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Abstract
Our paper constitutes a theoretical analysis framed by fictitious, yet factually informed, case scenarios, constructed using a technique called 'critical fiction'. Based on our research experience in rural Newfoundland, these scenarios are used to illustrate how health subjectivities are enmeshed in social and economic conditions. While people perceive and make sense of health issues related to youth as signs of change in both community life and the way health is defined, more vulnerable youth are framed as 'at-risk' and efforts to address these issues are often institutionalised, medicalised, and relegated to a health domain. Consequently, we argue that by paying attention to the situated context of these issues, service providers and policy makers must look not only at the opportunities for preventing problems, but also at redefining what constitutes healthy environments for youth to thrive.

Key words culture of consumption, health subjectivities, socio-cultural environment, youth

The Culture of Consumption and the Construction of Youth At-Risk as a Health Issue in Rural Communities

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Introduction

As modern science and technology increasingly govern the task of caring for our health, there is a growing trend towards delegating full responsibility for disease and pathologies to a health care system and its teams of experts and service providers.[1] The dilemma is that modern medicine and technology have radically improved the outlook on debilitating illness and disease, but goals of fostering autonomy and participation within a broader concept of social health, citizenship, and agency remain largely underachieved. Moreover, concepts of health and healthy behavior are increasingly shaped by the need to consume technologies. In this paper, we will argue that a culture of consumption not only dominates health care practices, but is present in other venues of life, including conceptions of youth's health and well-being. Consequently, it also influences new generations' socialisation in health related endeavors.

Our theoretical analysis will start with fictitious case scenarios based on our research experiences in rural Newfoundland (NL). Our fictional scenarios are constructed using a technique called 'critical fiction,' involving the use of recurring themes from real situations and framing them into fictionalised stories.[2,3] Although deliberately stereotypical, these cases are framed to illustrate our analysis about how the construction of youth at risk results from a dynamic that is present in the broader socio-cultural environment of rural communities, a construction that ends up reproducing itself. The NL contextual background is influenced by the consequences of the cod moratorium in 1992. Since then, out-migration in rural communities

in NL has been on the rise as people are challenged to look for working opportunities elsewhere. This has had an impact on a dwindling rural population and on the quality of life of these communities. Consequently, after the fictional scenarios, we will analyze issues exposed in the three scenarios presented as follows: (a) environmental influences on youth development and youth health in rural areas, (b) the complaint about youth boredom and 'addiction to technology', and (c) the construction of 'youth at-risk' and the concern about addictions. Our final considerations will critically discuss that greater attention is needed on the cultural conditions surrounding youth development, and on what constitutes healthy environments for youth to thrive.

The fictional scenarios

Case 1: Parent commuting to work away for weeks and single mothering

Fred is a trained welder working away in Fort McMurray, Alberta for the past decade, while his wife and four children live in a small rural town in NL. He is usually in town for two weeks for every four weeks he is away. While his job brings a fair income into the household, his intermittent absences contribute to inconsistent parenting and strain on his marital relationship. His wife takes care of the children, the household, and their seasonal vegetable garden. She also has to keep an eye on her aging retired parents, while also caring for Fred's ailing mother, sharing the task with Fred's two siblings in town. Jane is sometimes so busy that she is thankful that the children are able to entertain themselves with TV and computer games. Their four boys (two in high school and two in elementary school) are used to being 'fatherless' and, particularly the older ones, are not interested in doing the things that Fred enjoyed doing with his father when he was growing up, such as rabbit hunting during the winter or going fishing during the summer. As a child, Fred's extended family and friends would gather at the diamond in town to play soft-ball, preparing for the summer competitions with the neighbouring communities. The now abandoned softball diamond is a silent reminder of the once-popular sport. Jane blames Fred for the fact that, when not engaged in computers or videogames, the older children only seem to care about riding ski-doos in the winter and motor bikes in the summer.

Case 2: 'Nothing to do' and boredom among teenagers

Mary, a divorced mother of two teenage girls, works as manager at the only supermarket in the area. Her former husband was a commuter worker, until he met somebody else in Alberta and the marriage ended. She defends staying in the small town as she considers it '*a safe place for children to grow up*.' She is also an active member at her church in the neighbouring community and on the 'Come Home Events' committee organised by the Town Hall every four years to welcome back the high number of residents who are now living and working in urban areas. Although she enjoys living in the community she grew up in, she also laments about how much things have changed from when she was a teenager. Most parents in her community are seasonal workers, living on Employment Insurance for most of the year. She believes that the parents who have chosen to remain at home are not necessarily the best role models to inspire the younger generation. Even when not working, most of them are not willing to engage in any kind of community commitment. The church membership has radically decreased because members do not regularly attend services anymore, unless is for a special occasion.

As a working mother she laments the lack of extra-curricular activities in her community. While growing up, she recalls youth always had something to do, either a hangout at somebody's house, a kitchen dance at a neighbour's place, or they would simply go outdoors to play, regardless of weather conditions. Mary complains that these days, her daughters and friends are not as active and usually complain of 'being bored', arguing that there is nothing to do. She asserts that her 15-year-old daughter is 'addicted' to her cell phone and the Internet and is unable to function without constant 'virtual' contact. She blames technology for these changes, but also talks about how the shrinking population has had a toll on the community. She claims that school premises are open only for an occasional party every two months and the only spaces available for youth to socialise in are the couple of fast-food outlets in the area, resulting in the increased consumption of unhealthy foods.

Case 3: Constructing youth at risk

Nancy, a low-income mother of two children, a teenage boy and a 4 year old daughter, also complains about the lack of activities for the youth in the neighborhood of the small town where she lives with a disabled husband, dependent on social assistance. Her main concern is the high number of 'youth at-risk' in town; as alcohol and hard drugs, such as cocaine, are easily obtainable. She is worried that her son may be into drugs because of the group of friends he is hanging with. As teenagers have nothing to do and are often exposed to drugs, it is easy for them to get hooked.

She noticed that when her son was nine years old he started smoking the butts that he collected from his father and her; she senses what little control they have as parents over their child's situation.

Nancy believes that there is need for more policing and services to deal with the high number of youth with addictions these days. She is glad that the local RCMP and health authorities are making efforts to raise awareness about the threats of drug addictions and have recently confirmed the arrival of a new addiction and outreach counsellor in the area. The counsellor is hired to connect with youth at the community level and to bring health promoting services as an early intervention strategy. However, feeling constrained by the structural conditions and lack of institutional collaborations, such as from the school system, he plans to address the addiction issues in youth through a harm reduction strategy approach.

Environmental influences on youth development and youth health in rural communities

Although existing research and plain common sense show that good living conditions in early life are pivotal for positive development, within a disease focused health system, scarce consideration is paid to the necessary social and physical environments for children and youth to thrive.[4-7] This is the case despite the fact that life-course epidemiology clearly shows the close relationship between quality of early experiences and health outcomes in adulthood.[8,9]

In rural areas, the situation is a complex one. Although people often argue about the positive aspects attached to living in rural communities with respect to social supports and pace of life, many organised occupational, cultural, recreational, and material resources that are common in urban areas are lacking in smaller communities. At the same time, youth are lured by the society's increasing consumerism and materialism within the media and Internet networks.[10,11] Commuting workers, represented in Case 1, often bring consumer goods into small communities that are simply unaffordable for people working and living in the local context. This adds to the disparity between households and the trend among youth to idealise urban areas and yearn for the chance to go elsewhere.

Lack of public transport and the predominance of a 'car culture' mentality only make things worse, especially for those who cannot afford to own a vehicle. In addition, the built environment commonly deters residents from gathering in any central place, as the few public places and commercial areas are usually spread out among other neighboring rural communities. This arrangement discourages active lifestyles, as walking is not a feasible method of getting around. In the case of youth, the need for parents to have the time and a vehicle to take them to potential extracurricular activities, compounds the problem of a very limited offering of these types of activities. Consequently, for low-income youth, the opportunities are even more limited. The result is a greater dependence on technology, such as cell phones and the internet for social interaction. For those in more isolated rural areas the virtual world might be the only source of entertainment, exposing youth to and entrenching them more deeply in the increasingly normative materialism and consumerism promoted through the media.

Current trends in the health sciences also emphasise health care consumption within a model that mirrors business principles, in which people are constituted as 'consumers' or 'clients' of disease-focused services. Clients are conditioned not only to use the services, but to depend upon them, and are held accountable for health outcomes, neglecting the actual social conditions framing their health and health practices. This relationship fails to account for the fact that health-related practices are shaped by our subjectivities – the socio-culturally driven sense of who we are in relation to the world – and the complex circumstances for any kind of agency[12] In other words, how we perceive ourselves in relation to our life circumstances has a direct impact on how much power we feel we can exercise and what decisions we can make in a given situation.[13]

This business model of production and consumption in the health care system is deeply eroding the network of non-professional caregivers,[14,15] and even the sense of community itself.[16] This model reproduces itself through people's perceptions of it being logical, self-evident, or even natural in what Bourdieu calls 'a quasi-perfect correspondence between the objective order and the subjective principles of organisation'.[17] The resulting relations of power limit people's ability to perceive potential social change and stifle citizens' activism in relation to the production of healthy communities.[18]

On this path, health care has become a powerful currency, and its processes of objectification (health care as a subjectivity-free experience), commodification (health care as a marketable service), and standardisation (health care considered through a one-size-fits-all approach) are highly influential in the way the health-illness process is conceived and health and social services are provided.[19] The hegemony of the biomedical model and the high level

of consumption arising from a disease care system have also contributed toward a *medicalisation* trend in society.[20,21] This trend encourages people to think of social and cultural issues through an individualized pathology lens that creates illnesses for which professional services and biotechnology, offered as commercial commodities, are the solution.[22-24] The dominant biomedical discourse has become incredibly powerful, as it defines, sorts out, and regulates human bodies from birth to death, playing not only a clinical role, but also a moral role in the exercise of disciplinary power at the level of individuals and society.[25]

Consequently, although the quality of their socio-economic environment frames children's developmental health, defining lifestyles, trajectories, and health outcomes from the earliest stages, these lifestyles and behaviours are often decontextualised from broader structures that shape living conditions. Most health promotion and disease prevention efforts are focused on individuals and on modifying lifestyle choices and risky behaviors.[26-30] For example, despite the strong focus on childhood and adolescent obesity in recent years[31-33] and the increasing concern regarding the number of emotional and behavioural difficulties among teenagers,[34-36] little attention is paid to the cultural and economic issues surrounding these behaviours. An increasingly influential part of this social environment is the disease-focused culture in which institutional medicine and health services are seen as the most important piece of any health program.[37]

With the ongoing focus on pathologies, explanations for challenging youth behaviours tend to concentrate on isolated factors: escalating violence in TV consumption, single parenting and marriage breakdown, deficiencies in the school system, low-income and other forms of social exclusion, excessive consumerism, or the effects of technological or social change, all identified in the case scenarios. However, this attention to single issues does not take into account that all these factors are interrelated and deeply ingrained in contemporary culture with consequences on people's health.[25,38,39] It also forecloses any opportunity for agency in promoting changes in the broader social environment when all efforts are addressed to the singular individual behaviours or factor.

This problem-focus approach seems even more prominent among the less advantaged members of society, particularly those with low-income, youth, the elderly, or people with disabilities, whose voices are muted or absent from the political and institutional processes that seek to represent them.[40,41] Disadvantaged individuals and populations are often medicalised in institutional discourses that draw attention to pathologies rather than to strengths and resources they also have, becoming increasingly dependent on health care workers and other service providers

'Nothing to do' and addiction to technology

While in rural areas there might be a lack of public spaces for social interaction and even less sporting and community activities, as evidenced in the case scenarios, there may also be a lack of enthusiasm and interest, reflecting a shift in cultural norms related to youth's activities and community life in general. The culture of ad hoc recreation with peers or self-directed participation in games or sports without formal structure and without the acknowledged achievement of something material or concrete (such as trophies, medals, or certificates) has been lost. Youth no longer seem to play because they like soccer or baseball or football, or because they enjoy this form of social interaction with peers, for example. Instead they play because there is a competitive and structured opportunity for personal gain, resulting in high-achieving families being the primary participants. The circumstances of participation are further stratified by economic resources, as many families cannot afford the cost of equipment, training and club fees associated with organized sports and other activities. Even among families who value participation, there is a feeling that the access to activities is limited.

However, parents' concerns tend to be focused on the lack of activities for consumption, rather than the lack of involvement and interest in communal activities, which were popular just a generation ago. The shift towards individualist social norms no longer supports imaginative and unstructured play and generalised physical activity as a part of healthy living. This trend is confirmed by other researchers. For example, research evidence on physical activity programs among youth showed that the most significant influence for adolescents' involvement in these programs is family support and reinforcing social norms,[42] as well as access within a school environment.[43] Using Bourdieu's social theory as framework,[17] Lee and Macdonald's research[42] shows that participation in physical activity is closely related to family's social, cultural, and economic capital. With regard to access to school facilities, in most rural communities in NL school space tends to be limited to academic activities, and school authorities are resistant to opening premises beyond regular hours, mainly because of potential liability issues and lack of volunteers to supervise the youth. Labour migration

patterns reduce the number of people available to provide the social framework for activities both in the household and in the community. In other words, the structures that should promote healthy activities for young people are disrupted on many fronts and both physical space and social networks to promote good health are diminishing in rural communities.

The social world for many young people in rural Newfoundland, like elsewhere in the world, is largely Internet and technology-based; the friendships and social connections are real but the space for interaction is a virtual one that fosters physical inactivity and emotional overload.[10] There is a widespread sentiment that youth *prefer* their virtual activities and although this kind of overconsumption is clearly defining sedentary lifestyles, and for parents working outside the home or isolated by distance and lack of transportation, there seems to be advantages to this. This is the point where we see an impasse in which socio-cultural conditions are discouraging physical and social activities, organised or otherwise, and yet people seem unable to envision alternative solutions.

The construction of 'youth at risk' and the concerns about addictions

In rural communities, youth are often constituted as a group-at-risk of developing social behaviours that will lead to poor health.[44] They are particularly at risk of becoming part of a cycle in which social conditions enable unhealthy behaviours, such as inactivity or poor diet. However, the most feared condition is substance abuse. In addition to the cultural shift towards increasing consumerist and materialist values, the affluence generated by commuting workers brings not only money, but an increasingly normative craving for fast relief to stressful lifestyles, both leading to an expanding drug dealing business.

The dissatisfaction generated by these values expresses a chronic emptiness in youth's social lives, and the sense of disconnection is usually framed as 'boredom'.[10,11] As youth participate in the same kind of consumer driven social world, if they cannot consume activities they look for alternatives to fill the void. Consuming alcohol and heavy drugs thus becomes not only a form of addiction, but also a form of resistance to the instituted system that holds few solutions to the lack of opportunities for a balanced life. In the meantime, the system medicalises the consequences and holds the youth accountable for the recklessness that this lack of opportunities generates.

It is beyond the aim of this paper to engage in a conceptual discussion about the derogatory construction of youth at-risk, which sets up a distinction between a labeled 'problematic' minority versus a 'normal' majority.[45-47] However, we agree with Kelly,[46] that the construction of certain populations of youth in terms of deviance, delinquency, and deficit, provides grounds for forms of governance and control through expert systems. This kind of professionalization obscures the contextual issues and power relations complicit in producing the conditions for such risky behaviors in the first place.

Thus, while youth services are geared toward the production of a health risk identity, this systemic emphasis on intervention focused on targeting the addiction, remains reactive rather than proactive, as shown in the last case scenario. This perception is carried through from the institutional service domain to the general public. Despite their frustration, youth and parents tend to participate and conform to the 'at-risk' fixed identity that is imposed on them, since a system already exists in which they can participate as medicalised subjects. Usually there is a dual sense of hopelessness and blame among the consumers of this service and their parents. The paradox deepens as they recognize both the stigmatisation and inadequacy of the medical system, yet desire greater medical attention to the problem as a health concern.

Coincidentally, the perceived risk of substance addictions seems to be associated with the same social factors as those related to youth's 'addiction' to technologies, such as computers and cell phones. However, rather than altering the social dynamic in which both the over-use of technology and substance abuse reside, a medicalised approach and consumption of professional services remains the focus.

Final considerations

While perceptions of 'youth at-risk' are rooted in the assumption that youth must be organized in directed and supervised recreational activities in order to be safe, this discourages possibilities for unstructured play and sports and further perpetuates these conditions by refusing the legitimacy of alternative ways of being healthy and active. While such problems are part of the social environment, the ongoing efforts to address these behaviours have been institutionalised, medicalised, and relegated to a health domain.The pathology-focused approach also creates conditions for the exercise of power.[25] Thus, while people are identified by their problem, they are also conditioned to accept some form of institutional intervention that addresses the problem, even if the intervention does little to alter the social conditions in which the problem exists. The conditions

that perpetuate a model of consumer behaviour reside in this cleavage, somewhere between a lack of essential social structures that promote and produce health and the health structures that medicalise the resulting problems.[38]

The culture of consumption shapes individuals as consumers of health services and intervention programs. As such, they are conditioned to use the services and are held accountable for health outcomes, neglecting the actual social conditions framing their health and health practices in the first place. Illness prevention programs end up constituting the subjects they purport to be helping by creating persons 'in need'.[14] Health subjectivities are consequently shaped by these discursive practices. As power-laden, institutionalised ways of talking, these practices localise and normalise concepts of health as if intrinsic to personhood by virtue of being embodied and of the body.[12] People come to think of themselves as being the health concern, as opposed to *having* a health concern.

To conclude, our exploration of experiences and understandings about youth health sheds light on the role of the symbolic, cultural context emanating from socio-economic and political structures.[17] We highlight the dynamic relationship between health and the social, cultural, historical, and economic conditions in community life. From this perspective, the situated context, in addition to being the object of study, shows also the location of potential forms of action.[48]

People perceive particular health problems as signs of change in both community life and the meaning of health itself. The stories people share, the fears they raise, expectations they identify, and challenges they describe all reflect a general concern for a rapid change in the social fabric and a general sense that the new social reality is not conducive to 'healthy living.' However, the tendency is to emphasise personal responsibility, supported by the prevailing biomedical trends of disregarding broader social and cultural concerns. The systems of economic practices and cultural meanings that shape thinking, personal and collective experience, and lifestyles are overlooked in favour of scientific evidence-based practices limited to proximal causes of health issues.[12] Consequently, we argue that service providers and policy makers must pay greater attention to the social and cultural conditions that encourage healthy lives. It requires that we look not only at the opportunities for preventing problems, but rather at redefining what constitutes healthy environments for youth to thrive. At the conceptual level, we emphasise the need to reflect on the interactive dynamic of health subjectivities and potential for action, maintaining discussion on how culture and social norms, as social determinants of health, permeate thoughts and actions of the whole population.

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