Subjective Experience of Health, Personal Health Resources and Beliefs: Supporting a Lifeworld Approach to Social Work in Youth Health

Rademaker, A. L [a]. and Holland, L. R.[b]

[a] Dr Anna Lena Rademaker (Dr. phil., M.A. Social Work)

[1] Administration of the Professorship for Social Work in Health Care, HAWK University of Applied Sciences and Arts, Hildesheim/ Holzminden/ Gottingen, Health Campus, Göttingen, Germany

[2] Subject specialist for concepts and research projects at the German Professional Association for Social Work in Health Care (Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen DVSG; dvsg.org).

Anna Lena Rademakers main research interests are Social Work and Health (Care), Health Promotion and Prevention and Clinical Social Work. Contact: anna.lena.rademaker@dvsg.org

Correspondence concerning this article should be addressed to this author.

[b] Lucy Ruth Holland (BSc, MSc, MSWQ, PhD Cand.)

[2] Senior Research Fellow, Queensland University of Technology, Brisbane, QLD, Australia

[3] Senior Social Worker, Children's Health Queensland, Brisbane, QLD, Australia

[4] PhD Candidate, The University of Newcastle, Newcastle, NSW, Australia.

Lucy Holland is a social worker, academic and researcher who has worked in adolescent health for over 12 years specializing in models of integrated and interdisciplinary care,

adolescent health, youth participation and social work in health care. She is also a member of the Australian Association of Social Workers and International Foundation for Integrated Care.

Abstract

The Salutogenesis model proposes that life experiences shape our Sense of Coherence (SOC), supporing the application of resources to help us cope with stressors. Along with our beliefs, these factors determine our health experience. Young people face rapid development in relation to persnonal resources. However, to date, there has been little exploration of the subjective health experience or availability of resources of young people within the German context. This research employed a 2 phase, mixed-methods study using a questionnaire (n=482) and focus groups (n=12) to examine: subjective health experience, personal health resources (SOC, self-efficacy (SE) and health locus of control (HLoC) and health beliefs. Results identified three participant typologies. Type 1 reported the highest levels of subjective health and resources and defined health as relating to functional performance. Type 2 reported moderate health and resources and prioritised both physical and social health. Type 3 reported the poorest health and resources and low health priority. This study demonstrates the important relationship between subjective health assessment and personal resources for young people. It illustrates the importance of developmentally-tailored approaches to social work practice, founded in a life-world-oriented approach, to enable understanding of subjective health experience and foster agency to maximise health outcomes.

Keywords

Lifeworld, Salutogenesis, Adolescent Health, Youth Health, Health Promotion, Health Social Work.

Subjective Experience of Health, Personal Health Resources and Beliefs: Supporting a Lifeworld Approach to Social Work in Youth Health

Health is an essential part of everyday life. It can be considered a phenomenon that encompasses a set of practices by which one materially, culturally, socially and morally demonstrates the legitimacy of the body to oneself and others (Williams, 1998). It becomes a moral performance (ibid.). Health is therefore a phenomenon that is based on both subjective interpretation, everyday knowledge and experiences as well as scientific or objective knowledge (Schütz, 1971). This highlights the importance of understanding both objective measures, and health within its subjectively considered construction (Faltermaier, 2015; Faltermaier & Brütt, 2013; Flick, 2003; Leventhal, Bodnar-Deren, Breland, Hash-Converse & Phillips, 2012).

Health is unequally experienced throughout societies. Poverty is associated with poorer health, more limited access to education and other social disadvantages (WHO, 2011, 2017). Most explanations of health inequalities refer to the availability and provision of resources including personal skills and environmental, social or structural supports (Hurrelmann & Richter, 2016). A framework by which health can be understood is the Salutogenesis Model (Antonovsky, 1987). This resource orientated approach proposes that life experiences shape our sense of coherence (SOC), by which we understand life to be more or less comprehensible, manageable and meaningful. Having a strong SOC enables the application of personal resources to help us to cope with stressors. SOC and other personal resources including include self-efficacy (SE) (Bandura, 1977) and health locus of control (HLoC) (Rotter, 1989) can determine how health is constructed. In practice, this is useful to support the identification of factors that promote resilience or risk in the context of an individual's situation or experience and that can be adapted to promote healthy behavior and improve health (Mittelmark & Bauer, 2016). However, these factors in isolation do not determine health status. Health theories and beliefs, or one's subjective interpretation of health, also determines health behaviours and

health status (Flick, 2003; Leventhal et. al., 2012). To understand how health is constructed and the emergence of health and healthy behaviour it is therefore important to apply a holistic model to understand the subjective health experience as well as the availability and use of personal health resources and health beliefs (Hurrelmann & Richter, 2016 Leventhal et al., 2012; Williams, 1998).

Youth Health

Processes and trajectories of adolescent development influence; and are influenced by, the health of the young person (Patton et al., 2016; Sawyer & Patton, 2011; Sawyer et al., 2012). It is now well recognised that adolescents experience a unique profile of illness and face specific barriers in relation to healthcare engagement (Gates, 2016; Patton et al., 2016; Sawyer et al., 2012). It is also well understood health mediates social opportunity for young people in relation to education, employment, financial wellbeing, relationships and independence (Coles, 2000; MacDonald & Shildrick, 2013; Williams et al., 2008).Specifically, elements of the normal life course, such as opportunities for education, employment and personal growth, are both considered basic resources to maintain health and are also hand shaped by socio-cultural structures and health status (Rademaker & Liel, 2018).The lifespan is also full exposure to health risks including environmental risks, social inequity, risk taking behaviour, alcohol and drug use, dangerous driving and risky sexual behaviour. While some young people experience these, they still develop strategies to promote health in long term. Others do not. Some relationships between social and health inequalities can be explained by gender, age, the socioeconomic and educational status of young people. MacDonald & Shildrick (2013) also show how experiences of health, wellbeing and bereavement interact with processes of youth transition and social exclusion. However, these factors in isolation do not determine health status over the life course for young people. It is understood that the development and availability of personal resources change rapidly over the course of adolescent development with changing social variables,

availability of resources and developing cognitive capacity (Braun-Lewensohn, Idn & Margalit, 2016). Health theories and beliefs also play an important role. However, to date, there has been little investigation into the availability of personal health resources for youth or the role of health theories and beliefs in determining health outcomes. There has also been limited exploration of the social inclusion of youth and the ways in which health mediates social opportunity for young people in relation to education, employment, financial wellbeing, relationships and independence (Coles, 2000; MacDonald & Shildrick, 2013; Williams, Costa, Odunlami & Mohammed, 2008). As the goal of social work in youth health is to support both normative development and health, this practice may benefit from a lifeworld approach, to understand the interface between health and the social world of young people and promote the best developmental and health-related outcomes.

The lifeworld oriented approach

The concept of the lifeworld orientation in social work was established in the 1970s by German theorist Hans Thiersch and now represents a significant foundation to practice in many European countries. According to this theory, individuals must be understood in terms of their own self-concept as this is formed in a process of exchange and interaction with others and emphasizes the value of the individual's autonomy and self-representation (Grunwald & Thiersch, 2009). Lifeworld orientation in relation to health is therefore focused on understanding the individual's subjective experiences, their beliefs, perceptions and experiences, which underpin the space available for them to action health-supporting behaviors and determine the resources available to support this action. This approach supports practice based approaches based in understanding and supporting individual agency and the associated barriers and facilitating factors supporting agency (Emirbayer & Mische 1998; Emirbayer & Mische, 2017; Rademaker & Liel, 2018).

1.

Method

This 2-phase, mixed-methods study was undertaken between 2013 and 2015. A quantitative questionnaire and qualitative focus group discussions were employed. In phase 1, young people aged 15-16 years (n=482), attending three different schools in East-Western Germany, completed a 260-item, purpose designed questionnaire[1]. All three schools were selected to ensure a representative sample of German youth by education and socio economic status. The questionnaire examined the following domains[2], with the use of validated measures, purpose designed items based on previous research and some open ended questions for each domain.

- Subjective perception of biopsychosocial health: This included items about habitual well-being (Dalbert, 1992); life-satisfaction (Hampel & Petermann, 2005; Ravens-Sieberer & Bullinger, 2000); level of sentiment (Dalbert, 1992); physical wellbeing (Ravens-Sieberer & Bullinger, 2000); future worries (Hampel & Petermann, 2005); and the number of health concerns or illnesses experienced by each participant.
-
- Personal health resources: The availability and nature of individual resources commonly examined in relation to coping and adjustment were examined. These included SOC (Braun-Lewensohn et. al, 2017); SE (Bandura, 1977) and HLOC (Rotter, 1989). These were examined using the short German version of the Sense of Coherence Scale (Singer

[1] The survey included students in the three different school levels in East-Western Germany. In Germany there are three main kinds of general schools and degrees: The basic Secondary School (Hauptschule) leads to the Certificate of Compulsory Education (Hauptschulabschluss) after five years (nine including primary school). This track typically prepares young people usually for vocational education. In most Case is complete by age 15. The Middle Secondary School (Realschule) provides a Certificate of higher status after six years (ten in total). Approximate age of completing is 16 years. The Grammer School (Gymnasium) provides a qualification (Abitur) giving access to higher education after nine (thirteen in total) years. This diploma from German secondary school allows for university admission or matriculation and university-entrance diploma (Abitur) prepares young people for university education. This is complete by 18 or 19 years.

[2] Dimensionality reduction and quality of domains in the questionnaire were analysed by using PCA.

& Brähler 2007), Self-Efficacy Questionnaire (Beierlein, Kovaleva, Kemper & Rammstedt, 2012), and Health Locus of Control scale (Roth, 2012) as standardised validated scales. Social health resources were also examined in relation to friends, family and school supports.

-

- Health beliefs: The domains of: health related communication; health participation; body awareness (Roth, 2012); health behaviours and subjective health theories were examined (Faltermaier, 2015). These were assessed with the use of questions adapted from prior studies examining the same variables (e.g. Faltermaier, 2015; Faltermaier & Brütt, 2013; Flick, 2003; Leventhal el al., 2012; Nordlohne & Kolip, 1994). Open ended questions included: 'For me, health means...', 'I'm feeling healthy, if I…', 'For me, ill-health means …', 'I'm feeling sick, if I …' (Nordlohne & Kolip, 1994).

The data was cleaned and from data about the subjective perception of biopsychosocial health, a six component Model of Biopsychosocial Health (BMH) emerged by using PCA (Figure 1). This comprised 6 domains including subjective wellbeing, life satisfaction, physical disease, sentiment, physical wellbeing and future worries which explained 60.2% (R^2 0.602) of variance in subjectively reported health.

- [Insert Figure 1 here].

The impact of personal and social health resources on MBH, and health perceptions and beliefs on health ressources were examined. This analysis was undertaken with the use of multiple regression analysis.

-

Based on the MBH cluster analysis was applied to the Phase 1 data. Three typologies emerged which differed significantly ($p>0.001$) from each other, based on perceptions of bio-opsychosocial health. These classified the participants into those considered healthy (n=176), of average health (n=101) and unhealthy (n=117). This informed Phase 2 to more thoroughly understand how youth within each typology manage health challenges they face, their subjective perceptions of health, the availability of personal health resources and their health beliefs.

1. [Insert Figure 2 here].

In phase 2, three focus groups were conducted with participants from each typology who participated in Phase 1. These participants were now (2015) aged 17-18 years old, and were from one of the schools participating in Phase 1. This school was chosen because it ensured a high comparison in typology. The representation of all three schools within Phase 1 ensured a representative sample of youth which informed the identification of the three health typologies. Including one school in Phase 2 was therefore considered adequate to more thoroughly explore the factors associated with perception of health for each typology. Each focus group comprised 3-4 participants who were identified to fit one of three typologies. The use of homogenous focus groups with members of each type was based on the assumption of commonality connecting participants of each type and differentiating them from members of the other types (Bohnsack 2014). This method enabled a reconstruction of similarities and differences among the three typologies referring to their subjective perceptions of health, health resources and health beliefs. Focus group discussions involved the use of one narrative impulse question 'Are you living healthily?' followed by emerging questions that arose throughout the interview process. The data from each focus group was subject to qualitative content analysis (Schreier, 2012) to further explore the characteristics associated with each typology.

Results

Phase 1

The majority of participating students in phase 1 represent a middle class socioeconomic background.

Using principle content analysis applied to Phase 1 data, the six component MBH emerged resulted (Figure 1). Additionally, results of multiple regression analysis, examining the impact of personal health recourses on the six-components of the MBH. Data illustrated that SOC, SE and HLOC, significantly impact wellbeing, state of health and the number of illnesses experienced by participants. Almost 30% of variance in subjective habitual wellbeing (R^2 0.3) could be explained by these variables.

- [Insert Figure 3].

This illustrates that the extent to which participants feel a "pervasive, enduring though dynamic, feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected" (Antonovsky 1979) significant effects biopsychosocial health. Even the number of illnesses reported was influenced by the level SOC. In a weaker but still significant way, HLOC and SE also impacted habitual and physical well-being.

In addition, perception of health significantly impacted on personal health resources (Figure 4).

- [Insert Figure 4].

Body awareness and the belief that health can be promoted by preventive strategies including healthy eating and physical activity, explained 25% of the variance (R^2 0.25) in HLOC. The multivariate model of believing a) health relates to subjective wellbeing (feeling good, being happy…) b) can be promoted by preventive strategies and c.) is an aspect of life young people feel able to talk about and can participate in, explained 14% of variance (R^2 0.14) in SE and SOC. This illustrates that how young people engage in health-promoting behaviours, feel involved in health-related decision making process and associate health with wellbeing

(health definitions) impacts on the availability of personal resources for maintaining health in everyday lives. In total, participants defined health ("what health means to me") using an average of 1.3 categories. Definitions of health included health in absence of disease (25% girls; 30% boys), relating to well-being (31% girls; 28% boys), associated with performance in school, sports or other everyday activities (10% girls; 15% boys) and being associated with behavioural aspects like healthy eating (31% girls; 25% boys).

On the basis of these findings, cluster analysis was applied to identify three health typologies divided by the MBH. Type 1 members reported the highest level of health (n=176). Type 2 members represented those with average self-reported health (n=101). Type 3 represented those with the lowest level of health (n=117). Table 1 illustrates the scores across domains of the MBH by typology.

- [Insert Table 1 and 2].

Over all, type 1 members were not only the most optimistic in assessing their health but also reported the highest SOC, SE, and HLOC. However, the three typologies did not significant differ by the number of illnesses reported. Moreover, type 3 participants reported more life-satisfaction compared to type 2 participants.

Phase 2

Phase 2 sought to further examine the health perceptions, resources and beliefs associated with each typology. Results demonstrate that each typology demonstrated specific conceptualizations of health and health beliefs and behaviours. This data was subject to qualitative content analysis. These results are discussed by typology and summarised in Table 3.

[Insert Table 3]

Type 1: Functional-performance orientation

Type 1 members defined health in a functional, medical or somatic way associated with having a functional impairment, the need to consult a doctor or having objective symptoms

(e.g. fever). These participants reported the highest wellbeing, life satisfaction, sentiment scores, lowest levels of future worry (Table 1) and highest SOC, SE and internal HLOC values (Table 2). While the objective levels of illness between the typologies did not differ significantly (see Table 1), by trend, they reported moderate levels. The content associated with this typology focussed mainly on health as categorised by functional performance in the context of participants' everyday lives. For this group, ill-health was recognized as something that reduces quality of life and impacts on daily functioning (e.g. school attendance). Having control over one's life, function, the physical body and physical performance was considered to be a priority.

'Well health for me is related to keeping control over my body, because if you are ill or you can't control your body anymore... if you lose control over your body, it makes you feel bad too' (P1)

These participants also described past physical health impairments, consultations with doctors and specific aspects of German healthcare system including differences between private and public health insurance.

'What else comes in my mind about health is, I have been to the doctor recently because I am ill and am not getting well again' (P2)
'I don't go often to the doctor and for this reason I don't have a doctor' (P3)
'Normally I never consult a doctor, but this stomach ache has lasted for a year now…I have been to the doctor often… but she didn't find anything…'(P2)

These participants rarely focussed on health in everyday life unless they were experiencing a physical problem or functional impact. The interplay between physical and psychosocial health was not well recognised and psychological health was not prioritised. P2 talks about long-term stomach ache that her doctor suggests may be associated with school related stress or depressive symptomatology, rather than a physical cause, but P2 dismisses this possibility.

'I often feel above average well and my doctor would like to tell me that I am depressed? Well, I think I can't always explain my problems so well (laughing)' (P2).

Within this typology, the responsibility to maintain health was placed both on medical professionals as well as themselves. These results likely relate to the high availability of personal resources including a high SOC, SE and HLOC, offering them security in terms of managing currenet health and any future health concerns that may arise. This was also reflected in an apparent high level of health literacy also identified for this group as they spoke openly, demonstrating good understanding about physical health and the healthcare system.

Type 2: Balance-aware orientation

The participants in the Type 2 cohort reported moderate wellbeing, sentiment scores, levels of future worry (Table 1) and moderate levels of SOC, SE and internal HLOC s (Table 2). While the objective levels of illness or disease between the typologies did not differ significantly (see Table 1), by trend, they reported the lowest levels. However, interestingly, they also reported the lowest levels of life-satisfaction. This typology considered both physical and psychosocial components of health and well recognised the role of health in everyday life. In contrast to Type 1, these participants appeared to be more aware about the importance of maintaining biopsychosocial health, rather than focused on physical function or performance alone. They also had greater awareness of attaining a balance involving physical care, social care and connection with others.

'Well living healthily for me means to get enough sleep and time off from school to be able to do sport and meet friends, so that I can really forget about this pressure to perform' (P5)

'Well maybe because I'm doing physically really well, I'm more focussed on my mental health, especially because you always hear in the media about students' burnout and I really want to avoid that for myself somehow' (P6)

These participants managed holistic health by consciously removing stressors. Specifically, they would more readily leave work, school or home, taking no tasks or material dependencies (e.g. *mobile phone*) and make more use of quiet spaces and nature to balance health and well-being, restore and have fun (e.g. jogging outside, swimming, or playing sport). These participants reported high levels of reflection which, coupled with their holistic perspectives about health, promotes physical and psychosocial health in everyday life. The low life satisfaction scores reported by this cohort may reflect greater reflexivity and a more critical approach to health and life as well as heightened awareness of the multifactorial nature of health. Alternatively this may be the result of experiencing more health challenges. These explanations however, require exploration in further research.

Type 3: Reactively-compensate orientation

These participants reported the lowest levels of wellbeing, sentiment, highest levels of future worry (Table 1). They also reported the lowest SOC, SE and internal HLOC values (Table 2). While the objective levels of illness between the typologies did not differ significantly (Table 1), by trend, these participants reported the highest levels. However, they also reported moderate life-satisfaction. Qualitative analysis associated with this typology illustrated that health was not a priority and that young people did not think about, nor discuss health as long as they felt well. Whereas all participants in Type 1 and 2 typologies discussed health, Type 3 participants focussed more on other factors associated with everyday life, only mentioning concepts associated with health that related to daily life, including nutrition and sport. Moreover, they reported fewer preventative health strategies compared to Type 1 and 2 participants.

'Today's youth {laughing}, are not able to say anything about health' (P8)

These respondents rather talked more about everyday concerns and current leisure topics. Health came second to maintaining wellbeing and auxiliary benefits. For example, good nutrition was discussed by one participant in the context of attaining the *'perfect bikini figure' (P7)* rather than being associated with general health. In relation to health risks in the context of everyday life, these participants reported optimism.

> *'If your friends or if anyone else suddenly goes into the hospital then you start thinking about that, like ey, what would happen if… But at some point you forget about it again' (P9).*

The increased focus of this cohort on everyday life and concerns rather than health may reflect low prior exposure to ill-health or engagement with, or understanding of, the health system. Alternatively, it may reflect the priorities of these young people.

Discussion

The mixed-methods design provided a broad insight into participant's life- and health worlds. The results demonstrate a complex interplay between subjective perceptions of health, health behaviour, personal health resources and health beliefs. These findings demonstrate three specific health typologies among young people that define the health status, available personal resources and health perceptions of youth in the German context. Type 1 participants, with a functional-performance orientation, demonstrated the highest levels of health, and life satisfaction, lowest levels of future worry and greatest availability of personal resources relating to SOC, SE and internal HLOC. This cohort focused largely on health as it related to maintaining functional performance in the context of everyday life. These results likely relate to the high availability of personal resources for these young people, offering security in terms of managing health and any future health concerns that may arise. This was also reflected in an apparent high level of health literacy. In contrast, Type 2 participants with a balance-aware orientation reported average health, sentiment, future worry scores and moderate availability

of personal resources. They also focussed more on holistic health, describing the balance between physical, mental and social health and wellbeing. Interestingly, this cohort reported the lowest life satisfaction scores. This may be related to greater reflexivity or experiencing more health challenges. Type 3 reported the lowest levels of health, and sentiment, highest levels of future worry and lowest levels of personal resources. However, they also reported moderate life-satisfaction. This cohort also focussed more on everyday life and concerns, with health coming secondary to general wellbeing. This may reflect low prior exposure to ill-health or the priorities of these young people.

Together these results specifically highlight the importance of personal resources including SOC, SE and internal LOC in determining the subjective experience of health for young people. Conversely, they also demonstrate the impact of health perceptions on personal health resources. This has significant implications for youth health practice. Specifically, the importance of targeted assessment in youth health social work is evident, to understand the nature, availability and strength of personal resources for young people and identify both strengths in this domain and opportunities to support and strengthen available resources through education or targeted intervention. This provides additional opportunity to tailor interventions to promote the availability and use of these personal resources to support young people to achieve their best developmental and health outcomes.

While the importance of supporting self-management in relation to youth health has long been recognised, and health promotion approaches have been deemed important, this research highlights the specific need to understand the lifeworld of young people to address and support the availability of personal resources in work with young people to foster health in a way that extends beyond self-management and highlights the importance of an environmental health promotion approach. This means to promote an environment, where young people can achieve the best health. Are school structures healthy? Do youth get enough time off from school?

What is challenging them day in and day out, and how does it impact their health? To achieve this in practice health-related agency must be fostered through developmentally-tailored approaches to health promotion that take a holistic lifeworld approach (Rademaker & Liel, 2018). A lifeworld oriented approach in the context of youth health may therefore enable a comprehensive understanding of the subjective experience of young people and of their available personal health resources and beliefs. This is necessary to understand how health is shaped by the social context and moreover how health shapes the opportunities of young people to participate in a full and meaningful life.

The concept of *agency* is central to health promotion practice in social work. It is defined as 'the capacity of human beings to shape the circumstances in which they live' (Emirbayer & Mische 1998, Otto, Scherr & Ziegler 2013). Youth must be understood to be capable actors and constructors of their own life (Rademaker, 2018; Rademaker & Liel, 2018). Understanding and fostering agency necessitates a partnership approach to practice between the individual client and social worker, where the client is understood to be to the expert in the context of their life (Grunwald & Thiersch, 2009). In practice with young people, this requires engaging in meaningful youth participation and partnership (Patton et al., 2016; Zeldin et al. 2009). These tenets are core foundations of social work practice (Thiersch & Obert, 2015). However, they are not consistently applied in practice across settings, nor within the systems with which young people interact. In fact, many of these systems retain a paternalistic approach to care that reinforces power imbalance between the system, professional and young person, that reinforces the marginalisation of young people and the youth voice (Lightfoot & Slopper, 2002; Patton et al., 2016; Thiersch & Obert, 2015). Complacency in practice and assumptions about young people can also hinder meaningful engagement and outcomes if the specific lifeworld and subjective experience of the individual young person is not at the centre of the interaction

and care (Thiersch & Obert, 2015). Support from this approach comes from increasing recognition that young people deserve the right to participate all in decisions about their life, including in relation to shaping healthcare, systems and policy (Institute of Medicine, IOM, 2015; Lightfoot & Slopper, 2002; Patton et al., 2016; Sawyer et al., 2012; United Nations, 2007). Youth participation is also now recognised to lead to the best developmental and health outcomes (Patton et al., 2016; United Nations, 2007; Zeldin et al. 2009). There is also strong evidence that youth benefit when they actively contribute to health promotion as they gain a stronger sense of agency, belonging and connection to their communities, develop personal and civic competencies, show lower levels of risk taking behaviour and improved mental health (Zeldin et al., 2009). As the goal of social work in youth health is to support both normative development and health, social workers are in a key position to advocate for youth focused, lifeworld approaches to health promotion that prioritise meaningful participation and in fact have a responsibility to do so with other professions and within the range of systems that young people interact.

The strengths of this study relate to the in-depth exploration of the health of young people within the German context and within the broadest cross-section of society, examining these factors in school attending young people, rather than solely those with complex or chronic health conditions. This lends strength to the broad applicability of these findings. However, the low numbers of participants within the focus groups may limits the generalisability of the findings and the relevance of these outcomes therefore require exploration in future research. Additionally, investigating the nature of the relationship between health resources and young people's health also requires exploration in future research. Specifically, how the presence of these resources contributes to health outcomes over the life course and health beliefs and behaviours. This would further assist in tailored interventions to support health in youth health social work practice. Future work evaluating the implementation of a lifeworld oriented approach within

social work practice and, indeed, across professional domains would further strengthen understanding about the most effective approaches to youth focussed practice

Conclusion

This research illustrates value in a lifeworld oriented approach to health promotion in the context of youth health. To promote the best developmental and health outcomes for young people, youth must be understood to be experts in the context of their lives in order to truly fulfill their health potential. Additionally, a comprehensive understanding of the subjective individual experience of young people's lifeworld including their health, availability and use of personal health resources and structural life circumstances relating to developmental, social and structural health system factors, is required. To fulfil this, a partnership approach to practice between young people and social workers is essential for health promotion. This is necessary to inform intervention and understand how the health of young people is shaped by the social context and moreover how health shapes the opportunities of young people to participate in a full and meaningful life that they have reason to value. The social work role has a key part to play in advocating for this approach to be implemented within the systems with which young people interact, to overcome historical marginalisation and ensure meaningful partnership with young people as experts in their life and care.

References

Antonovsky, A. (1987). *Unravelling the Mystery of Health: How People Manage Stress and Stay Well.* San Francisco, Jossey-Bass.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191–215.

Beierlein, C., Kovaleva, A., Kemper, C. J., & Rammstedt, B. (2012). Ein Messinstrument zur Erfassung subjektiver Kompetenzerwartungen. Allgemeine Selbstwirksamkeit Kurzskala (ASKU). *Leibnitz Institut, GESIS-Working Papers*, Nr. 17/2012.

Bohnsack, R. (2014). *Rekonstruktive Sozialforschung. Einführung in qualitative Methoden.* Opladen & Toronto: Verlag Barbara Budrich.

Braun-Lewensohn, O., Idan, O., Lindstro, B., & Margalit, M. (2017). Salutogenesis: Sense of coherence in adolescence. In M. B. Mittelmark, S. Sagy, M. Eriksson, G. F. Bauer, J. M. Pelikan, B. Lindström, & G. Arild. (Eds.). *The Handbook of Salutogenesis*. Switzerland: Springer International Publishing.

Coles, B. (2000). *Joined Up Youth Research, Policy and Practice.* Leicester: Youth Work Press.

Dalbert, C. (1992). HSWBS. Habituelle subjektive Wohlbefindensskala. Glöckner-Rist, A. (Eds.). *Zusammenstellung Sozialwissenschaftlicher Items und Skalen*. Bonn: GESIS.

Emirbayer, M., & Mische, A. (1998). What is agency? *The American Journal of Sociology, 103*(4), 962-1023.

Emirbayer, M., & Mische, A. (2017). Was ist agency? In H. Löwenstein, & M. Emirbayer. (Eds.). *Netzwerke, Kultur und Agency. Problemlösungen in Relationaler Methodologie und Sozialtheorie.* Weinheim und Basel: Beltz Juventa.

Faltermaier, T. (2015). Subjektive Gesundheit: Alltagskonzepte von Gesundheit. Bundeszentrale für gesundheitliche Aufklärung (Eds.): *Leitbegriffe der Gesundheitsförderung. Berlin.*

Faltermaier, T., & Brütt, A. L. (2013). Gesundheits- und Krankheitsvorstellungen: Bedeutung für Forschung und Praxis. In H. W. Hoefe, & E. Brähler (Eds.). *Krankheitsvorstellungen von Patienten. Herausforderungen für Medizin und Psychotherapie.* Lengerich: Pabst Science Publishers.

Flick, U. (2003). Editorial health concepts in different contexts. *Journal of Health Psychology, 8*(5), 483–484.

Gates, M. (2016). Advancing the adolescent health agenda. *Lancet, 387*(1), 2358-2359.

Grunwald, K., & Thiersch, H. (2009). The concept of the lifeworld orientation in social work and social care. *Journal of Social Work Practice. 9*(2), 131–146.

Hampel, P., & Petermann, F. (2005). *Screening Psychischer Störungen im Jugendalter (SPS-J).* Deutschsprachige Adaption des Reynolds Adolescent Adjustment Screening Inventrory. Hogrefe Verlag GmbH & Co KG: Göttingen.

Hurrelmann, K., & Richter, M. (2016). Life course influences on health and health inequalities: A socialisation perspective. *ZSE Zeitschrift für Soziologie der Erziehung und Sozialisation*. *36*(3), 264-281.

Hutchison, J. S. (2015). Anti-oppressive practice and reflexive lifeworld-led approaches to care: A framework for teaching nurses about social justice. *Nursing Research and Practice, 5*(1), 1-5.

Institute of Medicine. (2015). *Definition of Patient Centred Care.* Retrieved online from: http://www.oneviewhealthcare.com/the-eight-principles-of-patient-centered-care/.

Leventhal, H., Bodnar-Deren, S., Breland, J. Y., Hash-Converse, J., & Philips, L. A. (2012). *Modelling Health and Illness Behavior: Handbook of Health Psychology* (2nd ed.). New York: Psychology Press.

Lightfoot, J., & Slooper, P. (2002). *Having a Say in Health: Guidelines for Involving Young Patients in Health Services Development.* York: SPRU.

MacDonald, R., & Shildrick, T. (2013). Youth and wellbeing: experiencing bereavement and ill health in marginalised young people's transitions. *Sociology of Health & Illness, 35*(1), 147–161.

Mittelmark, M.B. & Bauer, G. F. (2017). The Meanings of Salutogenesis. In M. B. Mittelmark, S. Sagy, M. Eriksson, G. F. Bauer, J. M. Pelikan, B. Lindström, & G. Arild. (Eds.). *The Handbook of Salutogenesis*. Switzerland: Springer International Publishing.

Nordlohne, E. & Kolip, P. (1994). Gesundheits- und Krankheitskonzepte 14- bis 17jähriger Jugendlicher: Ergebnisse einer repräsentativen Jugendbefragung. In P. Kolip (Hrsg.), *Lebenslust und Wohlbefinden. Beiträge zur geschlechtsspezifischen Jugendgesundheitsforschung* (S. 121-138). Weinheim: Juventa.

Otto, H. U., Scherr, A., & Ziegler, H. (2013). On the normative foundation of social welfare-capabilities as a yardstick for critical social work. In H. U. Otto, H.U., & H. Ziegler. (Eds.). *Enhancing Capabilities. The Role of Social Institutions.* Opladen, Berlin, Toronto: Barbara Budrich Publishers.

Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B., Arora, M., Azzopardi, P… & Viner, R. M. (2016). Our future: A Lancet commission on adolescent health and wellbeing. *Lancet, 387*(10036)*,* 2423-2478.

Rademaker, A. L. (2018). *Agency und Gesundheit in Jugendlichen Lebenswelten. Herausforderungen für die Soziale Arbeit.* Weinheim und München: Beltz Juventa Verlag.

Rademaker, A.L., & Liel, K. (2018). New paradigms in German health promotion: Challenges for social work. *ERIS Journal, English edition of the Journal for Czech and Slovak Social Work*, *18*(4). 45-61.

Ravens-Sieberer, U., & Bullinger, M. (2000). *KINDL-R. Fragebogen zur Erfassung der Gesundheitsbezogenen Lebensqualität bei Kindern und Jugendlichen.* Revidierte Form: Jugendversion.

Robert-Koch-Institut (RKI). (2013). D*ie Gesundheit von Kindern und Jugendlichen in Deutschland 2013*. Berlin. http://www.kiggs-studie.de/deutsch/ergebnisse/kiggs-welle-1/ergebnisbroschuere.html (02.02.2019).

Roth, M. (2012). Fragebogen zur Körpererfahrung für Jugendliche. In A. Glöckner-Rist. (Ed.). *Zusammenstellung Sozialwissenschaftlicher Items und Skalen.* Bonn: GESIS.

Rotter, J. B. (1989). Internal versus external control of reinforcement. A case history of a variable. *American Psychologist, 45*(4), 489-493.

Sawyer, S. M., Afifi, R. A., Bearinger, L. H., Blakemore, S. J., Dick, B., Ezeh, A. C., Patton, G. C. (2012). Adolescence: A foundation for future health. *Lancet, 379,* 1630-1640.

Sawyer, S. M. & Patton, G. (2011). Why adolescent health matters, *Health, 1*(1), 110-127.

Schreier, M. (2012). *Qualitative Content Analysis in Practice.* London, Thousand Oaks, New Delhi, Singapore: SAGE Publications.

Schütz, A. (1971). *Gesammelte Aufsätze, Bd. 1: Das Problem der sozialen Wirklichkeit.* Den Haag.

Singer, S., & Brähler, E. (2007). *Die Sense of Coherence Scale: Testhandbuch zur Deutschen Version.* Göttingen: Vandenhoeck & Ruprecht GmbH & Co. KG.

United Nations. (2007). *World Youth Report: Young People's Transition to Adulthood.* New York: United Nations.

Williams, D.R., Costa, M.V., Odunlami, A.O., & Mohammed, S.A. (2008). Moving upstream: how interventions that address the social determinants of health can improve health and reduce disparities. *Journal of Public Health Management Practice, 14*, 8–17.

Williams, S. (1998). Health as moral performance: Ritual, transgression and taboo. *Health*, *2*(4), 435–457.

World Health Organisation (WHO). (1986). *Ottawa-Charta for Health Promotion.* Geneva: World Health Organisation.

World Health Organization (WHO). (2011). *Soziale Determinanten der Gesundheit und des Wohlbefindens junger Menschen. Zentrale Ergebnisse der Studie „Gesundheitsverhalten von Kindern im schulpflichtigen Alter (Health Behaviour in School-aged Children – HBSC).* Internationaler Bericht über die Befragung 2009/2010. Link: http://www.euro.who.int/__data/assets/pdf_file/0008/163790/Key-Findings-German.pdf

World Health Organization (WHO). (2017). *Comission of the Social Determinants of Health. Key Concepts.* Geneva: World Health Organisation.

Zeldin, S., Petrokubi, J., Collura, J., Camino, L., & Skolaski, J. (2009). *Strengthening Communities through Youth Participation: Lessons Learned from the ACT for Youth Initiative.* Ithaca, New York: ACT for Youth Center of Excellence.

Tables

Table 1: Typologies and Domains of the Model of Biopsychosocial Health

	Habitual Wellbe-ing*	Life Satis-faction*	Diseases	Level of Sentiment*	Physical Wellbe-ing*	Future Worries*
Type 1 (n=176)	3.75	3.52	4.00	3.06	3.13	1.61
Type 2 (n=101)	3.28	2.46	3.81	2.50	2.76	1.70
Type 3 (n=117)	2.93	2.96	4.51	2.43	2.23	2.32
Total (n=394)	3.38	3.08	4.10	2.73	2.77	1.84

* differences across all typologies are significant p>0.001

Table 2: Typologies and Level of Personal Health Resources

	SOC*	SE	Internal HLOC	External HLOC
Type 1 (n=175)	2.96	3.20	3.12	1.93
Type 2 (n=99)	2.69	2.97	3.06	1.93
Type 3 (n=116)	2.53	2.93	3.01	2.07
Total (n=390)	2.76	3.06	3.07	1.97

* differences across all typologies are significant p>0.001

Table 3: Typologies and Results by Qualitative Content Analysis

Type 1: Functional-Performance Orientation	Type 2: Balance-Aware Ori-entation	Type 3: Reactively-Compen-sate Orientation

• medical-somatic health beliefs • high priority in performance • maintaining health gets assigned to experts • broad interest in topics regarding health	• health as physical, psychological and social wellbeing • self-critical body awareness • preventive awareness • high priority in balance in everyday life	• health gets hardly perceived • youth-everyday topics are most relevant • less preventive strategies

Figures

Principal content analysis model of subjective biopsychosocial health (60.2%*; m=30)	(1) Subjective habitual wellbeing (18.7%*; m=10; n=427; α=0,891)
	(2) Life satisfaction (10.6%*; m=6; n=446; α=0,799)
	(3) Physical diseases (9.4%*; m=3; n=448; α=0,877)
	(4) Level of sentiment (9.2%*; m=4; n=448; α=0,774)
	(5) Physical wellbeing (6.3%*; m=4; n=450; α=0,603)
	(6) Future worries (6.0%*; m=3; n=452; α=0,534)

**explained variance within the correlation matrix in percentage*

Figure 1: Model of Biopsychosocial Health

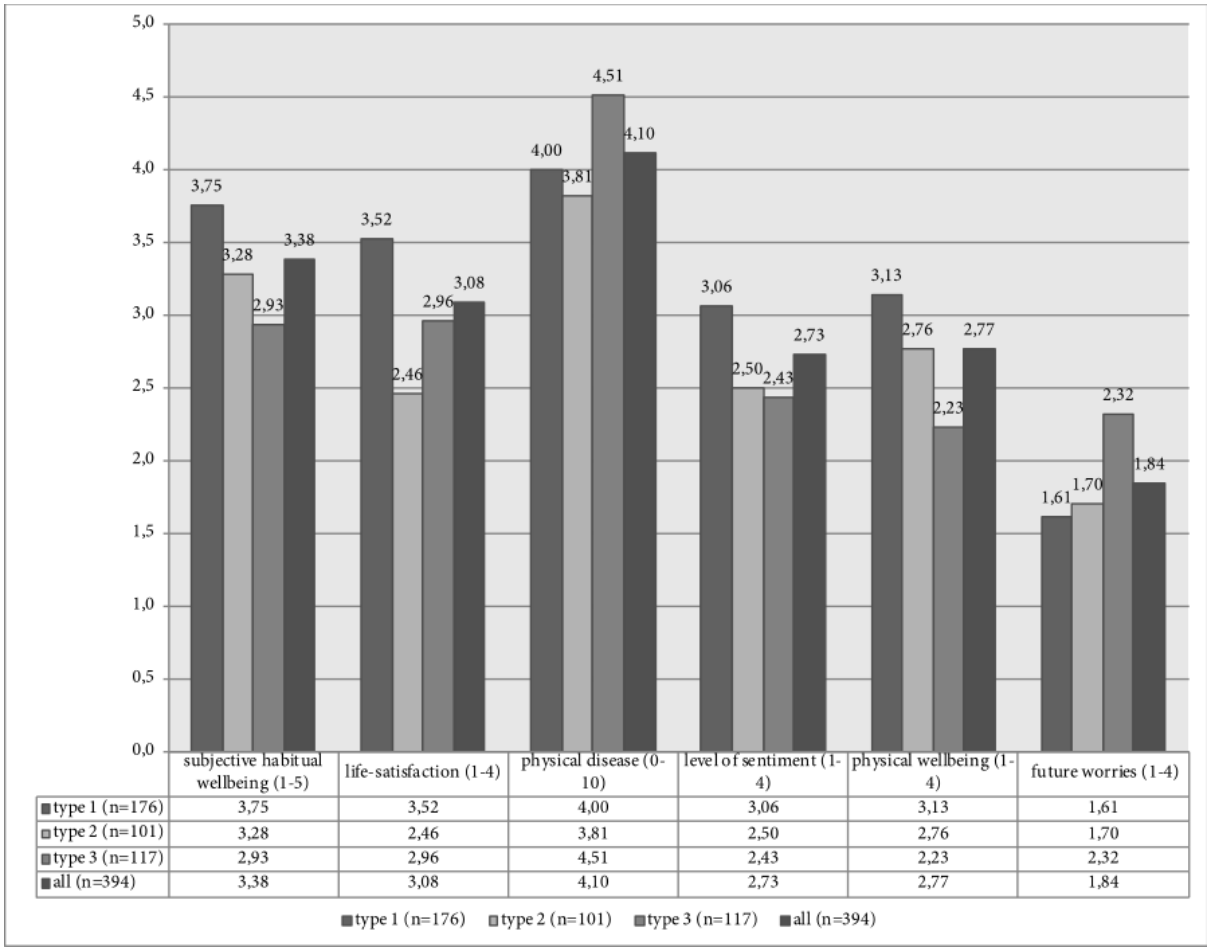

Figure 2: Phase 1 Cluster Analysis and Health Typologies based on the components identified within the Model of Biopsychosocial Health.

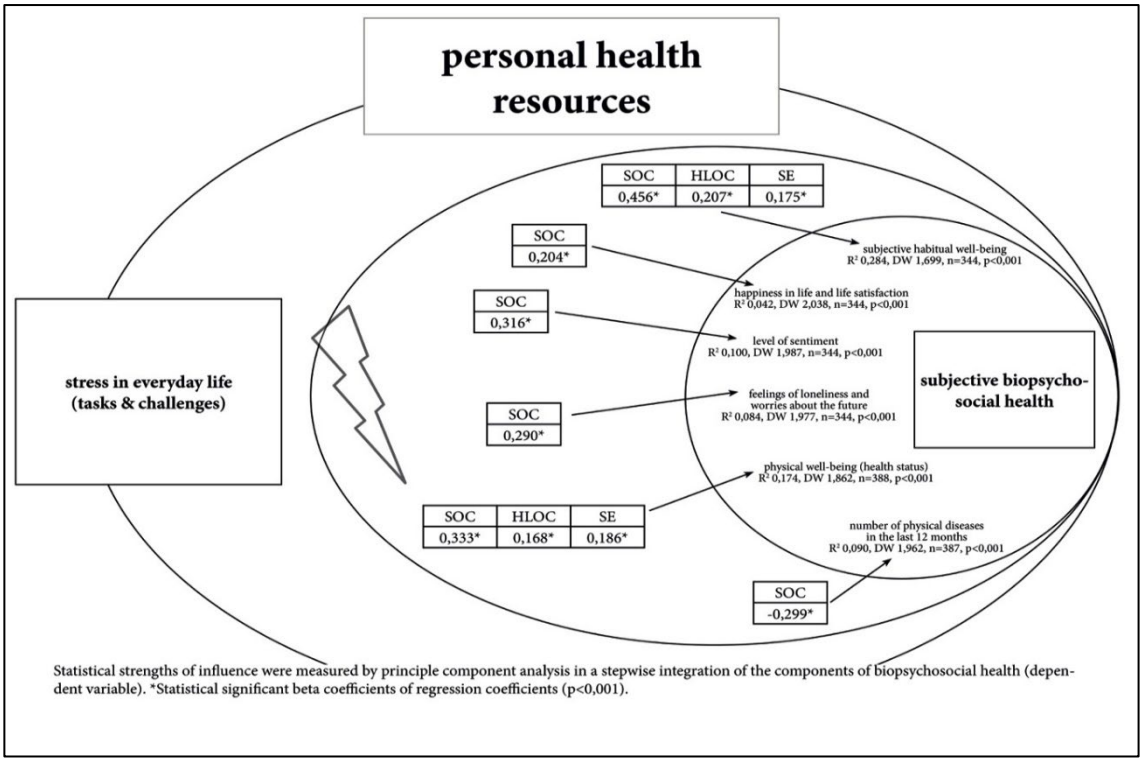

Figure 3: Personal Health Resources and Impact on Dimensions of the Model of Biopsychosocial Health.

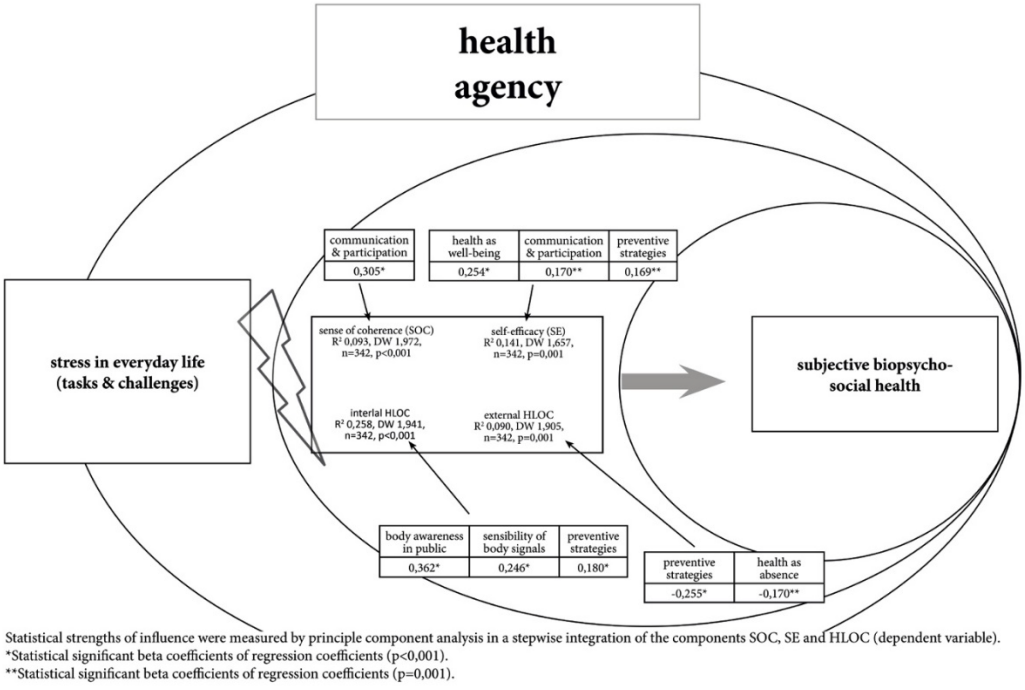

Figure 4: Impact of Preventive Strategies, Communication about Health Issues, Participation & Health Beliefs on Personal Health Resources.