

# The Social Health Process of Adolescents: A Grounded Theory Study

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## Research article

**Keywords:** Adolescent, Adolescent health, Social health, Grounded theory, Qualitative study

**Posted Date:** July 30th, 2020

**DOI:** <https://doi.org/10.21203/rs.3.rs-30123/v1>

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## Abstract

**Background:** The social health of adolescents is the main pivot of community health in the whole world. Understanding how the social health of adolescents is affected by socio-cultural context and individual factors is still equivocal, and the available data are limited. This study aimed to explore the process of forming social health in Iranian adolescents.

**Methods:** This grounded theory study has been conducted through purposive sampling and theoretical sampling on 47 adolescents (23 boys, 24 girls) and 19 key informants living in Mashhad, Iran. Data was collected through semi-structured in-depth interviews and group discussions. Data analysis was conducted using continuous comparison, open, axial, and selective coding based on the Corbin and Strauss's (2008) approach.

**Results:** In the process of forming social health in adolescents, five categories were extracted: 1) multi-layered social structure: from favorable to unfavorable, 2) facing with multifaceted role models, 3) contemplating and self-discovery, 4) trying to manage interactions, and 5) social presence: from being together to separating. The core category is "the paving the way for the realization of social identity" that connected to all extracted categories in this study.

**Conclusions:** social context needs to provide appropriate conditions to develop and promote social health among adolescents through supportive, happy, and safe environments. Also, adolescents need to apply effective individual, interpersonal, and collective strategies. The results also revealed that social identity plays a main role in forming the social health. These factors need to be considered by policymakers for designing and interventional programs.

## Background

Maintaining and promoting adolescent health is one of the aspects of health equity [1]. Success in promoting adolescent health provides the health of the present and future generations of countries and achieves the sustainable development goals [2]. Adolescents constitute about one-sixth of the world's population, which is 1.2 billion people [3]. Most of these adolescents live in developing countries [4]. Adolescents are often considered as healthy people, but many adolescents die due to physical, psychological, and social problems. These problems can inhibit achieving potential growth and development, and threaten not only their current health, but also their future health [5].

The increasing acceleration of globalization and social change introduces new needs in the field of adolescent health [1]. The rapid economic and social changes that are currently made on the lifestyle of young people in the world, especially developing countries [4, 6], have affected the health-related behaviors and the health status of adolescents in different dimensions [7, 8], as well as development and formation of adolescent identity [9]. These variations have led to a considerable increase in psychological, behavioral, and social problems and the prevalence of various social pathologies among young people, so that the situation of some has been worried [10, 11].

Adolescent health is highly dependent on positive perceptions of school, quality of relationships with parents, and peers [12]. and as a health determinant environment affecting adolescent health [13]. Many aspects of social life, family factors such as process of incomplete socialization in the family, generation gap between children and parents, socio-economic status of the family, lack of faith in the norms of society, poor and inefficient family relationships, school, and the mass media are the causes of these problems [14-17]. The key role of adults, physical, financial, informational, supportive environments have been identified in supporting adolescents to maintain their health [18]. One of the important issues in adolescent health, including their social health, is attention to the role of contexts and social conditions on it [19].

The concept of health and its dimensions in any community depends on the perception of individuals and the culture of that community [20]. Social health is a concept that forms in the context of the community and in the relationships between social networks [21]. Social health is the perception and experience of individuals from social conditions and the level of their successful responses to social functions [22].

### **Rationale of the study**

According to the literature review, many researchers are studied the social status and demographic factors of social health in a quantitative method [23, 24]. Although these studies provide much information about the social health of young people in their communities, they limit deep understanding of factors behind social health among adolescents. This study is the first qualitative exploratory research to achieve an in-depth understanding of the process of social health based on adolescents' unique experiences to find a realistic solution and program for policy-making and implementation of interventions for promoting the social health of adolescents.

### **Research question**

How is the process of adolescent's social health?

## **Methods**

### **Research design**

This study employed grounded theory approach to describe the experiences of adolescents and to obtain the knowledge on context of social health of adolescents. The use of qualitative study helps the deeper perception a process and various aspects of phenomena as a unique experience [25].

### **Study setting**

The field of data collection was the natural places of daily life of adolescents in Mashhad, Iran. This city is one of the largest cities in Iran with different races and highest socio-cultural differences. The key adolescents and adults with different conditions (sex, age, lifestyle, values, customs, and ethnicity, place

of residence) were chosen from different places in the city. Including schools, municipality cultural centers, parks, and other places of the presence of adolescents.

## **Study participants**

Participants in this study were 47 adolescents (24 girls and 23 boys). Furthermore, other adults ( $N = 19$ ) who were related to the studied phenomenon (social health of adolescents) who could help enrich the data resulting from the experience of participants were included through theoretical sampling from different places.

## **Sample and sampling**

Initially, a purposive sampling framework was used to achieve a wide range of experiences and reach the maximum variability in the data. Then, the selection of participants was continued through theoretical sampling during the study. The adequacy of the sample size was based on the data saturation and completion of the theory extracted from the study.

## **Eligibility criteria**

In this study, the inclusion criteria for adolescents were Iranian nationality, living with at least one parent, age range of 13-18 years old, fluency in Persian language, lack of psychological problems, desire to participate in the study, and ability to transfer experiences. The inclusion criteria for other people were desire to participate in the study, ability to transfer experiences, and experience of interaction with adolescents.

## **Data collection methods**

The data were collected via semi-structured in-depth interviews ( $n = 40$ ; adolescent = 21, Key informant = 19) and four focus group discussions (adolescent = 26, 5-6 adolescents in each group). A semi-structured interview guide was used for the interviews. During the study, the interview questions were changed. Interviews began with a general question, "How do you feel about your social health". This question was followed by other questions such as "You feel, what factors can affect your social health?" and "what are the situations that make you better/ worse feel about your social health?" Following these questions, exploratory questions, such as why, how, when, and who, were used for deep perception of experiences and feelings of adolescents.

Most of the interviews (25 out of 40) were carried out in the conference room or quiet rooms at schools. Fifteen interviews were performed in informal places such as mosques, parks, and cultural centers in different municipality districts. To conduct the interview, comfortable conditions, quiet place, and appropriate time were selected. The interviews lasted for 50-110 minutes. After the analysis of each interview, the next interview was conducted. The data collection continued until the data saturation; when no new concept was emerged (after 18 interviews), three semi-structured individual interviews were conducted with adolescent for assurance this.

Four-focus group (FG) were held after semi-structured individual interviews with adolescents. The group discussions were conducted with respect to the comments of participants in two schools for girls and two schools for boys. The number of participants in each group was between five and eight. In the group discussions, 14 participants were female adolescents and 12 were male. The time for group discussions lasted for 90 to 120 minutes. Each session of group discussions began with the introduction of participants, researcher, and secretary. Prior to the sessions, the written consent of the participants was obtained and the confidentiality of what was recorded was assured. In addition to the interview and group discussion, another method for data collection was field notes. During the study, the field notes were taken from real situations and the data were analyzed.

### **Establishing rigor of the study**

In the present study, several methods were employed to increase the quality of study. For the scientific accuracy and validity of the data, all the qualitative evaluation criteria of qualitative studies proposed by Guba and Lincoln [26] were used, including a long time was spent for data collection and analysis to achieve the in-depth perception of the phenomenon, all researchers were involved in the analysis process. The data collected from different places and groups that provided triangulation and maximum variation, the findings were also evaluated by two external researchers who were specialized. All research activities were maintained, such as memos on continuous comparison, field notes, coding and theoretical sampling. In addition, participants reviewed the data after the analysis. Finally, detailed explanations were recorded of the study methods and findings, along with participant quotes, to assist readers in deciding on transferability of the emerging theory of data.

### **Data analysis**

All interviews and group discussions were listened for several times. Then, they were transcribed and loaded in MAXQDA10 software. The text of each interview and group discussions was separately coded line by line and broken into semantic units based on their differences and similarities. Data collection and analysis were done concurrently alternately. The analysis began with open coding and continued with axial and selective coding based on Corbin and Strauss's (2008) method. In all analyze stages; the constant comparative method was used. In addition, from the beginning of coding, memos were written and identified conceptual relationship between codes, categories and themes. Finally, a conceptual framework developed.

## **Results**

Table 1 shows the demographic characteristics of the participants. In This study, five categories were extracted: 1) facing with multifaceted role models, 2) multi-layered social structure: from favorable to unfavorable, 3) contemplating and self-discovery, 4) trying to manage interactions, 5) Social presence: from being together to separating. The study results revealed that adolescents faced with concerning conditions in their social health process. This main concern resulting from social modeling led to the adoption of individual and interpersonal strategies including contemplating and self-discovery, and trying

to manage interactions. These strategies, in turn, provided social presence. The core category, "paving the way for the realization of social identity", covered and connected all categories extracted in this study (Fig. 1).

### **Themes 1: Facing with multifaceted role models**

Facing with multifaceted role models had a key role in the social health process. Adolescents seeking and assessing their social role models in each social environment for social role modelling. The following adolescent story demonstrate this social role modeling process in the family:

*"Well, Those who are our around are so important, for example, if my father is an addict or robber, there is 50% chance of becoming an addict, because we modeling their behaviors" (a 16-year-old boy).*

Beyond the family, adolescents encountered models of social role in the school, community, and the media, particularly the virtual space, each inducing various attitudes and behaviors.

*"When I see my friend's behaviors and he says of his experiences in cyberspace for me, so I want to have the same experiences. I become motivated to do the same things ..." (a 15-year-old girl).*

The adolescents said that this social role modeling was very difficult for them. The observation and perception of conflicting behaviors and attitudes led the adolescents to experience many challenges across different social environments.

*"I see all the behaviors of people in the community. When my teacher speaks to my friends in a bad way in the class, I do not react at that moment. Then, I ask myself if that teacher deserves to be a model for me?" (a 15-year-old girl).*

Another participant said:

*"My father is a judge and a lawyer. A very important man, who makes decisions for people, he has alcohol use and illegitimate relationships with women, while he put many people in jail for the same things. His behaviors make me confused" (a 13-year-old girl).*

A psychologist who worked at the school said: *"Most adolescents in our country face with many problems in developing their social health. Teachers, parents, and media don't have the same attitude and behavior to educate teenagers ..." (a 41-year-old female).*

### **Themes 2: Multi-layered social health context: from favorable to unfavorable**

When facing with multifaceted role models, most of adolescents experienced intervening conditions that played an important and wide role in the process of their social health and included individual characteristics: competencies and defections, family and community atmosphere: from favorable to unfavorable.

Individual characteristics and competencies were identified as a main intervening condition based on the participants' perceptions and experiences. One mother said about the weakness of his 14-year-old.

*"My son still has weak decisiveness. I can't let him go out with his friend. " (a 48-year-old female).*

One of the adolescents said:

*"We are from the same community ... Their life is also important for us. Just do not think to our self" (a 16-year-old female).*

Most adolescents pointed to the importance of comprehensive social support within the family and outside the family for their social health. One of the adolescents said:

*"... Our school appreciated the students who were active in the social activities. Well, my family supported me too. It was great because it gave me energy to improve my social activities more than before" (15-year-old girls).*

Quite the opposite, According to the experiences of a number of participants, the adolescents who lived in an unbalanced family atmosphere, perceived bad conditions in the atmosphere of society, and could not manage these conditions used strategies that did not have a good outcome for them:

*"My parents don't care about me. I feel that they have no interest in me. I have no interest in them either" (a 16-year-old boy).*

Another participant said:

*"When we have a peace and joyful atmosphere in the community, we are certainly healthier. It makes a good sense for us. It makes us reject other values, turn back to our own values in our culture" (a 14-year-old boy).*

### **Themes 3: Contemplating and self-discovery**

Understanding the conflicts and the internal and external challenges of facing with multifaceted role models led most adolescents contemplate and discover themselves by identifying their strengths and weaknesses, analyzing the conditions, and determining their goals of life.

*"I'm thinking a lot about myself, it is very effective to look at our self. It makes us understand ourselves, recover our goal ..." (a 15-year-old girl).*

By applying contemplation and self-discovery strategies, most participants intended to change in their feeling and actions that was a stimulating factor for entering the next stage of the process.

*"I try to make a wise decision. I believe that these wise decisions provide a better life and a in the community and in the future for me" (a 16-year-old girl).*

## **Themes 4: Trying to manage interactions**

The adolescents who intention to make change used different strategies for reducing their problems. These actions were interpersonal strategies including decision-making, resolving conflicts with parents, self-control, logical interaction with others, avoiding of extremism in behavior and compliance with perceived facts.

One participant who had eighteen years of teaching experience said:

*"In today's society, the adolescent must be able to control himself or herself to maintain and improve his or her social health" (a 43 years old male, teacher).*

Other participants said:

*"We learned from our parents the skills that were needed for secure social interaction. In fact, it is logical interactions with others" (a 16-year-old boy).*

Try to avoid extremism in behavior was another strategy to manage social interactions and reduce problems. Most of the adolescents believed that this action was a very important strategy.

*"I try to prevent going to extremes in behaviors, because I want to have a lot of friends and more communication to achieve a sense of peace I want ..." (a 14-year-old boy).*

## **Themes 5: Social presence: from being together to separating**

In the process of social health, social presence was identified as the major consequence of adolescent strategies. Internalization of social values, membership in groups, and participate in social activities were components of social presence.

One of the consequences of social health was internalization of social values. According to the most of the participant's experiences, internalizing social values brigs their social health for them. One of the adolescents said:

*"Community values are important to me; I follow the rules anywhere. I never behave contrary to the laws we have at family, at school and community... I'm also a member of this community ..." (a 16-year-old boy).*

Another consequence of adolescent's strategies was membership in groups.

*"I always take part in group entertainment organized by our teacher. I'm happy when we are together" (a 17-year-old girl).*

Most of the participants believed that participate in social activities brought a good sense about their social health:

*"I'm proud of myself for having so many social activities at school that it can provide a good sense for me" (a 18-year-old girl).*

In addition, Most of the participants believed that through grouping, they could have a better understanding of each other because they could see themselves in the mirror of other, come closer to them and feel better.

*"At this age, we like to be in our friend group, we have a good feel. Along with my friend, I have learned a lot about myself ..." (an 18-year-old boy).*

Quite the contrary, a number of participants who lived in an unbalanced family and perceived unfavorable community conditions felt disintegrated from being with others.

*"Becoming friends with someone who I felt loved me but saw that I was wrong, I was destroyed, I should not have trusted early" (a 16-year-old boy).*

## Discussion

This study aimed to explain the process of social health among Iranian adolescents. Our findings explain that this process is stimulated by facing the social role models in the family, school, media and society. The family and community atmosphere, and individual characteristics also affected it. This process involved strategies, such as contemplating and self-discovery, and trying to manage interactions. The consequence of these strategies was social presence: from being together to separating. Furthermore, paving the way for the realization of social identity" was core category in the present study. The following discusses each process component and its relationship to the core category.

Our findings indicate that adolescents dealt with many reference models in the society and media in addition to the family, which caused challenging conditions for them in the process of their social health. Randel et al. also highlighted that exposure and interaction with several social contexts, including family, school, peers, and others have a synergistic role on adolescent behavior and attitudes that affect their emotional and social experiences [27].

Dealing with perceived conflicts by sociable factors, such as school, family, and the media, can affect the behavior and attitudes of adolescents [28]. Conflicts between adolescents and their parents, which can be caused by collision of cultural, familial, and individual factors, contribute to the unhealthy behaviors of adolescents in society [29]. Researchers noted that adolescents live in the mutual interaction with family and others environment such as media, school, and masque that they have different socio-cultural effects on their development and psycho-social outcomes [30, 31]. It can be said that modernization has removed the protective framework of traditional society in socialization [32]. Expansion of modernization has gradually destroyed the traditional identity resources, which have been often from the family, and has lost its dominating power in providing meaning for the identity of actors [33].

It is also reported in another study that modeling from other, especially peers and media, has played an important role in the attempt for destructive behaviors in adolescents. In fact, the multiplication of sociable institutions, each of which having its own different and unique values, norms, and behavioral models, when there is a functional interference among them, can cause confusion and imbalance in identity-seeking of actors [34].

In this study, the balanced atmosphere in the family provides an easier and more appropriate role modeling condition for adolescents, with clarity of rules, balanced control and freedom, appropriate educational and counseling support, adherence to religious values and beliefs, and their proper transfer to children. In these conditions, participants felt less conflict followed by their interactions with others for their social health. According to socialization theories, positive parenting is associated with pro-social behaviors of children [35]. The intimate relationships between parents and children in the family and the similarity of social value between adolescents and their parents are associated with further internalization of family and social values such as help and respect for others. In fact, family acts as a filter in transition of social values to children [36].

Perception of social inequalities in the community was a main intervening factor for most participants in the present study, which increased their perceived challenges in facing with their social role modeling. The findings of a study showed that an unhealthy society, which has been described with no access to recreational facilities and equal opportunities, is an intervening role for the health of adolescents [20].

The individual characteristics of participants in this study was an intervening variable that affected the process of their social health. For example, in the present study, despair was identified as an intervening variable, which was considered as a threat in the social health process of adolescents. The role of these factors is also explained in another study [37].

The consequence of adolescent strategies was social from being together to separating. Most of the adolescent highlighted a being together with several component including the internalization of social values, membership in groups, and participate in social activities. Hogg et al. reported that the normative behaviors of individuals reflect the emergence of their social identity [38]. Taras et al. also revealed that values not only help configure individual and social identity but also play an important role in resolving the identity crisis [39].

The researcher indicated that social groups are important psychological resources that have a potential role to improve and maintain health and well-being [38, 40]. Similarity, in the social health model presented by Keys, participation is one of the components of one's social health [21]. According to the social identity approach to health, the sense of social identity provided by group membership provides benefits to one's health, called social cure. Because people share specific attitudes, and behaviors with this feeling, and get closer to each other [41].

Paving the way for the realization of social identity, core category of the social health process of adolescents were identified in this study. The scientific documents reported that social identity is one of

the psychological and social needs of all social actors and a prerequisite for social life. The social identity provides the possibility of stable and acceptable relationships with others, which is the basis of social life. Individuals cannot have a stable and acceptable relationship with each other without a social identity that is a framework for differentiation from others [42]. Evidence suggests that identification with social groups can preserve and promote the health and well-being of individuals. In fact, it is considered as a type of social care and treatment [43]. In addition, Identity development is a buffer for risky behavior in adolescents [44].

## **Strengths Of The Study**

This study had some strengths, such as performing research in a large city of Iran, which is a multicultural and multiethnic city and a suitable representative of various regions of the country. All interviews and focus group discussions conducted by one researcher who was directly involved in the study process. Also, The results of this study, which are the findings of interviews conducted specifically for this study, could be used as the fundamental data for future studies.

## **Limitation Of The Study**

One of the limitations of this study was the lack of presence in the family for writing field notes. To resolve this problem, the interview was conducted with parents and other family members in other places where parents were present, including schools, health centers, mosques, and municipal cultural centers. Another limitation of the study was the lack of desire of some adolescents to give their phone numbers for continuous communication during the study. To overcome this problem, it was decided to give the phone number one of the researchers to the participants for having a constant contact.

## **Future Research**

More qualitative studies should be conducted to explore the nature of the process of social health in different groups of societies.

## **Conclusions**

The conceptual model presented in this study revealed that social identity plays a central role in the formation of social health. The research findings highlighted that the social and cultural conditions of society included the availability of social support, security, justice, and happiness, are necessary in the social health of adolescents. The social health of adolescents requires policy-making and planning for the development of social identity by the educational institutions of society, in particular families, schools, and media, especially cyberspace. This study provided valuable results for health professionals to determine the factors affecting the process of social health for adolescent health promotion interventions.

## **Abbreviations**

Not applicable

## **Declarations**

### **Acknowledgments**

We acknowledge all the study participants for involving in this study, as well as professionals who helped us with their thoughtful notes and feedback on the study results.

### **Ethics approval and consent to participate**

The Ethics Committee of Iran University of Medical Sciences approved the study protocol with the approval number IR.MUI.REC. 1394.4.270. A letter was received from the Deputy of Research and Technology of Iran University of Medical Sciences to conduct the study. Informed consent was obtained from all participants including adolescents (interviews with adolescents depended on the consent of their parents), parents, and other key informants. The aim of the study was shared with the participants. The participants consented to the recording of their voices during interviews and focus groups. In addition, they were informed that they could be withdrawn at any step of the study.

### **Authors' contributions**

AT, MS, and MM have made substantial contributions to the design of the study. MM, AT and A-A A-F participated in the analysis of the data. MS and AT involved in writing and revising the manuscript were. All authors approved the final manuscript.

### **Funding**

Iran University of Medical Sciences supported this study as a doctoral thesis in all stages of design and implementation of the study with the registration number 27098.

### **Availability of data and materials**

The datasets analyzed during the current study are available from the corresponding author.

### **Consent for publication**

Not applicable

### **Competing interests**

The authors declared no conflicts of interest with respect to authorship and publication of this article.

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44. **Aditional files.**
45. **Aditional file 1:** Interview guide.
46. **Main Questions.**
47. How do you feel about your social health?.
48. Please explain the. behavior or feelings that reflect your social health.
49. In addition to these main questions, other questions are asked depending on the response of each participant during the interview and participants were asked to answer including.
50. Why is. this behavior or feeling important to your social health?.
51. How can these. behaviors and emotions that you said improve or deteriorate your social health?.
52. You feel. what factors can affect your social health?.
53. Who or. what are important to your social health. Why? How?.
54. What. did you do when you encountered this situation?.
55. What. happened after you encountered this feeling or behavior?.
56. Why is the. role of the family important to your social health? Why? How?.
57. Did you say. it is very important to be role models like others, friends, family members, teachers and family members? Why?.
58. How do the behavior. of friends, siblings, teachers, and parents affect your social health? Why? When will their behavior have a positive impact on your social health?.
59. Did you say. cyberspace plays an important role for your social health? Why? How?.
60. What did you. do when you encountered someone or something that threatened your social health in cyberspace? Why? Please explain more.
61. When did the behavior. of your role model have a negative impact on your social health? Why? How did you feel then? What would you do then? Please explain more.
62. What. is in the family that makes you feel better about social health? Why? When are they more important?.

63. What is it like at school. that makes you feel better about social health? Why? When are they more important?.
64. Did you say. parent support is important for your social health? Why? When is it more important? Please explain more.
65. What is in. the community that makes you feel better about social health? Why? When are they more important? How did you feel then? What would you do? Please explain more.
66. You said there are bad conditions in. your society that threaten your social health. What are they? Why? How did you feel at that time? What would you do? Please explain more.

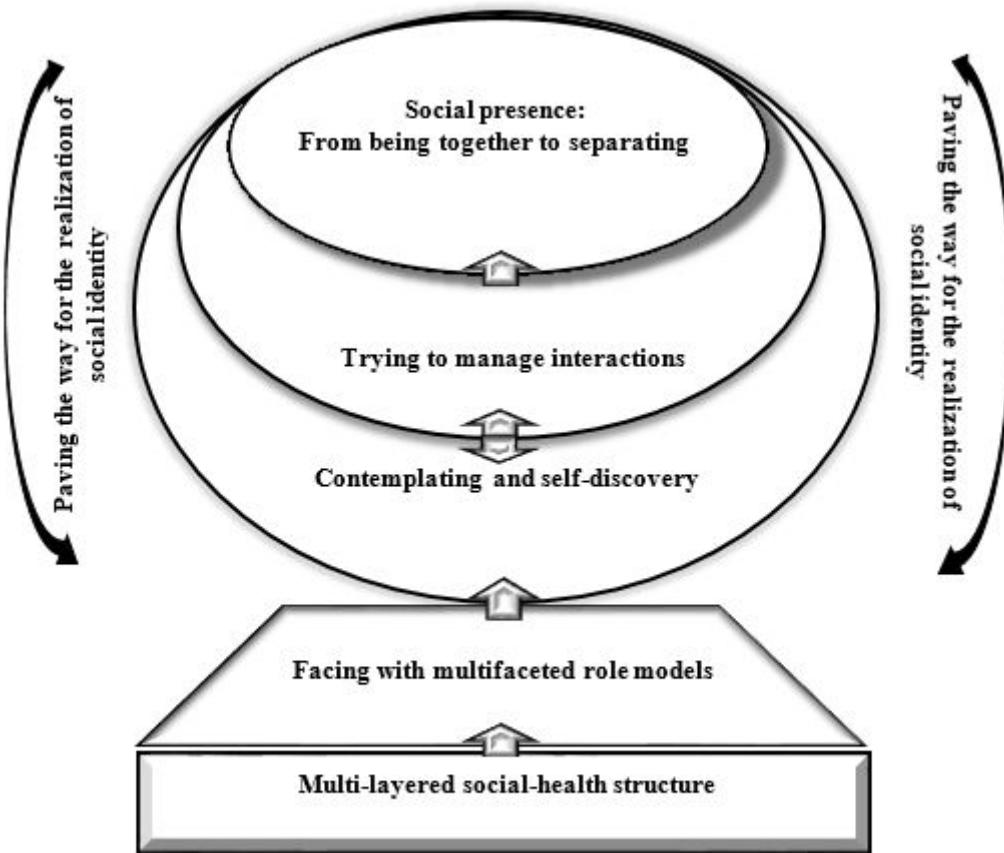
## Tables

**Table 1** Characteristic of the study participants

Participants	Gender	N	Age	Data source
Adolescent	F	10	Mean= 15.58	individual interviews, In-depth, semi-structured
	M	11	Mean= 14.81	individual interviews, In-depth, semi-structured
	F	14	Mean= 16.71	Focus groups
	M	12	Mean= 15.61	Focus groups
parents	F	4	Mean=44.6	individual interview, In-depth, semi-structured
	M	3	Mean= 51.5	individual interview, In-depth, semi-structured
other family members	F	2	Mean= 23.1	individual interview, In-depth, semi-structured
	M	1	25	individual interview, In-depth, semi-structured
Consultant psychologist	F	2	Mean= 49.3	individual interview, In-depth, semi-structured
	M	1	46	individual interview, In-depth, semi-structured
teachers	F	2	Mean= 44.5	individual interview, In-depth, semi-structured
	M	2	Mean= 48.1	individual interview, In-depth, semi-structured
cleric	M	1	53	individual interview, In-depth, semi-structured
Cultural expert	M	1	36	individual interview, In-depth, semi-structured

M = male; F = female.

## Figures



**Fig. 1** Conceptual model of the process of social health among Iranian adolescents.

**Figure 1**

Figure 1