



University of
Salford
MANCHESTER

Adolescents' lived experience of making health choices : an ethical point of view

Moilanen, T, Pietila, AM, Coffey, M, Sinikallio, S and Kangasniemi, M

<http://dx.doi.org/10.1111/scs.12526>

Title	Adolescents' lived experience of making health choices : an ethical point of view
Authors	Moilanen, T, Pietila, AM, Coffey, M, Sinikallio, S and Kangasniemi, M
Type	Article
URL	This version is available at: http://usir.salford.ac.uk/id/eprint/43614/
Published Date	2018

USIR is a digital collection of the research output of the University of Salford. Where copyright permits, full text material held in the repository is made freely available online and can be read, downloaded and copied for non-commercial private study or research purposes. Please check the manuscript for any further copyright restrictions.

For more information, including our policy and submission procedure, please contact the Repository Team at: usir@salford.ac.uk.

Adolescents' lived experiences of making health choices: an ethical point of view

Abstract

This paper describes and interprets adolescents' lived experiences of their rights, duties and responsibilities in relation to their health choices. Fourteen focus group interviews with 67 adolescents aged 15 and 16 were conducted and analysed using the phenomenological hermeneutical method. Adolescents' lived experiences of their rights in relation to their health choices were described as things that were allowed. Duties and responsibilities were perceived as something that they were required to carry out for their own health or other people's health. Although their experiences of rights, duties and responsibilities overlapped, they referred to different aspects of their health choices. Adolescents viewed their rights, duties and responsibilities in the wider context, with parents and society defining their opportunities to make independent choices. We found that ethical considerations influenced adolescents' choices and, the opportunities to exercise their rights, duties and responsibilities varied. Further consideration and recognition of these issues are needed.

Keywords: adolescent, duty, focus groups, health choice, phenomenological hermeneutical, responsibilities, rights

Introduction

Adolescents constantly make health choices in their every-day life and these are conscious or unconscious decisions (1–3) that can have a direct or indirect influence on their health (1). From an ethical point of view, health choices are related to autonomy (4), which refers to someone's capacity to be their own person and live according to their own values (5). When it comes to health choices, autonomy combines the ethical values of rights, duties and responsibilities (4). Rights are something adolescents are eligible for, that in turn, result in a duty to respect other people's rights (6). The realization of health-related rights includes responsibilities for everyone (7). Health-related duties refer to someone taking responsibility for looking after themselves, a commitment to own health-care and having respect for others, including the health-care-system (8,9). According to Horion (10) when someone takes personal responsibility for their own care, this includes eating healthily, exercising and seeking help for health problems.

Adolescents' lived experiences of autonomy vary in relation to their health choices and opportunities to make choices, because of individual and contextual factors (3,11). While adolescents begin to take more responsibility for themselves (12), they stay connected to, and influenced by, their family (13). In addition, health choices are influenced by adolescents' peers (14) and, increasingly, by the wider social environment (15) and society (16). It is worth noting, that influences can be negative or positive, resulting in varying opportunities, which lead to inequality and inequity in adolescents' lived experiences of health choices and the fulfilment of their rights, duties and responsibilities (11,17). In addition, health choices made in adolescence are one factor that can influence health inequalities in adulthood (18). Therefore, health choices made in adolescence are critical, because of the possible long-term impact on future health (19) as well as the effect on the educational and socioeconomic levels reached in adulthood (18).

Adolescents' rights, duties and responsibilities in relation to their health choices are justified (20) and their importance is undeniable (9,21,22). However, there have been very few previous studies in this area (23) and there is a lack of understanding about adolescents' lived experiences of the ethical point of views of their health choices (7). Therefore, there is a need to focus on how adolescents' feel about their rights (24), duties (9,21) and responsibilities (10) in relation to health choices. The knowledge provided could be used to strengthen adolescents' opportunities to participate in their own health-care (25) and support health-related equity and justice in society.

Aim

The aim of this study was to describe and interpret the essential meaning of adolescents' lived experiences of the ethical point of view of their health choices. The ultimate aim was to build up a detailed picture of adolescents' rights, duties and responsibilities in relation to their health choices and to understand how themselves would describe these values. The research questions were: i) how do adolescents understand their rights, duties and responsibilities in relation to their health choices and ii) what are adolescents' lived experiences of these rights, duties and responsibilities in their everyday life?

Method

This phenomenological hermeneutical research (26,27) studied adolescents' lived experiences of their rights, duties and responsibilities in relation to their health choices using focus groups (28,29) and semi-structured interviews (30). In our study, phenomenological hermeneutic referred to the process that, enabled interpretations of the deeper meanings of lived experiences. The phenomenological hermeneutic method has been found to be suitable for investigating and understanding morals and ethical thinking. (29.)

Research environment

Our target group was adolescents aged 15 and 16, in the ninth grade of the Finnish public school system, which is the last level of compulsory basic education (31). Four schools in Eastern Finland agreed to be involved in the study: three schools were both primary and secondary schools and one was just a secondary school. Two schools in urban areas and two were rural areas. The number of pupils in the schools varied from 130 to 456.

Data collection

Development of the interview guide. We collected data through semi-structured interviews in focus groups and developed an interview guide based on five stages (30). In the first phase, the prerequisites for using semi-structured interviews were identified, which were chosen because they were suitable for studying perceptions of complex issues that participants were not used to talking about. In the second phase, we gained a comprehensive understanding of the research subject using previous knowledge (9,21,23). In the third phase, we formulated the preliminary interview guide, which consisted of themes and questions related to rights, duties and responsibilities in relation to health choices (Table 1). During the fourth phase, two kind of piloting was used, internal testing and field testing, to test internal consistency, intelligibility and usability. Internal testing was conducted by evaluating and modifying the guide in collaboration with the research team. In the field test of the interview guide, two focus groups with a total of 11 adolescents, were conducted in a real-life situation. Based on the field-testing we excluded a confusing question and changed some words to focus more comprehensively on the adolescents' descriptions of their rights, duties and responsibilities. Since the changes were only minor and focused on wording issues, we still included the data gathered from the field -tests in the final analysis. The fifth phase was presenting the complete semi-structured guide, which contained themes concerned with adolescents' experiences of *health and health choices, rights, duties and responsibilities and freedom* and follow-up questions to clarify and prompt further questions about the issues emerging from the discus-

sions (32) (Table 1). In addition, an open question was asked at the end of each focus group so that the adolescents could provide additional descriptions (33).

Table 1. The semi-structured interview guide for adolescents' focus groups

Recruitment and focus group interviews. During spring 2016, we recruited voluntary participants, in collaboration with the schools, to participate in focus group interviews. After approvals from the ethical committee and school district, one of our researchers (XX) contacted the schools and presented the study to adolescents during lessons, together with the principal and teacher. The adolescents had the opportunity to ask the researcher questions and discuss the focus groups with their parents before agreeing to participate in the research.

We enrolled a total of 67 adolescents in the study. They were all volunteers aged 15 or 16 years -old and 42 were girls and 25 were boys (Table 2). This enabled the researcher to create 14 groups, which consisted of between three and six adolescents. Keeping the numbers small ensured that they all had the chance to participate in the discussion (34). The focus groups took place during the school day, in a quiet room on the school premises. Each focus group lasted between 30 and 45 minutes and all the interviews were transcribed verbatim and resulted in 161.5 pages of text (1.5 line spacing, *Times New Roman* font size 12).

Table 2. Profile of the 67 adolescents in the 14 focus groups (Fg).*

Data analysis

We used the phenomenological hermeneutical method to analyse the interviews. The analysis comprised three steps to interpret the meaning of adolescents' lived experiences of health-related rights, duties and responsibilities (26,27). The first step was *naïve reading*, where the text was read several times to get an overall impression of the content. Secondly, we conducted *the structural analysis*, where we selected the meaning units 1.981, referring to words, a couple of words or sentences. The selection was based on our pre-understanding of rights, duties and responsibilities related to health choices, which was outlined in the introduction

section. We then condensed the meaning units, compared the similarities and differences and created themes and subthemes based on the comparison. In the third step, *comprehensive understanding*, we read the text again as a whole and reflected on it in relation to the created themes, the study aim and the previous knowledge about the subject. In the end, we decided on five main themes and presented the results in the summarizing figure. The preliminary coding was conducted by one researcher (XX) and the final analysis was completed and validated by all the authors.

Results

Understanding of health and health choices

According to the adolescents' lived experiences (Figure 1), their health choices referred to making independent decisions and the opportunity to influence choices, whereas unconscious choices were perceived as habits. Health choices were part of being independent, which made the adolescents feel free from other people's guidance and constraints. Participants said that friends, family and other people could guide them when they make choices, but could not make decisions on their behalf. Health choices were meant to produce health and control the risk of developing health problems. Adolescents described their health as feelings of physical and mental wellbeing and having positive and responsive attitudes towards future, although health choices related more to their current situation, rather than the future.

Adolescents' interpretation of their rights in relation to health choices

Adolescents' lived experiences of their rights in relation to health choices were described as something that they were allowed to have or do, that was undeniable and unprohibited (Figure 1). Participants believed that health-related rights should be universal to all, regardless of their gender, age or religion and that rights should have equal value and importance. Rights were limited according to age, although some of the participants believed that rights were

equal and not dependent on age. Rights were thought to be necessary, but the reasons were unclear.

Adolescents felt that they had the **right to get their basic needs fulfilled**, including food, clean clothes and a place to live. Adolescents recognized their **right to make independent health choices** and to express their own opinions. They felt that they should have opportunities to decide, or at least influence, the issues that affected them. Rights, when seen as an opportunity to make choices, were linked to day-to-day health-related practice, such as eating healthy food, getting enough rest and exercising. In addition, participants identified the right to choose their extra-curricular activities and appearance. They linked these issues to health because of the impact on their self-esteem and wellbeing.

Participants recognized that they had the **right to access health-care services**, including the right to get treatment from a physician or school nurse. Participants linked their rights related to health-care to cost, particularly to the potential to get treatment regardless of their financial situation. Thus, money was considered to be a factor in adolescents' rights, because it affected things like the ability to purchase healthy food, exercise or seek health-care services or medication.

“You should be able to get to the doctor or school nurse when she is in school. If you have a broken arm you should be able to go to the hospital and have the rights to get treatment there.” (Fg9b)

Adolescents identified the **right for free basic education and a school lunch**. Participants believed that teachers had the right to make decisions on their behalf during the school day, such as whether they could go home when they felt ill. Also, they felt it was the teachers' duty to take care of their safety and the school's responsibility to take care of factors affecting on healthiness, such as providing healthy food for lunch.

Adolescents' felt their **rights were influenced by other people and their family**. Advocates for their rights made implementing them easier, but people with opposing views made it more difficult, especially if the adolescent was unable to stand up for their own rights. Adolescents' rights were described as limited because of restrictions and rules at home and they felt that their rights should be separated from parental control.

Rules within society were described as a means to **secure, but also restrain**, adolescents' health-related rights. Legislation could restrict adolescents' opportunities to smoke or use substances, which narrowed their rights and freedom. But these restrictions were perceived to limit their rights, mainly by prohibiting independent health choices that could have a negative influence on their health, which protected their safety and wellbeing. Although participants acknowledged positive aspects of these restrictions, they also believed that overly strict restrictions diminished their freedom and independence, which could encourage them to try prohibited things.

“If there was more freedom given to adolescents, such as removing age limits, this would not be good as substance use would increase. Limiting adolescents' rights and prohibiting things that are bad for our health is a good thing.” (Fg3b)

Adolescents' shared duties in relation to health choices

Health-related duties were described as things that needed to be done or were recommended (Figure 1). Participants' conceptions of duties varied and were felt to be either unique or universal, but they believed that everyone had these duties. Duties increased as adolescents got more opportunities to make independent choices. Some participants believed that they had enough duties and that more could result in increasing health complaints. Others thought that there could be more duties in relation to their own health and lives, which could support their future independency, but this could only happen, if their parents removed some restrictions.

Participants' lived experiences were that they had **duties mainly towards themselves and their own health**. Taking care of their own health included monitoring food choices, getting enough sleep, exercising, controlling screen time and also substance use. Other duties included taking care of their own medication and seeking help from health-care services.

“You have a duty to eat properly and you must eat properly, get enough sleep and exercise if you want to be healthy.” (Fg14b)

A duty to take other people into consideration when making health choices was identified, for example, using alcohol and smoking. Participants also felt that it was their duty to help others: to seek help if there was an emergency, intervene if a friend was going to get involved in harmful activities or if they witnessed bullying at school. Adolescents' lived experiences were that it was easier to help someone they knew rather than strangers, but that helping others was their legal and moral duty. Participants had a duty to follow the law, which comprised rules that protected overall safety in society.

“If someone falls a bike near you and you are late for an exercise class, are you going to help that other person and miss the practice or are you going to carry on and leave the person behind? In those situations, you really should think of other people and not just yourself.” (Fg4b)

Although participants believed that they had a duty to take care of their own health, they also felt that **parents had the final or some responsibility for their health**. Participants felt this was a good thing as they had more experience, but although adolescents believed that their relatives would take care of them, they didn't feel they had a duty to do so. Adolescents felt that it was easier if parents took care of appointments or they could be neglected. They said it was good that parents kept track of their healthcare related issues, but that if they refused to look after own health, it was their own problem. Adolescents did, however, feel that social- and health-care professionals had a duty to help them. Social- and health-care professionals

were described as being responsible for adolescents' health when they were in hospital, and therefore, society was recognized as having responsibilities in relation to their health.

“Do we have the right to take care of our own health or a duty? Or is it more a duty to take care of other people's health? At our age, you aren't responsible for anyone else but yourself, and even then you are not completely responsible. But mainly it is a duty to take care of yourself and if you don't, then it is no-one else's problem. Or it shouldn't be.” (Fg3b)

Adolescents' responsibilities towards their health and that of others

Participants defined responsibility as looking after themselves and taking care of assigned tasks and things that had to be accomplished, because no one else would do them (Figure 1). Defining responsibility was perceived to be complicated. In descriptions of adolescents' lived experiences, responsibility was focused mainly on the adolescents themselves, because they believed that the person who made the choices was also responsible, although other people could support them in making health choices and taking responsibility.

“You have the responsibility, because you are the one who makes the choices. Friends and other people can help and guide you, but in the end you make your own choices.”
(Fg9b)

Adolescents' lived experiences were that they were and should be responsible for **independent health choices and taking care of their own health and wellbeing**. This included practical tasks such as choices related to nutrition, hygiene, dental health, rest, exercising, using health-care-services and taking care of their own mental wellbeing. Responsibility for mental wellbeing included controlling their appearance, behaviour, thoughts and stress -levels. In addition, participants felt that it was their responsibility to take care of relationships with those close to them. When it came to substances, participants felt that if they were responsible for themselves and truly understood what this meant they would stay away from harmful

substances. They believed that they needed to take care of themselves because of their own health and wellbeing, not because of others.

“Keeping stress levels low is one (responsibility). It is something you need to do, parents can’t do this. No one can see your thoughts, so you need to take care of your mental health yourself.” (Fg11g)

Adolescents identified **responsibilities towards other people**, including those close to them and also legal responsibility they had in relation to health choices. Responsibilities in relation to other people were described as making choices that wouldn’t harm others and taking care of others in a way that wouldn’t harm themselves. Participants believed that they should have no responsibilities relating to their parents or their problems. They didn’t feel they could be fully responsible for others, although they believed they could be partly responsible for other people’s actions, if they provoked the action. In addition, responsibilities related to health choices were defined being linked to other people’s opinions, such as the expectations others had for adolescents.

“Responsibility is looking after others so they won’t do anything stupid and won’t hurt themselves” (Fg9b).

Fulfilling responsibilities related to health choices eased when adolescents were conscious that completing task was their responsibility. Learning their responsibilities early was a factor that supported independency and helped adolescents to cope with day-to-day tasks. However, adolescents’ lived experiences were that learning to take responsibility early, could be harder, although it did help them to manage their own lives independently. Too many responsibilities or fear of failure to take responsibility made accomplishing tasks more difficult. Rewards and punishments were factors that could either ease or complicate willingness to take responsibilities. Possible punishments could include illnesses or having a bad conscience or parental

restrictions. If services were free or low-cost it helped to ease the implementation of health-related duties and responsibilities.

“Some might do those (duties and responsibilities), because they don’t want punishments, but most people do them because they don’t want a bad conscience.” (Fg13g)

Independence linked to adolescents’ rights, duties and responsibilities

In adolescents’ lived experiences, rights, duties and responsibilities in relation to health choices were perceived as being **closely connected and separating them was challenging** (Figure 1). Participants perceived that duties came with rights, which resulted in having a responsibility to accomplish the tasks and an increase in rights lead to an increase in duties. In addition, duties were linked to freedom, which was understood to be the opportunity to make independent choices. However, adolescents reported that they were never completely free to make their own choices, because of the influence of their parents and other restrictions.

“There are a lot of things connecting what you must do, what you can do and what you are allowed to do.” (Fg14b)

The link between duties and responsibilities was perceived as complex. Adolescents thought that duties and responsibilities were needed to help them to become independent and learn to do basic things. Adolescents described the need for duties and responsibilities to help society function, including health, overall hygiene and safety, but they also contributed to the order and structure of society. Thus, duties and responsibilities were perceived to protect the safety and wellbeing of people.

“(Duties and responsibilities) mean you can cope in future, if you are living alone. And the world would be better place. Everybody would feel good and safe.” (Fg13g)

Adolescents’ lived experiences were that their rights, duties and responsibilities were not stated in an open way, but rather through suggestions, which required interpretation of the

expectations placed on them. Some participants felt that they had enough **information concerning their rights, duties and responsibilities in relation to health choices**, which they had gained from newspapers, the Internet and particularly from school teachers or parents as well as through other people's experiences. However, they felt it was possible that some peers might have no information about their rights, duties and responsibilities in relation to health choices. They felt they should be highlighted more and discussed in detail. For example, having clear rules around adolescents' duties was perceived as making it easier to implement them as they didn't have to work them out for themselves.

"It is stated strongly what would be good, but no-one says that you need to do this, or that this is your responsibility. But it would be really good to do it this way rather than through suggestions." (Fg5g)

Adolescents' **rights, duties and responsibilities in relation to health choices were linked to parents' trust and relationships**. Participants felt that when their parents trusted them, they were given more opportunities to exercise their independence, fulfil their rights and meet their responsibilities. Parents and those close to them could support adolescents' responsibilities and duties, especially in case of failure, but if they were overprotective it could be an obstacle to adolescents implementing their responsibilities and duties. In these cases, adolescents were not allowed any independency regarding rights, duties and responsibilities, which resulted in them growing up unable to take care of their own issues.

Figure 1. Adolescents' lived experiences of making health choices: an ethical point of view

Discussion

This study produced new knowledge of adolescents' lived experiences and ethical views regarding their rights, duties and responsibilities in relation to health choices. Rights relating to health choices were understood to be something adolescents were allowed to have or do, including being able to make independent health choices and having opportunity to contribute

to issues affecting them. Adolescents described their duties and responsibilities as tasks that they were required or recommended to carry out in relation to their own health or someone else's health and wellbeing. Adolescents' lived experiences of their rights, duties and responsibilities were interrelated and partially overlapping but also referred to different meanings in relation to health choices: for example, the right to get nutrition, the responsibility to take care of eating and the duty to monitor their own food choices. They viewed their rights, duties and responsibilities in the broader social and environmental context and parents were reported to play a crucial role in defining adolescents' abilities to be independent. In addition, they were linked to the wider opportunities in society.

There were many different lived experiences when it came to the ethical point of view of adolescents' health choices. In our study, the adolescents recognised that their rights, duties and responsibilities needed to be universal and equal. Although they felt their rights, duties and responsibilities restricted, they recognised they were privileged to have the opportunities in society. They also realised that adolescents around the world had varied and unequal opportunities when it came to their rights, duties and responsibilities (11,17,35,36). Thus the lived experiences of adolescents varied, which need to be taken into account in future studies.

According to our results, there seemed to be tension between adolescents and their parents, in balancing restrictions and freedom in relation to adolescents' independence in their health choices. Previous literature has reported that adolescents with a lack of parental involvement had more behavioural problems than those with more involved parents (37). However, adolescents and their parents' views of adolescents' independence can differ (38) and thus lead to parents being overprotective. The lived experiences of adolescents we interviewed, were that strict control and restrictions were the main limiting factors for fulfilling their rights, duties and responsibilities. It is important that future studies also examine the factors that promote

or inhibit the implementation of those values. In order to do so, there is need for further testing of these concepts.

Identifying and openly discussing adolescents' rights, duties and responsibilities in relation to their health choices is vital in all levels of society, including individuals, communities and social- and health-care environments. This knowledge is needed in order to understand the reasons for the health choices and to support adolescents' involvement in making decisions for themselves and implementing their ethical values. The adolescents' descriptions of the rights, duties and responsibilities provide an important insight into the content of these values, which should be taken into account in health-care and society in general. However, definitions of these concepts in adolescents' everyday life, should not be too strict, so that they also have the opportunity to exercise independence and are able to make conscious judgements about their own health choices later on.

It is only possible to focus on and promote adolescents' rights, duties and responsibilities in relation to their health choices when adolescence is viewed as a critical distinct phase of life that is different from childhood and adulthood (25). This study gives us the tools to take into account adolescents' views in practical health-care and also highlights the support needs of adolescents. Adolescents need confidence in their own abilities to accomplish these values and opportunities to make good decisions about their health. However, like health promotion in general (25), adolescents and their parents need information and support from teachers and health professionals. Instead of just focusing on what is "right or wrong", adolescents' decision-making processes should be considered in more detail. In addition, further consideration is needed to determine when, and in what form, early support should be provided in order to be influential.

Ethical approval

In this study we followed the research ethics principles outlined in the Declaration of Helsinki (39) and responsible research practice (40). We received approval from the Ethical committee of Eastern Finland (Statement 17/2015), the district's school system and the principals of each participating school. We obtained oral and written informed consent from the adolescents. According to Finnish law, this type of study did not need approval from parents for the adolescents to participate, but the parents were informed about the study (Medical Research Act 488/2010).

Strengths and limitations

The strengths and limitations in this study were related to the research methods and the strategies we applied to mitigate limitations. Focus groups were a suitable data collection method, because the research topic was complex and there was only little previous knowledge available (28). The focus groups encouraged the participants to voice their opinions and thoughts openly in conversations between their peers, thus producing a wide understanding of their lived experiences (29). We aimed to support the trustworthiness of the data by creating a good rapport through an open and trusting atmosphere during the interviews (27,33). We used pre-existing groups because they were natural social contexts for the adolescents, which made them feel comfortable talking to each other (42). In addition, participants were encouraged to engage with each other and ask questions, and make comments during the focus groups. However, the need for peer approval may have affected the quality and quantity of the shared information in the focus groups (28). We collected data until the adolescents' descriptions started to be repeated and no new themes emerged from the discussions (43,44).

The interviewers' understanding of the research topic may have affected the additional questions that emerged during the focus groups, the selection of the meaning units from the data and the phenomenological hermeneutical analysis (27). According to the premise of the phenomenological hermeneutical approach, there are always other possible ways to interpret the

text (26,27), so to strengthen the credibility of the study analysis, we completed and confirmed it in collaboration with all the authors.

Conclusion

This study produced new knowledge about adolescents' lived experiences of their rights, duties and responsibilities from an ethical point of view in relation to their health choices. These values represented an ethical perspective that motivated adolescents' decision-making. Although rights, duties and responsibilities were understood to be universal and belonged to all adolescents, the individual and contextual factors to implement those values varied, resulting in inequalities. The adolescents' phase of life, including their maturity, family and friends, all influenced their ability to exercise independent decision about their rights, duties and responsibilities in relation to their health choices. There is a need for wider consideration and recognition of those ethical values at all levels of adolescents' everyday life, in order to find effective health promoting interventions to support adolescents with their health choices.

Acknowledgements

No acknowledgements.

Author contribution

Study design (XX), data collection (XX), data analysis and manuscript writing (XX), and critical review (XX).

Funding

No funding was received.

References

- 1 Ioannou S. Young people's accounts of smoking, exercising, eating and drinking alcohol: Being cool or being unhealthy. *Crit Public Health* 2003; 13: 357–371.
- 2 Barnett J, Ogden J, Daniells E. The value of choice: A qualitative study. *Br J Gen Pract* 2008; 58: 609–613.
- 3 Paternoster R, Pogarsky G. Rational choice, agency and thoughtfully reflective decision making: The short and long-term consequences of making good choices. *J Quant Criminol* 2009; 25: 103–127.
- 4 Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 2012. 7 th ed. Oxford University Press, New York.
- 5 Christman J. Autonomy in Moral and Political Philosophy. *Stanford Encycl Philos* 2015. <https://plato.stanford.edu/archives/spr2015/entries/autonomy-moral/> (Last accessed 17 th April 2017)
- 6 Draper H, Sorell T. Patients' responsibilities in medical ethics. *Bioethics* 2002; 16: 335–352.
- 7 de Campos TC. Health as a Basic Human Need: Would This Be Enough? *J Law, Med Ethics* 2012; 40: 251–267.
- 8 Hirjaba M, Haggman-Laitila A, Pietila AM, Kangasniemi M. Patients have unwritten duties: experiences of patients with type 1 diabetes in health care. *Heal Expect* 2015; 18: 3274–3285.
- 9 Kangasniemi M, Halkoaho a., Lansimies-Antikainen H, Pietila a.-M. Duties of the patient: A tentative model based on metasynthesis. *Nurs Ethics* 2012; 19: 58–67.
- 10 Horion SE. What is Personal Health Responsibility?: EBSCOhost. *ABNF J* 2014; 5–9.
- 11 Elgar FJ, Pfortner TK, Moor I, De Clercq B, Stevens GWJM, Currie C. Socioeconomic inequalities in adolescent health 2002-2010: A time-series analysis of

- 34 countries participating in the Health Behaviour in School-aged Children study. *Lancet* 2015; 385: 2088–2095.
- 12 Soenens B, Vansteenkiste M, Lens W, Luyckx K, Goossens L, Beyers W *et al.* Conceptualizing parental autonomy support: adolescent perceptions of promotion of independence versus promotion of volitional functioning. *Dev Psychol* 2007; 43: 633–646.
- 13 Spear HJ, Kulbok P. Autonomy and adolescence: A concept analysis. *Public Health Nurs* 2004; 21: 144–152.
- 14 Susman EJ, Rogol A. Puberty and Psychological Development. In: Lerner RM, Steinberg L (eds). *Handbook of Adolescent Psychology: Second Edition*. 2004. John Wiley & Sons, Inc, New Jersey, 15–44.
- 15 Vera-Estay E, Dooley JJ, Beauchamp MH. Cognitive underpinnings of moral reasoning in adolescence: The contribution of executive functions. *J Moral Educ* 2014; 7240: 1–17.
- 16 Civaner M, Arda B. Do Patients Have Responsibilities in a Free-Market System? a Personal Perspective. *Nurs Ethics* 2008; 15: 263–273.
- 17 Fitchett JR. The right to health in practice. *Int J Clin Pract* 2011; 65: 245–248.
- 18 Koivusilta L, West P, Saaristo V, Nummi T, Rimpelä AH. From childhood socio-economic position to adult educational level - do health behaviours in adolescence matter? A longitudinal study. *BMC Public Health* 2013; 13: 711.
- 19 Craigie AM, Lake AA, Kelly SA, Adamson AJ, Mathers JC. Tracking of obesity-related behaviours from childhood to adulthood: A systematic review. *Maturitas* 2011; 70: 266–284.
- 20 United Nations. Convention on the Rights of the Child. 1990.
- 21 Snelling PC. Saying something interesting about responsibility for health. *Nurs Philos*

- 2012; 13: 161–178.
- 22 Ulriksen MS, Plagerson S. Social Protection: Rethinking Rights and Duties. *World Dev* 2014; 64: 755–765.
- 23 Moilanen T, Coffey M, Kangasniemi M. Adolescents ' health choices related rights , duties and responsibilities : An integrative review. *Nurs Ethics* 2016; 1–18.
doi:10.1177/0969733016654316
- 24 Ross H. Children 's Rights and Theories of Rights. *Int J Child Rights* 2013; 21: 679–704.
- 25 WHO. Health for the World ' s Adolescents A second chance in the second decade. 2014.
- 26 Ricoeur P. *Interpretation Theory: Discourse and the Surplus of Meaning*. The Texas Cristian University Press: Forth Worth, Texas, 1976.
- 27 Lindseth A, Norberg A. A phenomenological hermeneutical method for reasearching lived experiences. *Scand J Caring Sci* 2004; : 145–153.
- 28 Jayasekara RS. Focus groups in nursing research: Methodological perspectives. *Nurs Outlook* 2012; 60: 411–416.
- 29 Flanagan SM, Greenfield S, Coad J, Neilson S. An exploration of the data collection methods utilised with children, teenagers and young people (CTYPs). *BMC Res Notes* 2015; 8: 61.
- 30 Kallio H, Pietilä A-M, Johnson M, Kangasniemi M. Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *J Adv Nurs* 2016; 72: 2954–2965.
- 31 Finnish National Board of Education. Education system. 2016.
http://www.oph.fi/english/education_system (Last accessed 23 Feb 2016).
- 32 DiCicco-Bloom B, Crabtree BF. The qualitative research interview. *Med Educ* 2006;

- 40: 314–321.
- 33 Mack R, Giarelli E, Bernhardt BA. The Adolescent Research Participant: Strategies for Productive and Ethical Interviewing. *J Pediatr Nurs* 2009; 24: 448–457.
- 34 Gibson F. Conducting focus groups with children and young people: strategies for success. *J Res Nurs* 2007; 12: 473–483.
- 35 Bambra C, Gibson M, Sowden A, Wright K, Whitehead M, Petticrew M. Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *J Epidemiol Community Health* 2010; 64: 284–291.
- 36 WHO. Growing up unequal: gender and socioeconomic differences in young people's health and well-being. 2016; 213–236.
- 37 Van Petegem S, Beyers W, Vansteenkiste M, Soenens B. On the association between adolescent autonomy and psychosocial functioning: Examining decisional independence from a self-determination theory perspective. *Dev Psychol* 2012; 48: 76–88.
- 38 Butner J, Berg C a, Osborn P, Butler JM, Godri C, Fortenberry KT *et al.* Parent-adolescent discrepancies in adolescents' competence and the balance of adolescent autonomy and adolescent and parent well-being in the context of Type 1 diabetes. *Dev Psychol* 2009; 45: 835–849.
- 39 World Medical Association. World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. *Clin Rev* 2013.
- 40 TENK. *Responsible conduct of research and procedures for handling allegations of misconduct in Finland*. Finnish Advisory Board on Research: Helsinki, 2012.
- 41 Medical Research Act 488/1999. Medical Research Act 488/1999.
- 42 Redmond R, Curtis E. Focus groups: principles and process. *Nurse Res* 2009; 16: 57–69.

- 43 Guest G, Bunce A, Johnson L. How Many Interviews Are Enough ? An Experiment with Data Saturation and Variability. *Fam Heal Int* 2006; 18: 59–82.
- 44 Trotter RT. Qualitative research sample design and sample size: Resolving and unresolved issues and inferential imperatives. *Prev Med (Baltim)* 2012; 55: 398–400.