autonomy in psychological well-being. On the basis of this study and previous research (e.g. Ryff 1995; Oishi et al. 1999b) realised values may serve both as predictors and components of SWB. For instance, adolescent sense of autonomy (i.e. ability to resist social pressures to think and act in certain ways) is one key aspect of well-being and improves life satisfaction at the same time.

#### A complex relationship between SWB, school satisfaction and health behaviour

One third of the adolescents were satisfied with school, whereas one out of five adolescents did not enjoy schoolwork. Most of the teenagers had never smoked or had not been intoxicated in the previous three months, supporting the findings of Brener and Collins (1998) that most adolescents under 14 years and 41 % of young people aged 14-17 years did not engage in any health-risk behaviours such as smoking, alcohol or drug use. However, one out of four female and one out of ten male respondents reported smoking at least once a week and one out of five teenagers had been intoxicated at least three times in the previous three months. These findings are quite consistent with those of other studies in Western countries (e.g. Office on Smoking and Health, Division of Adolescent and School Health...2000; Rodondi et al. 2000; Lintonen 2001)

A complex relationship between adolescent subjective well-being, school satisfaction and health behaviour was found. This study did not find a direct relation between smoking and life satisfaction as reported by Zullig et al. (2001). They revealed that adolescent smoking was significantly associated with reduced life satisfaction. Adolescent smoking, however, was strongly associated with ill-being, supporting the findings reported by Escobedo et al. (1998), Patton et al. (1999), Goodman and Capitman (2000) that smoking has shown significant associations with perceived ill-being. Jones and Heaven (1998) also reported that negative

attitude to school was associated with adolescent smoking as does the present study. There were two further factors, perceived health and body satisfaction, which were also related to adolescent SWB in the present study. The finding supported the results of several studies (Okun and George 1984; Wolman et al. 1994; Kainulainen 1998; Välimaa 2000a) claiming that self-rated health and body image were associated with subjective well-being.

Although there were few gender differences in school satisfaction and health behaviour, the predictors of global satisfaction were stronger and partly different among girls compared to boys. School satisfaction, body satisfaction and self-rated good health explained 50 % of the variance in global satisfaction among female respondents. The most significant predictors for the global satisfaction of males included, in addition to those observed among girls, low intensity drinking, which explained 31 % of the variance. School dissatisfaction, high intensity drinking, and self-rated moderate health were the most significant associations for global ill-being for females, explaining 34 % of the variance. In terms of the global ill-being of boys, the variables of body dissatisfaction and regular drinking only explained 14 % of the variance. SWB of females appears to be easier to predict than that of their male counterparts. One possible explanation is that the instrument did not include external factors, such as aggressiveness and norm breaking, which are more typical for men than for women (see e.g. Rönkä 1999, 30).

These results confirm the claim that intoxication-oriented drinking alone is not correlated with adolescent subjective well-being, but that coupled with low levels of school satisfaction, perceived moderate health and body dissatisfaction it does contribute to adolescent ill-being. The results also support the results of Rönkä's (1999) study suggesting that risk factors and problems of social functioning tend to interact, co-occur and form chains.

### **Familial mutuality and stability as predictors for adolescent SWB**

It is noteworthy that the teenagers' perception of family dynamics was remarkably poorer than that of their parents, except in role reciprocity, with which the adolescents were more satisfied than their parents. The older the adolescents, the less happy they were with their family dynamics. These findings concur with those of Barnes and Olson (1985), Olson (1986) and Ohannessian and Lerner (1995), who found that adolescents are less satisfied with the

family functioning compared with their parents. This is likely to be related to adolescents' increasing awareness of dependence on family while concurrently moving toward increasing psychological and structural independence. As expected, teenagers' perceptions of family dynamics and their own subjective well-being were concurrently related, but parental assessment of family dynamics did not correlate with adolescent perceptions of this or subjective well-being. Similarly, Toivakka (2002, 20) found no significant correlation between adolescent and parental perception of problematic life situations. These results are contrary to those of Huebner et al. (2002), who found that correspondence between parent and normally achieving adolescent SWB reports has been substantial. On the other hand, Olson et al. (1989) emphasised that family members experience the family environment differently from each other.

Adolescent satisfaction was predicted by adolescents' perception of high level of stability and mutuality in the family, male gender and their parents' assessment of no severe problems in the family. This finding is consistent with the earlier findings of Henry (1994), who suggested a strong correlation between family stability and adolescent family life satisfaction, and of Wolman et al. (1994), who emphasised the strong association between family connectedness and adolescent emotional well-being. The present results also support the claim that, although adolescents seek for autonomy within the family, they also need a base of security and stability at home (Conger and Petersen 1984).

The most profound predictors for ill-being of adolescents were adolescents' perception of high level of disorganisation in the family, being female, serious problems and illness in the family perceived by parents and moderate or poor parental relationship assessed by adolescents. Earlier research evidence has shown that low level of familial cohesion has been related to higher level of adolescent depressive mood and negative thoughts (Aydin and Öztütüncü 2001). The findings also support the claim that lack of security and consistency in the family increase ill-being of family members (Barnhill 1979; Henry 1994). Finnish teenagers seem to need consistency and mutuality as much as their counterparts in other countries in order to be satisfied with life.

## Adolescents' subjective well-being and ill-being have different familial antecedents

The teenagers interviewed experienced various familial elements, such as physical, functional, emotional and communicational elements contributing to their satisfaction. The familial contribution was described as experiences of a comfortable home, emotionally warm atmosphere, open communication, familial involvement and opportunities for external relations in the family. Some of the functional elements discovered in this study were parallel to Barnhill's (1979) healthy family system model as well as the results of the quantitative part of the study (Study III). For instance, the categories of loving atmosphere and sense of significance in the family may refer to familial mutuality and the category of external relations may be identified as a consequence of individuation and flexibility in the family. Adolescents mentioned open communication in the family as an important element contributing to their well-being. This finding supports that of Huang (1999), who pointed out an association between conversation-oriented families and adolescent positive attitude toward themselves. The findings of this study also showed that besides functional aspects, adolescents perceived the family as a source of physical protection and existential significance.

In terms of ill-being, adolescents described familial hostility, ill-being or death of a family member as well as excessive dependency as contributing to their ill-being. Steward and McKenry (1994) in their study similarly stated an association between increased arguments between parents and adolescents and adolescent ill-being. The familial elements of adolescent ill-being were only partly characterised as lack of those of satisfaction which supports the claim of Headey et al. that well-being and ill-being have different antecedents. Well-being includes optimism and a supportive social network, which refers e.g. to familial involvement and loving atmosphere in this study, whereas ill-being is caused by poor health and poor financial situation, which refers to illness of a family member in the present study. (see e.g. Headey et al 1984; Grob et al. 1991; Pietilä et al. 1994; Schneider 2000).



## Familial involvement in adolescent life includes both support and critique

Familial involvement was experienced by adolescents as quite consistent in both peer relations and school attendance. This supports the findings of Metsäpelto et al. (2001) indicating that parents tend to behave consistently across different situations with their adolescent children. Characteristics of familial involvement in adolescent peer relations and school attendance were described in terms of positive and negative expressions. Positive involvement was identified as enablement, continual conversations about adolescent activities, support and taking an active role in adolescent activities, and negative involvement as negligence, criticism, restrictiveness, or coercion. These classification partly support that of Baumrind (1978) and Maccoby and Martin (1983) who identified authoritative, authoritarian, permissive and neglectful parenting styles. However, siblings' involvement was included in this study. The teenagers participating in this study, however, did not perceive positive or negative involvement in terms of good or bad, but found negative aspects useful or even necessary for them. Additionally, each family in this study displayed both negative and positive aspects of familial involvement. More research is needed to investigate the significance of different aspects of familial involvement.

## Personal, family and school satisfaction are the most significant contributors to adolescent SWB

The most significant predictors for adolescent SWB were realised values, personal satisfaction (with health and body), familial stability and mutuality as well as school satisfaction. This finding supports Bronfenbrenner's claim that the immediate environment is crucial in human development (Bronfenbrenner 1977; 1988). Qualitative data further explained in more detail that familial contributors to adolescent well-being included functional, emotional and existential aspects of family life. No theory or model of adolescence subjective well-being is absolutely comprehensive, nor is it able to fully explain adolescent subjective well-being in all its richness and diversity (Heaven 2001, p. 25). I do contend and the qualitative data proved well that adolescents are a diverse group of people with varieties of thoughts and perceptions about their well-being and family.

### 6.3 Implications for practice

Subjective well-being or quality of life can be linked to health promotion and ill-being prevention among adolescents in several ways. First, subjective well-being can be identified as a means of promoting positive health and healthy behaviours. Second, aspects of SWB can recognise a sensitive adolescent issue that may be affected by illness or disability and the effects of treatments and interventions.

Nurses and teachers need to be aware of multiple types of life experiences faced by adolescents, both social and personal, to better understand adolescent resilience and need for support. Results reported by Pirskanen et al. (2001) showed that school health nurses provided the best support in the development of the pupils' positive body image, whereas there was lack of support in social coping skills perceived by Finnish adolescents from 9<sup>th</sup> grades. According to the findings reported by Tossavainen et al. (2004a) school health nurses in the Finnish European Network of Health-Promoting Schools perceived that traditional aspects of health counselling were mostly covered well. In a further study, Tossavainen et al. (2004b) found that teachers were more promotional and community-oriented, while school health nurses emphasised a more preventive and individually oriented approach to health counselling. Thus, there is still a need for the school health nurse to adopt a more active participatory role as a health promoter in the whole school community (Tossavainen et al. 2004a).

Interventions in health and social care should pay attention to the adolescent's overall situation, to developing general life skills and to close school-family interaction instead of only focusing on distinct aspects of personality or behaviour patterns such as self-esteem or health behaviour. There are some positive encouraging results of effective intervention. For example, a study conducted in the Finnish European Network of Health Promoting Schools showed that collaboration in a network of participants from inside and outside the school as well as the organisational culture of the schools seemed to change for the better during a health promotion programme (Turunen et al. 2004).

Furthermore, family nursing practice should pay more attention to the fact that a gap or no interdependence may exist between the adolescent and parental perception of family dynamics. Gathering the assessments of family life of all the family members may be a

prerequisite for family support and intervention. Additionally, not only family dynamics but also familial involvement and attitudes (both quality and quantity aspects of these) should be identified while viewing adolescent family. School health nurses have several possible occasions, such as a health dialogue, to focus more on familial and psychosocial issues and to identify adolescent and familial resources in order to improve well-being and mutual support in the family (Borup 1998; Tossavainen et al. 2004ab).

Health education should take into consideration various aspects of knowledge concerning health, health behaviour and well-being. School health education may include themes and interactive teaching strategies that will help teenagers to identify, express and control emotions of all kinds, to discuss attitude formation and support adolescents' reflection on their lives and futures. Kannas (1994, p. 49-51) suggested that the patterns of health knowledge should be composed of knowledge of way of life (elämäntapätieto), view of life (näkemystieto), way of living (menetelmätieto) and of culture (kulttuuritieto).

Different sets of risky and healthy behaviours emerge as new products, new fads, and new trends in behaviour appear. Thus, constant updates of interventions will most likely be required in future (see Spruijt-Metz, 1999). Further, health interventions concerning adolescents should be derived through the perceptions and experiences of adolescents. Both official and non-governmental organisations, such as the scouts, the Red Cross and the Church youth work should pay more attention to so-called self help groups where young people may help each other.

#### 6.4 Challenges for future research

These findings suggest that it is crucial to consider both the personal and social dimensions of adolescent life when examining adolescent subjective well-being. A longitudinal study would be needed to confirm these results and to permit greater generalisation about the potential changes in adolescent SWB and family dynamics. An interesting challenge would be to continue data collection for several years until the adolescents become adults. Unfortunately this is not possible in this study as the questionnaires were filled in anonymously.

A need for complex interactional models of positive well-being in adolescence still exists (cf. McCullough et al. 2000). Thus, future research should investigate adolescent well-being in terms of the dimensions of hope, optimism, courage, forgiveness as well as responsibility and tolerance (see more Seligman 2002). For instance, Juvakka (2000) in her dissertation found that *hope* can be identified as both adolescent wishes and resources in challenging life situations. Further, adolescent well-being should be viewed from the perspective of parents, siblings, grandparents and compared with adolescents' perceptions. Additionally, the qualitative elements in peer-group processes and their impact on adolescent well-being and ill-being should be identified in future research.

The results of this study may provide evidence of the assumption that realised values may be part of the subjective well-being construct. Rokeach (1973, p. 28, 93-94) considered a comfortable life, happiness and self-respect as terminal values and argued that values are social indicators of the quality of life. An interesting question still remains: *Why* were realised values the most important predictors of adolescent subjective well-being? Further, it would be important to understand how the perceived values and realised values are related to each other and whether there exists a relationship between perceived values and subjective well-being (see e.g. Laine 1999).

The impact of social context and social change on adolescents is receiving more attention. Current/future trends should include the increasing examination of the context and co-occurrence of adolescent health-related resources and problems and especially the emphasis on the resilience and strengths of adolescent and their families. Qualitative data analysis can facilitate a more profound understanding of individual and familial differences in adolescent development. On the other hand, the perspectives of adolescents who do not have a family should be investigated in order to understand other significant ones' impact on adolescent well-being. The health risks and developmental deficits as well as resilience are obviously different in this group (see e.g. Call et al. 2002). University-community and interdisciplinary collaborations should increase in number as developmental scholars pursue ways to solve the problems of youth and improve the chances for their healthy futures (Galambos and Leadbeater 2000).

## 7 Conclusions

The study generated new knowledge of the intense and complex relations between adolescent subjective well-being, values, school and family.

1. Most of the adolescent females and males who participated in the study were satisfied with their lives. Ill-being was experienced more frequently by girls and 9<sup>th</sup> graders (mean age of 15) than by boys and 7<sup>th</sup> graders (mean age of 13).
2. Certain realised values, such as a strong sense of personal autonomy, equilibrium, safe family relations and humour were connected to adolescent global satisfaction whereas a weak sense of equilibrium and poor family relations were associated with higher levels of ill-being.
3. School satisfaction, body satisfaction and self-rated good health contributed to female satisfaction, and in addition to these, low-intensity drinking contributed to global satisfaction among boys. The associations were significantly stronger among girls than among boys.
4. Adolescents' and their parents' perceptions of family dynamics differed significantly from each other. Parents mostly evaluated the family dynamics better than their adolescent children did.
5. Familial stability and mutuality perceived by teenagers were related significantly to their global life satisfaction, whereas disorganization within the family perceived by adolescents was associated with their global ill-being.
6. Adolescents experienced both positive and negative familial elements and involvement as a natural part of their daily lives.

## 8 Summary

The purpose of this study was twofold: to gain more information about adolescent subjective well-being and the factors related to this, and to understand more profoundly the familial contribution to adolescent well-being and life. First, three original papers examined adolescent subjective well-being (SWB) and the relationships between this and realised values, health behaviour, school satisfaction and family dynamics using quantitative data. Second, the remaining two papers scrutinised familial contribution to adolescent SWB, peer relations and school attendance using qualitative data. The study is based on an ecological framework and it used nursing, psychological and family theories. The focus is on the individual's well-being.

The samples in the first phase of the study consisted of 245 adolescents from 7<sup>th</sup> and 9<sup>th</sup> grades (12-17 year olds) and 239 parents. The response rate among teenagers was 48 % and among parents 47 %. Fifty-one percent of the adolescents were females and seventh graders. Eighty-three percent of the parents were mothers. The structured self-report adolescent questionnaire consisted of demographic data, the Berne Questionnaire of Subjective Well-being (BSW/Y), the Family Dynamics Measure (FDM II) as well as items concerning relations with family members and friends, school satisfaction and health behaviour. Additionally the questionnaire included a 52-item Finnish Questionnaire on Adolescent Values and Subjective Well-being (FVSW) developed by the researcher. The parental questionnaire comprised the Family Dynamics Questionnaire (FDQ) and the Family Dynamics Measure (FDM II). The sample in the second phase of the study was a subsample of 19, selected from among the 245 pupils who participated in the first phase. The subsample consisted of twelve girls and seven boys, and ten participants were 7<sup>th</sup> graders, and nine 9<sup>th</sup> graders. The data gathering method was a semi-structured interview concentrating on adolescent subjective experiences and perceptions of the familial factors related to their well-being. The data analysis consisted of statistical analysis (e.g. multiple regression analysis) and content analysis.

The results showed that the majority of the adolescents participating in the study were satisfied with their lives. Nevertheless one out of ten participants experienced no joy of life. Ill-being was experienced more frequently by girls and 9<sup>th</sup> graders than by boys and 7<sup>th</sup> graders. Certain realised values, such as a strong sense of personal autonomy, equilibrium,

safe family relations and humour were associated with adolescent global satisfaction, whereas a weak sense of equilibrium and poor family relations were connected to ill-being. School satisfaction, body satisfaction and self-rated good health contributed to female satisfaction, and in addition to these, low-intensity drinking contributed to global satisfaction among boys. The associations were significantly stronger among girls than among boys. Adolescents' and their parents' perceptions of family dynamics differed significantly from each other. Parents evaluated the family dynamics mostly better than did their adolescent children. Additionally, parental and adolescent evaluations of family dynamics did not correlate with each other. Familial stability and mutuality perceived by teenagers were related significantly to their life satisfaction, whereas disorganisation within the family perceived by adolescents was associated with their ill-being.

The adolescents interviewed experienced both positive and negative familial elements and involvement as a natural part of their daily lives. They were especially satisfied with the loving atmosphere, supportive familial involvement and open communication in the family. Familial expression of affection, adolescents' perception of their significant roles in family or comparisons to other family members demonstrated that the teenagers were important persons in the family. The sense of having a comfortable home and still the opportunity for external relations contributed to their joy of life. Familial discord, conflicts and parental divorce, as well as illness or death of a family member or excessive dependency on the family members were responsible for adolescent worries and negative feelings in the family. Conflicts in the family stemmed from e.g. curfew, use of money, poor school achievement or breaking the rules at home. Positive familial involvement in adolescent peer relations and school attendance was described by the interviewees as enablement, continuing conversations about adolescent activities, actual support and taking an active role in adolescent activities. Negative involvement included negligence, criticism, restrictiveness or coercion.

The study generated new knowledge of the intense and complex relations between adolescent subjective well-being, values, school and family. The findings provide a basis for the assessment of adolescent subjective well-being and realised values and for understanding the diversity of personal, familial and social well-being in adolescence.

Keywords: adolescence, ecological model, family dynamics, health behaviour, school satisfaction, subjective well-being, realised values, triangulation

## 9 Tiivistelmä

Tutkimuksen tavoite oli kaksitahoinen: saada tietoa nuorten koetusta hyvinvoinnista ja siihen liittyvistä tekijöistä sekä ymmärtää paremmin perheen vaikutusta nuoren hyvinvoinnin kokemuksessa, kaverisuhteissa ja koulunkäynnissä. Ensimmäiset kolme artikkelia tutkivat nuorten koettua hyvinvointia ja sen suhdetta toteutuneisiin arvoihin, terveyskäyttäytymiseen, koulutyytyväisyyteen ja perhedynamiikkaan. Viimeiset kaksi artikkelia taas keskittyivät tarkastelemaan perheen roolia nuoren hyvinvoinnissa, koulunkäynnissä ja kaverisuhteissa. Tutkimus perustui ekologiseen viitekehykseen ja siinä hyödynnettiin perheteorioita sekä aineksia hoitotieteen ja psykologian teorioista.

Tutkimuksen aineisto koostui ensimmäisessä vaiheessa 245 seitsemäs- ja yhdeksäsluokkalaisesta nuoresta (12-17 -vuotiaita) ja heidän 239 vanhemmastaan. Vastausprosentti oli 48 nuorilla ja 47 vanhemmilla. Nuorista vastaajista 51 prosenttia oli tyttöjä ja 7.-luokkalaisia. Vanhemmista 86 prosenttia oli äitejä. Nuorten kyselylomake sisälsi taustamuuttujia, koettua hyvinvointia mittaavan berniläisen Nuorten koettu hyvinvointi – mittarin (BSW/Y), perheen toimintaa tarkastelevan Perhedynamiikka -mittarin (FDM II) sekä kysymyksiä perhesuhteista, ystävistä, koulutyytyväisyydestä ja terveyskäyttäytymisestä. Lisäksi lomake sisälsi tutkijan kehittämän nuorten arvoja ja koettua hyvinvointia kartoittavan -mittarin (FVSW). Toisen vaiheen otos syntyi niistä 19 nuoresta, jotka vastasivat kyselytutkimukseen ja halusivat osallistua myös haastatteluun. Tämä kohdejoukko muodostui 12 tytöstä ja seitsemästä pojasta. Kymmenen haastateltavaa kävi 7.-luokkaa ja yhdeksän 9.-luokkaa. Aineisto kerättiin puolistrukturoidulla haastattelulla, jossa keskityttiin nuoren kokemuksiin ja käsityksiin perheen vaikutuksesta hänen hyvinvointiinsa. Aineistot analysoitiin tilastollisesti (mm. usean muuttujan regressioanalyysi) ja sisällön analyysillä.

Tulosten mukaan valtaosa nuorista oli tyytyväisiä elämäänsä. Joka kymmenes nuori ei kuitenkaan kokenut elämäniloa. Tytöt ja 9.-luokkalaiset vastaajat kärsivät poikia ja 7.-luokkalaisia enemmän pahaolosta. Tietyt arvot, kuten vahva itsenäisyyden tunto, sisäinen tasapaino, turvalliset perhesuhteet ja huumori elämänvoimana liittyivät nuorten elämäntyytyväisyyteen. Arvojen osalta nuorten pahaolo taas selittyi heikolla sisäisellä tasapainolla ja keunoilla perhesuhteilla. Myös koulutyytyväisyys, tyytyväisyys painoon ja



itsearvioitu hyvä terveys vahvistivat tyttöjen tyytyväisyyttä. Näiden kolmen lisäksi vähäinen humalajuominen oli yhteydessä poikien tyytyväisyyden tunteeseen. Tyttöjen selitysosuudet olivat poikia suurempia. Nuorten ja heidän vanhempansa käsitykset perhedynamiikasta erosivat merkittävästi toisistaan. Vanhemmat arvioivat perheen toimivan pääosin paremmin kuin heidän murrosikäiset lapsensa. Lisäksi vanhemman ja nuoren käsitykset eivät korreloineet keskenään. Nuorten kokema perheen pysyvyys ja yhteenkuuluvuus oli vahvasti yhteydessä heidän elämän tyytyväisyyteensä, kun taas tunne perheen hajaannuksesta yhdistyi nuorten pahaolon kokemuksiin.

Haastatellut nuoret arvioivat sekä myönteisiä että kielteisiä tekijöitä perheessä luonnollisena osana arkeaan. He olivat erityisen tyytyväisiä perheessä rakastavaan ilmapiiriin, perheen toiminnalliseen tukeen ja avoimeen kommunikaatioon. Perheenjäsenten ilmaisu välittämisestä, nuoren oma käsitys merkittävistä rooleistaan perheessä tai nuoren vertailu itsen ja toisten perheenjäsenten välillä osoittivat nuorelle, että hän on tärkeä ihminen perheessä. Nuoren elämäniloa vahvisti tunto siitä, että on mukava koti, mutta myös mahdollisuus kodin ulkopuoliseen elämään. Huolta ja murhetta nuoren elämään toivat epäsopeus tai ristiriidat perheenjäsenten välillä, vanhempien avioero, perheenjäsenen kuolema tai sairaus sekä liiallisen riippuvuuden tunne. Ristiriitoja perheessä aiheuttivat muun muassa luvattomat poissaolot koulusta, rahankäyttö, huono koulumenestys tai kodin sääntöjen rikkominen. Nuoret kuvasivat perheen suhtautumista heidän koulunkäyntiinsä ja kavereihinsa sekä myönteisin että kielteisin ilmaisin. Perhe nähtiin toisaalta mahdollistajana, keskustelijana, tukijana ja toimijana nuoren koulunkäyntiin ja kaverisuhteisiin liittyvissä kysymyksissä. Toisaalta perhe saattoi toimia välinpitämättömästi, kriittikkona, rajoittajana tai pakottajana koulunkäynnissä ja kaverisuhteissa. Myös näitä rooleja nuoret kuvasivat pääosin tarpeellisina, osa jopa välttämättöminä tämän hetken elämäntilanteessaan.

Tutkimus tuotti uutta tietoa nuorten koetun hyvinvoinnin ja arvojen, koulun ja perheen välisistä vahvoista ja monimutkaisista yhteyksistä. Tulosten pohjalta voidaan arvioida nuorten hyvinvointia ja arvojen toteutumista sekä ymmärtää nuoren hyvinvoinnin monitahoisuutta.

Avainsanat: arvot, nuoret, ekologinen malli, koulutyytyväisyys, koettu hyvinvointi, perhedynamiikka, terveyskäyttäytyminen, triangulaatio

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Tampere, January 2005

Katja Joronen

# Appendices

## Appendix 1. The adolescent questionnaire and written consent

Nro

Nuorten hyvinvointi -tutkimus, syksy 2000  
Tampereen yliopisto / Hoitotieteen laitos

Seuraavat kysymykset koskevat Sinua, ystäviäsi ja perhettäsi. **Ympyröi** sopiva **vaihtoehto** tai tarvittaessa **kirjoita vastauksesi** viivalle. Mikäli joku kohta tuntuu oudolta, kirjoita kohdan viereen, miksi et vastannut siihen. Kiitos!

1. Olen \_\_\_\_-vuotias. Olen \_\_\_\_-luokalla.
2. Olen 1) tyttö 2) poika
3. Perheeseeni kuuluvat (ympyröi ne henkilöt, **kenen kanssa asut** tällä hetkellä)
  - 1) äiti
  - 2) isä
  - 3) sisko; \_\_\_\_ (lukumäärä)
  - 4) veli; \_\_\_\_ (lukumäärä)
  - 5) äitipuoli
  - 6) isäpuoli
  - 7) siskopuoli; \_\_\_\_ (lukumäärä)
  - 8) velipuoli; \_\_\_\_ (lukumäärä)
  - 9) joku muu; kuka \_\_\_\_\_
  - 10) asun yksin
4. Vanhemmistani
  1. molemmat ovat elossa
  2. vain äiti on elossa
  3. vain isä on elossa
  4. molemmat ovat kuolleet
5. Omat vanhempani
  1. ovat (keskenään) naimisissa
  2. ovat (keskenään) avoliitossa
  3. ovat eronneet (joko avio- tai avoliitosta)
  4. eivät ole koskaan asuneet yhdessä
6. Kuinka paljon vietät aikaa yhdessä perheesi kanssa?
  1. \_\_\_\_\_ tuntia **tavallisena arkipäivänä**
  2. \_\_\_\_\_ tuntia **viikonlopun päivänä**
  3. emme vietä aikaa yhdessä perheen kanssa
7. Perheeni kanssa yhdessä
  1. syömmе
  2. katsomme televisiota
  3. käymme kylässä
  4. harrastamme; mitä? \_\_\_\_\_
  5. teemme jotain muuta, mitä? \_\_\_\_\_
8. Perheeni kanssa vietettyä aikaa on mielestäni
  1. liian vähän
  2. sopivasti
  3. liian paljon
9. Perheessäni vanhempien välinen suhde on mielestäni
  1. hyvä
  2. keskinkertainen
  3. huono
  4. perheessä on vain yksi vanhempi
10. Suhteeni äitiini on mielestäni
  1. hyvä
  2. keskinkertainen
  3. huono
11. Suhteeni isääni on mielestäni
  1. hyvä
  2. keskinkertainen
  3. huono
12. Suhteeni sisaruksiini on mielestäni
  1. hyvä
  2. keskinkertainen
  3. huono
13. Mikä on **äitisi** ammatti? \_\_\_\_\_
14. Mikä on **isäsi** ammatti? \_\_\_\_\_



15. Vanhempani ovat
1. molemmat työssä
  2. isä työtön; vuodesta \_\_\_\_\_
  3. äiti työtön; vuodesta \_\_\_\_\_
  4. isä eläkkeellä; vuodesta \_\_\_\_\_
  5. äiti eläkkeellä; vuodesta \_\_\_\_\_
  6. muu tilanne, mikä? \_\_\_\_\_
16. Millainen on mielestäsi perheesi **taloudellinen tilanne**?
1. hyvä
  2. keskinkertainen
  3. huono
17. Onko **äidilläsi** jokin pitkäaikaissairaus tai vamma?
1. ei
  2. kyllä, mikä? \_\_\_\_\_
18. Onko **isälläsi** jokin pitkäaikaissairaus tai vamma?
1. ei
  2. kyllä, mikä? \_\_\_\_\_
19. Onko **sinulla itselläsi** jokin pitkäaikaissairaus tai vamma?
1. ei
  2. kyllä, mikä? \_\_\_\_\_
20. Millaisena pidät yleistä terveydentilaasi?
1. erittäin hyvänä
  2. melko hyvänä
  3. keskinkertaisena
  4. melko huonona
  5. erittäin huonona
21. Mikä on uskontokuntasi?
1. luterilainen kirkko
  2. ortodoksinen kirkko
  3. muu kristillinen kirkko / yhteisö, mikä? \_\_\_\_\_
  4. muu, mikä? \_\_\_\_\_
  5. en kuulu mihinkään uskonnolliseen yhteisöön
22. Onko sinulla ystäviä, joihin luotat ja joiden kanssa voit keskustella lähes kaikista asioistasi?
1. ei yhtään ystävää
  2. yksi ystävä
  3. 2 - 3 ystävää
  4. enemmän kuin 3 ystävää
23. Minkälaista on uusien ystävien saaminen sinulle?
1. helppoa
  2. keskinkertaista
  3. vaikeaa
24. Onko sinulla vakituista seurustelukumppania?
1. ei ole
  2. on
25. Harrastatko liikuntaa?
1. säännöllisesti, mikä laji/mitkä lajit? \_\_\_\_\_; \_\_\_ kertaa viikossa
  2. silloin tällöin, mikä laji/mitkä lajit? \_\_\_\_\_; \_\_\_ kertaa kuukaudessa
  3. en harrasta liikuntaa tai harrastan harvemmin kuin kerran kuukaudessa
26. Mitä muuta harrastat? \_\_\_\_\_
27. Painatko mielestäsi
1. liian paljon
  2. sopivasti
  3. liian vähän
28. Tupakoiko paras ystäväsi?
1. ei tupakoi
  2. tupakoi
29. Mikä on suhteesi tupakkaan?
1. en ole koskaan tupakoinut. Jos et ole tupakoinut, ole hyvä ja siirry kysymykseen 33.
  2. olen tupakoinut, mutta lopettanut
  3. tupakoin harvemmin kuin kerran viikossa
  4. tupakoin kerran viikossa tai useammin, en kuitenkaan päivittäin
  5. tupakoin kerran päivässä tai useammin

30. Käytätkö useimmiten
1. tehdasvalmisteisia savukkeita
  2. itse käärittyjä savukkeita
  3. piippua, sikareita
  4. nuuskaa
31. Kun aloit polttaa säännöllisesti päivittäin, kuinka vanha olit? \_\_\_\_ vuotta ja \_\_\_\_ kuukautta.
32. Oletko lakossa / lopettanut tupakoinnin
1. alle viikko sitten
  2. noin viikko - 2 kuukautta sitten
  3. noin 2 kuukautta - puoli vuotta sitten
  4. yli puoli vuotta sitten
33. Oletko maistanut alkoholia (mm. kaljaa, siideriä, viiniä, viinaa)?
1. en ole koskaan maistanut. Jos et ole maistanut, ole hyvä ja siirry kohtaan 37.
  2. olen maistanut
34. Kuinka monta kertaa olet **viimeisen 3 kuukauden aikana** käyttänyt alkoholia niin, että se on tuntunut humaltumisena?
1. en kertaakaan
  2. \_\_\_\_ kertaa
35. Kuinka usein juot keskiolutta?
1. en juo keskiolutta koskaan
  2. 3 - 4 kertaa vuodessa tai harvemmin
  3. noin kerran parissa kuukaudessa
  4. noin kerran kuukaudessa
  5. kerran viikossa
  6. pari kertaa viikossa
  7. päivittäin
36. Kuinka usein juot siideriä?
1. en juo siideriä koskaan
  2. 3 - 4 kertaa vuodessa
  3. noin kerran parissa kuukaudessa
  4. noin kerran kuukaudessa
  5. kerran viikossa
  6. pari kertaa viikossa
  7. päivittäin
37. Tiedätkö lähituttaviesi joukossa jonkun, joka on kokeillut huumeita (tarkoittaen esim. hasista, crackia, pillereitä, liimoja)?
1. en tiedä ketään
  2. tiedän yhden nuoren
  3. tiedän 2 - 5 nuorta
  4. tiedän useamman kuin 5 nuorta
38. Käytätkö itse huumeita?
1. en ole kokeillut enkä käyttänyt huumeita
  2. olen kokeillut kerran; mitä? \_\_\_\_\_
  3. olen käyttänyt; mitä? \_\_\_\_\_; \_\_\_\_ kertaa
  4. käytän parhaillaan (viimeisen 3 kuukauden aikana); mitä? \_\_\_\_\_; \_\_\_\_ kertaa viikossa
39. Oletko joutunut kiusaamisen kohteeksi?
1. useita kertoja viikossa
  2. noin kerran viikossa
  3. harvemmin kuin kerran viikossa
  4. en lainkaan
40. Kiusaatko itse muita?
1. useita kertoja viikossa
  2. noin kerran viikossa
  3. harvemmin kuin kerran viikossa
  4. en lainkaan
41. Onko lähipiirissäsi sattunut **viimeisen vuoden aikana** jokin/joitakin seuraavista tapahtumista?  
(Voit ympyröidä yhden tai useamman vaihtoehdon.)
1. läheinen ihminen kuollut; kuka? \_\_\_\_\_, vuosi/kuukausi \_\_\_\_\_
  2. läheinen ihminen sairastunut vakavasti; kuka? \_\_\_\_\_; vuosi/kk \_\_\_\_\_
  3. itse sairastunut vakavasti; vuosi/kk \_\_\_\_\_
  4. vanhemmat eronneet; vuosi/kk \_\_\_\_\_
  5. vakavia ristiriitaisuuksia perheenjäsenten välillä
  6. muutto uudelle paikkakunnalle; vuosi/kk \_\_\_\_\_
  7. lemmikkieläin kuollut; vuosi/kk \_\_\_\_\_
  8. muu, mikä? \_\_\_\_\_, vuosi/kk \_\_\_\_\_

<b>Rastita seuraavissa kysymyksissä elämäsi parhaiten kuvaava vaihtoehto. Pyri vastaamaan rehellisesti. Kysymyksiin ei ole oikeita tai väärä vastauksia.</b>		Ehdottomasti eri mieltä	Eri mieltä	Vähän eri mieltä/vähän samaamieltä	Samaa mieltä	Ehdottomasti samaa mieltä
1	Tulevaisuuteni näyttää hyvältä.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
2	Nautin elämästä enemmän kuin useimmat ihmiset	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
3	En ole tyytyväinen siihen, miten suunnitelmani elämäni suhteen ovat toteutuneet.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
4	Hyväksyn elämässäni ne asiat, joita ei voi muuttaa.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
5	Mitä tahansa tapahtuukin, pystyn näkemään asioiden valoisat puolet.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
6	Olen onnellinen elämästäni.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
7	Elämäni on oikeilla raiteilla.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
8	Pystyn tekemään asioita aivan yhtä hyvin kuin muutkin ihmiset.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
9	Tunnen olevani huonompi kuin muut.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
10	Minulla on kaiken kaikkiaan myönteinen asenne itseäni kohtaan.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
11	Tunnen itseni yksinäiseksi, vaikken haluaisikaan olla.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
12	Joskus minusta tuntuu, että minussa on jotain vikaa.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
13	Viihdyn koulussa.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
14	Koen koulutyön innostavaksi.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
15	Tunnen että jaksan suoriutua koulutyöstä.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
	<i>Kuinka usein olet ollut viime viikkojen aikana huolissasi...</i>	En koskaan	Harvoin	Joskus	Usein	Erittäin usein
16	... siksi, että sinulla oli ongelmia muiden ihmisten kanssa?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
17	... vanhempiesi vuoksi?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
18	... ystävyysuhteitiesi vuoksi?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
19	... koulun vuoksi?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
20	... aikuistumisesi vuoksi?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
21	... terveytesi vuoksi?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
22	... tyttö- tai poikaystäväsi vuoksi?      En seurustele <input type="radio"/>	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
23	... raha-asioiden vuoksi?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
	<i>Viime viikkojen aikana...</i>	Ei koskaan	Harvoin	Joskus	Usein	Erittäin usein
24	... onko sinulla ollut vatsakipuja?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
25	... onko sinulla ollut sydämentykytystä tai rintakipua?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
26	... oletko ollut niin kipeä, ettet ole päässyt kouluun?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
27	... oletko kärsinyt ruokahaluttomuudesta?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
28	... onko sinulla ollut huimausta?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
29	... onko sinun ollut vaikea nukahtaa?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
30	... oletko tuntenut itsesi epätavallisen väsyneeksi?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
31	... onko sinulla ollut kovaa päänsärkyä?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>

	Ehdottomasti eri mieltä	Eri mieltä	Vähän eri mieltä/vähän samaamieltä	Samaa mieltä	Ehdottomasti samaa mieltä
32 Minua ei huvita tehdä mitään.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
33 Olen menettänyt mielenkiintoni muita ihmisiä kohtaan enkä välitä heistä.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
34 En nauti enää mistään.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
35 Elämäni ei ole kiinnostavaa.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
36 Tuhlaan aikaani välillä.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
<i>Viime viikkojen aikana oletko ...</i>	En koskaan	Harvoin	Joskus	Usein	Erittäin usein
37 ... ollut iloinen, koska olet saavuttanut jotakin?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
38 ... ollut iloinen, koska muut ihmiset pitivät sinusta?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
39 ... tuntenut itsesi täysin onnelliseksi?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
40 ... tuntenut, että asiat ovat menneet toivomallasi tavalla?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
41 ... onnistunut ratkomaan ongelmiasi?	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>

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	Ehdottomasti eri mieltä	Eri mieltä	Vähän eri mieltä/vähän samaamieltä	Samaa mieltä	Ehdottomasti samaa mieltä
<b><i>Rastita seuraavissa kysymyksissä elämäsi parhaiten kuvaava vaihtoehto. Pyri vastaamaan rehellisesti. Kysymyksiin ei ole oikeita tai vääriä vastauksia.</i></b>					
1 Pystyn tekemään itsenäisiä päätöksiä.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
2 Minulla on turvallinen koti.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
3 Olen tyytyväinen ulkonäköni.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
4 Kaverit antavat elämäni sisältöä.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
5 Saan riittävästi turvaa läheisiltäni.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
6 Voin uskoutua kavereilleni.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
7 Tunnen oloni turvalliseksi koulussa (ei tarvitse pelätä opettajia tai muita oppilaita).	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
8 Minulla on paljon sisäisiä ristiriitoja.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
9 Kaverit ovat aina valmiina auttamaan minua.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
10 Pystyn vaikuttamaan asioihini toivomallani tavalla.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
11 Pelkään, että Suomi joutuu sotaan.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
12 Olen tasapainoinen ihminen.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
13 Olen valmis auttamaan kavereitani.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
14 Koen olevani itsenäinen ihminen.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
15 Maailmassa käytävät sodat horjuttavat turvallisuuden tunnettani.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
16 Nautin kauniista asioista ympärilläni.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
17 Välitän kavereistani paljon.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
18 Haluan tulla kuuluisaksi.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
19 Tunnen eläväni vasta koulun jälkeen vapaa-ajallani.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
20 Haluan mahdollisimman hyvätuloisen ja arvostetun työn.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>
21 Pyrin tekemään ympäristöstäni itselleni viihtyisän.	<input type="radio"/> O <sub>1</sub>	<input type="radio"/> O <sub>2</sub>	<input type="radio"/> O <sub>3</sub>	<input type="radio"/> O <sub>4</sub>	<input type="radio"/> O <sub>5</sub>

	Ehdottomasti eri mieltä	Eri mieltä	Vähän eri mieltä/vähän samaamieltä	Samaa mieltä	Ehdottomasti samaa mieltä	
22	Koulu antaa eväitä elämäni varten.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
23	Valitsen harrastukseni sen mukaan, kuinka se vaikuttaa hyvinvointiini.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
24	Jos perheeni tarvitsee ulkopuolista apua vaikeuksissaan, tiedämme mihin ottaa yhteyttä.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
25	Olen tärkeä ihminen perheessäni.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
	<i>Seuraavassa 4 kysymyksessä <b>huumorilla</b> tarkoitetaan hyväntahtoista leikinlaskua ja hauskanpitoa (ei esim. toisen naurunalaiseksi tekemistä tai "hampaat irtessä" kaiken kestämistä)</i>					
26	Huumori auttaa minua usein selviytymään hankalista tilanteista.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
27	Huumorin avulla kestan vaikeita asioita elämässäni.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
28	Huumori kuuluu perheemme arkeen.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
29	Huumori tekee elämästäni helpomman.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
30	Elämässä ei pidä ottaa asioita liian vakavasti.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
31	Voin uskoutua perheelleni.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
32	Minulla on terveelliset elintavat.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
33	Uskon että elämälläni on tarkoitus.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
34	Välitän perheestäni paljon.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
35	Koulu mahdollistaa minulle paremman tulevaisuuden.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
36	Tiedän, millainen terveydentilani on.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
37	Parannan hyvinvointiani omalla toiminnallani.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
38	Tiedän, mistä saan apua, jos minulla on vaikeuksia elämässä.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
39	Perheeni antaa elämäni sisältöä.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
40	Arjesta täytyy välillä irrottautua, vaikka siitä aiheutuisi harmia läheisilleni.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
41	Koulu parantaa mahdollisuuksiani saada hyvä ammatti.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
42	Harrastukseni lisäävät hyvinvointiani.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
43	Perheeni on aina valmis auttamaan minua.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
44	Koulu luo mielekkyyttä elämäni.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
45	Elintapani huonontavat hyvinvointiani.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
46	Koulusta saatava hyöty on olematon.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
47	Pyrin tekemään elämässäni vain sellaisia asioita, joista pidän.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
48	Usko Jumalaan auttaa minua selviytymään arkielämän ongelmista.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
49	Usko Jumalaan parantaa hyvinvointiani.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
50	Usko Jumalaan antaa mielekkyyttä elämäni.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
51	Usko Jumalaan luo turvallisuutta elämäni.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>
52	Usko Jumalaan antaa minulle toivoa elämässä.	O <sub>1</sub>	O <sub>2</sub>	O <sub>3</sub>	O <sub>4</sub>	O <sub>5</sub>

## Perhedynamiikkamittaus II\*\* ©

Ohjeet: Seuraavissa kysymyksissä perhe on määritelty ryhmäksi ihmisiä, jotka ovat sitoutuneet toisiinsa ja asuvat yhdessä. Lue jokainen kysymys ja päätele oletko *ehdottomasti eri mieltä, eri mieltä, vähän eri mieltä, vähän samaa mieltä, samaa mieltä vai ehdottomasti samaa mieltä.* Esim. jos olet täysin samaa mieltä, rengasta 6 (ehdottomasti samaa mieltä). Ellet ole aivan varma, mutta kallistut jompaankumpaan suuntaan, valitse silloin 4 (vähän samaa mieltä) tai 3 (vähän eri mieltä). Arvioi sopivimmalta tuntuvin vastaus vaikka olisitkin epävarma. Oikeita tai vääriä vastauksia ei ole.

	Ehdot- tomasti eri mieltä	Eri mieltä	Vähän eri mieltä	Vähän samaa mieltä	Samaa mieltä	Ehdottomasti samaa mieltä	Älä kirjoita tähän
<b>Perheessäni:</b>							
1. Perheen toimintoja voidaan muuttaa.	1	2	3	4	5	6	_____1
2. Tärkeistä asioista puhutaan tarpeeksi.	1	2	3	4	5	6	_____2
3. Huolehdin muista.	1	2	3	4	5	6	_____3
4. Minulla on kotona paikka omille tavaroilleni.	1	2	3	4	5	6	_____4
5. Olemme tyytyväisiä perheen tehtävien jakoon.	1	2	3	4	5	6	_____5
6. Puhuminen ei mielestäni auta ollenkaan.	1	2	3	4	5	6	_____6
7. Koen, että en saa tarpeeksi apua kotitöissä.	1	2	3	4	5	6	_____7
8. Vaihdan päivittäisiä rutiineja harvoin.	1	2	3	4	5	6	_____8
9. Tiedän mitä odottaa päivästä toiseen.	1	2	3	4	5	6	_____9
10. Teen itse päätökseni.	1	2	3	4	5	6	_____10
11. On tärkeää tehdä asiat oikein.	1	2	3	4	5	6	_____11
12. Osuuteni perheen töistä on sopiva.	1	2	3	4	5	6	_____12
13. Tehtyä päätöstä yhteisistä asioista on vaikea muuttaa.	1	2	3	4	5	6	_____13
14. Tunnelma on lämmin.	1	2	3	4	5	6	_____14
15. Pidän tunteet sisälläni.	1	2	3	4	5	6	_____15
16. Ilmaisen toisille mitä haluan.	1	2	3	4	5	6	_____16
17. Tiedän, että selviämme kun asiat menevät huonosti.	1	2	3	4	5	6	_____17
18. Tunnen itseni ulkopuoliseksi.	1	2	3	4	5	6	_____18
19. Meille sopii, että työt tehdään eri tavoin.	1	2	3	4	5	6	_____19
20. Kun olen alakuloinen, joku lohduttaa minua.	1	2	3	4	5	6	_____20

\*\*Kyselylomakkeen käyttöoikeus pyydettyä kirjallisesti professori, Ph.D. Marjorie Whitelta osoitteesta: College of Nursing, University of Florida, Gainesville, FL 32610, USA.

Virallinen suomennos: Stephen Evans, Maija Helminen, David Kivinen. Virallisesta suomennoksesta vastaa: Marita Paunonen, Tampereen yliopisto, Hoitotieteen laitos. Korjattu 1995.

	Ehdot- tomasti eri mieltä	Eri mieltä	Vähän eri mieltä	Vähän samaa mieltä	Samaa mieltä	Ehdottomasti samaa mieltä	
<b>Perheessäni:</b>							
21. Tärkeistä asioista ei mielestäni puhuta.	1	2	3	4	5	6	_____21
22. Toiset tarjoutuvat auttamaan minua tehtävissäni.	1	2	3	4	5	6	_____22
23. Suhteemme toinen toistemme kanssa toimii hyvin.	1	2	3	4	5	6	_____23
24. Saan aina kurjimmat tehtävät	1	2	3	4	5	6	_____24
25. Koen, että jotkut sanovat yhtä ja tarkoittavat toista.	1	2	3	4	5	6	_____25
26. Ystävien vierailut eivät häiritse perhettäme.	1	2	3	4	5	6	_____26
27. En voi luottaa tapaan, jolla perheen rahat käytetään	1	2	3	4	5	6	_____27
28. Minun odotetaan pitävän samasta ruoasta kuin kaikki muutkin.	1	2	3	4	5	6	_____28
29. Pitäydyn jokapäiväisissä rutiineissani.	1	2	3	4	5	6	_____29
30. Tunnen, että joku välittää minusta.	1	2	3	4	5	6	_____30
31. Minulla on lupa omiin mielipiteisiin.	1	2	3	4	5	6	_____31
32. Olemme läheisiä toisillemme.	1	2	3	4	5	6	_____32
33. Puhuessani joku kuuntelee mitä sanottavaa minulla on.	1	2	3	4	5	6	_____33
34. Pidän puoliani.	1	2	3	4	5	6	_____34
35. Kun asiat menevät huonosti, kokeilemme eri tapoja hoitaa niitä.	1	2	3	4	5	6	_____35
36. Kysymme, kun emme tiedä mitä muut tarkoittavat.	1	2	3	4	5	6	_____36
37. Minun on muistutettava toisia tekemään tehtävänsä.	1	2	3	4	5	6	_____37
38. En tee asioita joihin kukaan ei ole antanut suostumustaan.	1	2	3	4	5	6	_____38
39. On tärkeää, että me kaikki ajattelemme samalla tapaa.	1	2	3	4	5	6	_____39
40. Muut odottavat minun käyttäytyvän tavoilla, joita en hyväksy.	1	2	3	4	5	6	_____40
41. On helppo muuttaa suunnitelmia.	1	2	3	4	5	6	_____41
42. Koen, että teen enemmän kuin oman osuuteni töistä.	1	2	3	4	5	6	_____42
43. Tunnen yhteishengen vallitsevan.	1	2	3	4	5	6	_____43
44. Tiedän mitä odottaa muilta perheenjäseniltä.	1	2	3	4	5	6	_____44
45. Olen yksin.	1	2	3	4	5	6	_____45

	Ehdot- tomasti eri mieltä	Eri mieltä	Vähän eri mieltä	Vähän samaa mieltä	Samaa mieltä	Ehdottomasti samaa mieltä	
<b>Perheessäni:</b>							
46. Näen päältä, milloin perheen- jäsenet ovat poissa tolaltaan.	1	2	3	4	5	6	_____46
47. Väärinkäsityksen sattuessa puhum- me asiasta kunnes se selviää.	1	2	3	4	5	6	_____47
48. Ongelmistani puhuminen sekoittaa asioita entisestään.	1	2	3	4	5	6	_____48
49. Näyttää siltä, että jokin menee aina pieleen.	1	2	3	4	5	6	_____49
50. Minulla on paikka, jossa voin olla yksin.	1	2	3	4	5	6	_____50
51. Säännöistä ei jousteta minun vuokseni.	1	2	3	4	5	6	_____51
52. Annan muiden päättää asioista puolestani.	1	2	3	4	5	6	_____52
53. Koen, että perheen sääntöjä on vaikea muuttaa.	1	2	3	4	5	6	_____53
54. Minun on vaikea sanoa mitä tarkoitan.	1	2	3	4	5	6	_____54
55. Koen, että kukaan ei välitä minusta.	1	2	3	4	5	6	_____55
56. En ole läheinen kenenkään kanssa.	1	2	3	4	5	6	_____56
57. Minulla on ikiomia tavaroita, jotka ovat ainoastaan minua varten.	1	2	3	4	5	6	_____57
58. Tiedämme, kuinka tavoitamme perheenjäsenet, jos siihen on tarve.	1	2	3	4	5	6	_____58
59. Olen tyytyväinen tapaan, jolla työt tehdään.	1	2	3	4	5	6	_____59
60. Mielestäni me kaikki olemme samanlaisia.	1	2	3	4	5	6	_____60
61. Ongelman ilmaantuessa kaikki tuntuu kaatuvan päälle.	1	2	3	4	5	6	_____61
62. Vältämme ongelmista puhumista.	1	2	3	4	5	6	_____62
63. En tiedä mitä odottaa seuraa- valta päivältä.	1	2	3	4	5	6	_____63
64. On tärkeää tietää, missä perheenjäsenet ovat.	1	2	3	4	5	6	_____64
65. Selvitän asiat itsekseni.	1	2	3	4	5	6	_____65
66. En pidä töistä, joita joudun tekemään.	1	2	3	4	5	6	_____66

**Tarkista vielä, että olet vastannut kaikkiin kysymyksiin.  
Kiitokset avustasi!**

**Katso vielä seuraava sivu, kiitos.**





Olisitko halukas **osallistumaan noin tunnin kestävään haastatteluun**, joka koskisi omaa ja perheesi hyvinvointia. Haastattelijana on tutkija Katja Rask. Jos olet halukas, laita nimesi ja yhteystietosi, niin otan tarvittaessa yhteyttä tämän syksyn aikana. Vastauksesi käsitellään luottamuksellisesti. Kiitos!

Olen halukas osallistumaan haastatteluun, joka koskee omaa ja perheeni hyvinvointia.

Nimi\_\_\_\_\_

Osoite\_\_\_\_\_

\_\_\_\_\_

Puhelin\_\_\_\_\_

## Appendix 2. The parent questionnaire and parental permission form

### HYVÄ NUOREN VANHEMPI

Kädessänne on kyselylomake, joka liittyy perheenne toimintaan. Olemme tekemässä tutkimusta nuoren koetusta hyvinvoinnista ja perheen toiminnasta. Tarkoituksena on kartoittaa tamperelaisten nuorten kokemuksia omasta ja perheen hyvinvoinnista ja perheen toiminnasta sekä vanhempien kokemuksia perheen toiminnasta. Tutkimus on osa perhe ja koulu -hanketta, jonka tavoitteena on parantaa perheiden ja koulun välistä yhteistyötä.

Toivoisimme, että *toinen vanhemmista täyttäisi lomakkeen itsenäisesti* ja lähettäisi sen mahdollisimman pian vastauskuoressa tutkija Katja Raskille (postimaksu maksettu). Kaikki antamanne tiedot käsitellään luottamuksellisesti ja siten, ettei henkilöllisyytenne tule esille missään vaiheessa. Tutkimustulokset raportoidaan kokonaisuutena eikä yksittäisten perheiden tietoja luovuteta koululle.

Perhe-elämän asiantuntijana voitte auttaa nuoren ja perheenne hyvinvoinnin tutkimisessa. Kiitämme vaivannäöstänne ja mikäli Teillä tulee tutkimukseen liittyen jotain kysyttävää, voitte ottaa yhteyttä tutkija Katja Raskiin, os. Tampereen yliopisto, hoitotieteen laitos, 33014 Tampereen yliopisto, puh. (03)-215 7806.

Tampereella lokakuussa 2000

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Marita Paunonen-Ilmonen  
Professori  
Hoitotieteen laitoksen johtaja  
Tampereen yliopisto  
Hoitotieteen laitos  
33014 Tampereen yliopisto

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Päivi Åstedt-Kurki  
Professori  
Tampereen yliopisto  
Hoitotieteen laitos  
33014 Tampereen yliopisto

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Katja Rask  
Tutkija, terveystieteiden maisteri  
Tampereen yliopisto  
Hoitotieteen laitos  
33014 Tampereen yliopisto

1. Kuinka monta jäsentä kuuluu, **Teidät itsenne mukaan lukien**, perheeseenne? (Perhe on määritelty ryhmäksi ihmisiä, jotka ovat sitoutuneet toisiinsa ja asuvat yhdessä.)

1                  2                  3                  4                  5                  6                  7                  8

2. Mikä on Teidän asemanne perheessänne? **Merkitkää kaikki vaihtoehdot.**

- 1 puoliso  
2 äiti tai isä  
3 lapsi  
4 sukulainen; tarkentakaa \_\_\_\_\_  
5 ystävä  
6 asumme yhdessä (avoliitto)  
7 kihlattu

3. Luetelkaa jokaisen perheenjäsenen ikä, sukupuoli ja (sukulaisuus)suhde Teihin.

**Älkää laskeko mukaan itseänne.**

	Ikä	Sukupuoli	Suhde Teihin
Esimerkiksi	45	nainen	aviopuoliso

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Mikä on sukupuolenne?                  1. \_\_\_ nainen                                  2. \_\_\_ mies

5. Minkä ikäinen olette?                  \_\_\_v;                                  Syntymävuosi \_\_\_\_\_

6. Miten monta vuotta olette kaikkiaan käynyt koulua? (Rengastakaa yksi vaihtoehto)

1 2 3 4 5 6 7 8 9    10 11 12 13 14    15 16 17 18 19 20 21 22

Kansakoulu/keskik./perusk.    Lukio/ammattik./    Korkeakoulu/    Opistoaste tms.

7. Miten monta vuotta puolisonne tai muu aikuinen perheenne jäsen on kaikkiaan käynyt koulua?

1 2 3 4 5 6 7 8 9    10 11 12 13 14    15 16 17 18 19 20 21 22

Kansakoulu/keskik./perusk.    Lukio/ammattik./    Korkeakoulu    Opistoaste tms

8. Mitä työtä teette? \_\_\_\_\_

9. Mitä työtä puolisonne tai muu aikuinen perheenne jäsen tekee?

\_\_\_\_\_

10. Onko perheessänne sairauksia, jotka vaikuttavat Teihin voimakkaasti?

\_\_\_ ei

\_\_\_ kyllä, määritellä sairaus tai sairaudet \_\_\_\_\_

\_\_\_\_\_

11. Onko perheessänne tai elämässänne ongelmia tai muutoksia, jotka vaikuttavat Teihin voimakkaasti?

\_\_\_ ei

\_\_\_ kyllä, määritellä ongelmat tai muutokset \_\_\_\_\_

\_\_\_\_\_

## Perhedynamiikkamittaus II\*\* ©

Ohjeet: Seuraavissa kysymyksissä perhe on määritelty ryhmäksi ihmisiä, jotka ovat sitoutuneet toisiinsa ja asuvat yhdessä. Lukekaa jokainen kysymys ja päätelkää oletteko *ehdottomasti eri mieltä, eri mieltä, vähän eri mieltä, vähän samaa mieltä, samaa mieltä vai ehdottomasti samaa mieltä.* Esim. jos olette täysin samaa mieltä, rengastakaa 6 (ehdottomasti samaa mieltä). Ellette ole aivan varma, mutta kallistutte jompaankumpaan suuntaan, valitkaa silloin 4 (vähän samaa mieltä) tai 3 (vähän eri mieltä). Arvioikaa sopivimmalta tuntuvin vastaus, vaikka olisittekin epävarma. Oikeita tai vääriä vastauksia ei ole.

	Ehdot- tomasti eri mieltä	Eri mieltä	Vähän eri mieltä	Vähän samaa mieltä	Samaa mieltä	Ehdottomasti samaa mieltä	Älkää kirjoittako tähän
<b>Perheessäni:</b>							
1. Perheen toimintoja voidaan muuttaa.	1	2	3	4	5	6	_____1
2. Tärkeistä asioista puhutaan tarpeeksi.	1	2	3	4	5	6	_____2
3. Huolehdin muista.	1	2	3	4	5	6	_____3
4. Minulla on kotona paikka omille tavaroilleni.	1	2	3	4	5	6	_____4
5. Olemme tyytyväisiä perheen tehtävien jakoon.	1	2	3	4	5	6	_____5
6. Puhuminen ei mielestäni auta ollenkaan.	1	2	3	4	5	6	_____6
7. Koen, että en saa tarpeeksi apua kotitöissä.	1	2	3	4	5	6	_____7
8. Vaihdan päivittäisiä rutiineja harvoin.	1	2	3	4	5	6	_____8
9. Tiedän mitä odottaa päivästä toiseen.	1	2	3	4	5	6	_____9
10. Teen itse päätökseni.	1	2	3	4	5	6	_____10
11. On tärkeää tehdä asiat oikein.	1	2	3	4	5	6	_____11
12. Osuuteni perheen töistä on sopiva.	1	2	3	4	5	6	_____12
13. Tehtyä päätöstä yhteisistä asioista on vaikea muuttaa.	1	2	3	4	5	6	_____13
14. Tunnelma on lämmin.	1	2	3	4	5	6	_____14
15. Pidän tunteet sisälläni.	1	2	3	4	5	6	_____15
16. Ilmaisen toisille mitä haluan.	1	2	3	4	5	6	_____16
17. Tiedän, että selviämme kun asiat menevät huonosti.	1	2	3	4	5	6	_____17
18. Tunnen itseni ulkopuoliseksi.	1	2	3	4	5	6	_____18
19. Meille sopii, että työt tehdään eri tavoin.	1	2	3	4	5	6	_____19
20. Kun olen alakuloinen, joku lohduttaa minua.	1	2	3	4	5	6	_____20

\*\*Kyselylomakkeen käyttöoikeus pyydettyä kirjallisesti professori, Ph.D. Marjorie Whitelta osoitteesta: College of Nursing, University of Florida, Gainesville, FL 32610, USA.

Virallinen suomennos: Stephen Evans, Maija Helminen, David Kivinen. Virallisesta suomennoksesta vastaa: Marita Paunonen, Tampereen yliopisto, Hoitotieteen laitos. Korjattu 1995.

	Ehdot- tomasti eri mieltä	Eri mieltä	Vähän eri mieltä	Vähän samaa mieltä	Samaa mieltä	Ehdottomasti samaa mieltä	
<b>Perheessäni:</b>							
21. Tärkeistä asioista ei mielestäni puhuta.	1	2	3	4	5	6	____ 21
22. Toiset tarjoutuvat auttamaan minua tehtävissäni.	1	2	3	4	5	6	____ 22
23. Suhteemme toinen toistemme kanssa toimii hyvin.	1	2	3	4	5	6	____ 23
24. Saan aina kurjimmat tehtävät	1	2	3	4	5	6	____ 24
25. Koen, että jotkut sanovat yhtä ja tarkoittavat toista.	1	2	3	4	5	6	____ 25
26. Ystävien vierailut eivät häiritse perhettäme.	1	2	3	4	5	6	____ 26
27. En voi luottaa tapaan, jolla perheen rahat käytetään	1	2	3	4	5	6	____ 27
28. Minun odotetaan pitävän samasta ruoasta kuin kaikki muutkin.	1	2	3	4	5	6	____ 28
29. Pitäydyn jokapäiväisissä rutiineissani.	1	2	3	4	5	6	____ 29
30. Tunnen, että joku välittää minusta.	1	2	3	4	5	6	____ 30
31. Minulla on lupa omiin mielipiteisiin.	1	2	3	4	5	6	____ 31
32. Olemme läheisiä toisillemme.	1	2	3	4	5	6	____ 32
33. Puhuessani joku kuuntelee mitä sanottavaa minulla on.	1	2	3	4	5	6	____ 33
34. Pidän puoliani.	1	2	3	4	5	6	____ 34
35. Kun asiat menevät huonosti, kokeilemme eri tapoja hoitaa niitä.	1	2	3	4	5	6	____ 35
36. Kysymme, kun emme tiedä mitä muut tarkoittavat.	1	2	3	4	5	6	____ 36
37. Minun on muistutettava toisia tekemään tehtävänsä.	1	2	3	4	5	6	____ 37
38. En tee asioita joihin kukaan ei ole antanut suostumustaan.	1	2	3	4	5	6	____ 38
39. On tärkeää, että me kaikki ajattelemme samalla tapaa.	1	2	3	4	5	6	____ 39
40. Muut odottavat minun käyttäytyvän tavoilla, joita en hyväksy.	1	2	3	4	5	6	____ 40
41. On helppo muuttaa suunnitelmia.	1	2	3	4	5	6	____ 41
42. Koen, että teen enemmän kuin oman osuuteni töistä.	1	2	3	4	5	6	____ 42
43. Tunnen yhteishengen vallitsevan.	1	2	3	4	5	6	____ 43
44. Tiedän mitä odottaa muilta perheenjäseniltä.	1	2	3	4	5	6	____ 44

	Ehdot- tomasti eri mieltä	Eri mieltä	Vähän eri mieltä	Vähän samaa mieltä	Samaa mieltä	Ehdottomasti samaa mieltä	
<b>Perheessäni:</b>							
45. Olen yksin.	1	2	3	4	5	6	_____45
46. Näen päältä, milloin perheen- jäsenet ovat poissa tolaltaan.	1	2	3	4	5	6	_____46
47. Väärinkäsityksen sattuessa puhum- me asiasta kunnes se selviää.	1	2	3	4	5	6	_____47
48. Ongelmistani puhuminen sekoittaa asioita entisestään.	1	2	3	4	5	6	_____48
49. Näyttää siltä, että jokin menee aina pieleen.	1	2	3	4	5	6	_____49
50. Minulla on paikka, jossa voin olla yksin.	1	2	3	4	5	6	_____50
51. Säännöistä ei jousteta minun vuokseni.	1	2	3	4	5	6	_____51
52. Annan muiden päättää asioista puolestani.	1	2	3	4	5	6	_____52
53. Koen, että perheen sääntöjä on vaikea muuttaa.	1	2	3	4	5	6	_____53
54. Minun on vaikea sanoa mitä tarkoitan.	1	2	3	4	5	6	_____54
55. Koen, että kukaan ei välitä minusta.	1	2	3	4	5	6	_____55
56. En ole läheinen kenenkään kanssa.	1	2	3	4	5	6	_____56
57. Minulla on ikiomia tavaroita, jotka ovat ainoastaan minua varten.	1	2	3	4	5	6	_____57
58. Tiedämme, kuinka tavoitamme perheenjäsenet, jos siihen on tarve.	1	2	3	4	5	6	_____58
59. Olen tyytyväinen tapaan, jolla työt tehdään.	1	2	3	4	5	6	_____59
60. Mielestäni me kaikki olemme samanlaisia.	1	2	3	4	5	6	_____60
61. Ongelman ilmaantuessa kaikki tuntuu kaatuvan päälle.	1	2	3	4	5	6	_____61
62. Vältämme ongelmista puhumista.	1	2	3	4	5	6	_____62
63. En tiedä mitä odottaa seuraa- valta päivältä.	1	2	3	4	5	6	_____63
64. On tärkeää tietää, missä perheenjäsenet ovat.	1	2	3	4	5	6	_____64
65. Selvitän asiat itsekseni.	1	2	3	4	5	6	_____65
66. En pidä töistä, joita joudun tekemään.	1	2	3	4	5	6	_____66

**Tarkistaisitteko vielä, että olette vastannut kaikkiin kysymyksiin.**

**Kiitokset avustanne!**

## Tutkimuslupakysely

Nro

Tutkimus käsittelee nuoren koettua hyvinvointia, terveyskäyttäytymistä, arvojen toteutumista elämässä ja perhedynamiikkaa. Tutkimus on toteutettu siten, että nuori on täyttänyt halutessaan kyselylomakkeen oppitunnilla. Lisäksi nuori voi suostumuksen annettuaan osallistua haastatteluun. Kaikki tiedot tullaan käsittelemään nimettöminä eikä yksittäistä vastaajaa voi tunnistaa tuloksia raportoitaessa.

Mikäli annatte luvan lapsellenne osallistua tutkimukseen, pyydän rastittamaan alla olevan suostumuksen ja lähettämään sen vastauskuoressa minulle. Lisäksi toivon, että täyttäisitte myös perhedynamiikka -kyselyn ja lähettäisitte sen samassa kuoressa.

Mikäli ette halua lapsenne osallistuvan tutkimukseen, rastittakaa alla oleva kielto ja lähettäkää se vastauskuoressa minulle. Kieltäessänne lapsenne osallistumisen tutkimukseen hänen täyttämänsä vastauslomake hävitetään.

Lämmin kiitos Teille!

Annan suostumukseni lapselleni osallistua nuoren koettu hyvinvointi ja perhedynamiikka -tutkimukseen.

En anna lupaa lapselleni osallistua nuoren koettu hyvinvointi ja perhedynamiikka -tutkimukseen.

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Paikka ja aika

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Allekirjoitus

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Nimenselvennys

## Appendix 3. The themes of the semi-structured interviews

### **Adolescent subjective well-being and realised values in family**

#### **Themes:**

##### **1. Family roles**

- responsibilities at home
- activities together

##### **2. Family communication**

- issues talked about in the family
- understanding of other family members
- self expression (e.g. feelings)
- humour in the family
- knowledge related to well-being
- thinking of well-being (self+other)

##### **3. Family individuation**

- differences and similarities with the family members
- autonomy in the family
- self fulfilment in the family

##### **4. Family relations**

- satisfaction/dissatisfaction with the family relations and issues

##### **5. Family mutuality**

- closeness in the family
- important things in the family
- safety (things that create safety)
- peace
- religion and purpose of life

##### **6. Family flexibility**

- changes and transitions in family
- peer relations and family
- school attendance and family

##### **7. Family stability**

- future description of the family

##### **8. Subjective well-being and satisfaction in the family**

- attitude toward life and joy of life in family
- appreciation for aesthetics
- self-esteem in the family
- self-rated health and
- ill-being and depressive mood related to family
- conflicts with the family members



Appendix 4. Correlation matrix of Satisfaction scales and Ill-being scales

	<b>Ill-being (total)</b>	Problems (subscale)	Somatic complaints (subscale)
<b>Satisfaction (total)</b>	-.48**	-.51**	-.36**
Positive attitude toward life (subscale)	-.44**	-.44**	-.36**
Self-esteem (subscale)	-.44**	-.50**	-.29**
Joy of life (subscale)	-.22**	-.26**	-.14*
Lack of depressive mood (subscale)	-.42**	-.42**	-.34**

\*\*  $P < .01$  (Spearman's rank correlation coefficient)

\*  $P < .05$  (Spearman's rank correlation coefficient)

Appendix 5. Summary of instruments' and sub scales' reliability analysis

<b>Instrument and sub scales</b>	<b>Adolescent sample (N=245) (Studies I, II) Cronbach's alpha / r</b>	<b>Adolescent sub sample (n=239) (Study III) Cronbach's alpha</b>	<b>Parent sample (n=239) (Study III) Cronbach's alpha</b>
<b>BSW/Y</b>			
<b>Satisfaction (22 items)</b>	<b>.90</b>	<b>.90</b>	
Positive attitude toward life	.78	.79	
Self-esteem	.75	.76	
Joy of life	.78	.79	
Lack of depressive mood	.77	.74	
<b>Ill-being (16 items)</b>	<b>.84</b>	<b>.84</b>	
Problems	.77	.78	
Somatic complaints	.74	.77	
<b>FVSW</b>			
<b>Terminal values (26 items)</b>	<b>.88</b>		
Safe family relations (10 items)	.89		
Faith in God (5 items)	.98		
Mutual peer relations (6 items)	.86		
Equilibrium (3 items)	.63		
Sense of peace (2 items)	r=.40**		
<b>Instrumental values (18 items)</b>	<b>.75</b>		
Appreciation of school (6 items)	.80		
Humour (5 items)	.82		
Autonomy (3 items)	.66		
Achievement (2 items)	r=.31**		
Pleasure (2 items)	r=.24**		
<b>Knowledge related to SWB (3 items)</b>	<b>.56</b>	<b>.56</b>	
<b>Activities related to SWB (5 items)</b>	<b>.74</b>	<b>.73</b>	
<b>School satisfaction (3 items)</b>		<b>.77</b>	
<b>FDM II</b>			
Individuation (12 items)		.59	.65
Mutuality (11 items)		.88	.87
Flexibility (10 items)		.64	.69
Stability (8 items)		.72	.70
Clear communication (11 items)		.82	.85
Role reciprocity (12 items)		.81	.87

\*\*  $P < .01$  (Spearman's rank correlation coefficient)

Appendix 6.

## **Original publications**