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Health in everyday life. The competences and autonomy of children and adolescents in treatment practices

Anna Rosa Favretto and Francesca Zaltron***

Abstract: This paper presents some of the findings of research conducted to understand the representations and skills of children and adolescents in matters relating to health, illness and treatment practices. Before we discuss these findings, we present a number of theoretical considerations regarding criticism of works studying the relationship between childhood and illness, where children are viewed primarily as a “body” treated or taken care of by adults with different roles. Conversely, the approach adopted for the research holds that children and teenagers are subjects possessing agency, capable of understanding the experience of illness and able to cope actively with their own malaise and illness itself. The findings presented largely concern the competence that children and adolescents ascribe to themselves in recognising, understanding and communicating their states of malaise and illness, and in using remedies and medication. They also concern which subjects should be called upon in the event of malaise or illness, to how the work of care is shared within the family and what expectations are made of each gender. The research was conducted during two summer camps (summer 2011) with 80 children and teenagers (8-9 and 14-17 years of age) from different regions of Italy.

Keywords: competence, treatment practices, childhood, adolescence

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Rethinking embodiment and the competence of children and adolescents in health matters

This paper presents some of the findings of a pilot research project conducted to investigate the competence of children and adolescents in matters relating to health, illness and treatment practices. The research was prompted by the observation that children's competence in the area of well-being and malaise, health and illness has traditionally been studied in areas where, in the relationship between childhood, health and treatment practices, the child is considered to be a silent "body" that is treated or taken care of by adults, in their different roles (Mayall, 1998; Tates & Meeuswesen, 2001). Using a different analytical perspective, the approach used stems from the new sociology of childhood, with greater emphasis on the agency of children and adolescents even in the area of health. This includes an interest in assessing the capacity of growing subjects to understand their own embodiment and how it is altered during states of malaise and illness (Christensen, 2000; Lupton, 2012).

The experience of illness as a "social process" encompasses several dimensions: emotional, psychological, social, physical. Consequently, in order to understand the full complexity of this experience, we need to consider the importance of embodiment in human experience, not only as a biological fact, but as a multiform and composite phenomenon. This is particularly the case when it comes to children (Kelly-Field, 1996). Child embodiment has long been studied as a physical fact that is "taken for granted", rather than as a complex social and individual phenomenon (Prout, 2000; James & Hockey, 2007; Diasio, 2013). An example is when children are reduced to a mere silent "body" within treatment relationships. This attitude can be traced to a representation of childhood, still common and widespread in today's western society and in some areas of contemporary scientific thought, according to which, children are considered "changeable", "lacking" and "precious" on account of their "unfinished" bodies that are still undergoing transformation (Shilling, 2003). Moreover, they are consistently considered to be "at risk", since they have little physical and psychological stamina, and hence are "fragile" and "vulnerable".

This representation of the incompleteness of child embodiment, centred on the extreme vulnerability of children and adolescents, gives rise to the idea that all growing subjects are in need of constant care. This

representation points to the need for adult roles established to provide care, and to keep watch over and monitor growth using development models, and treatment and care practices, which, in today's western society, are increasingly geared towards the dominance of expert knowledge rooted in the biomedical paradigm. This is the legitimisation of a regulatory structuring of the social relations between adults and children, based primarily on scientific knowledge. This touches child and adult roles alike (consider the normalisation of the maternal role towards the biomedical paradigm and the myth of the "good mother"; Mayall, 1996; Johnson, 1995; Lupton, 2011). This relates first to embodiment and interprets both adult embodiment and competence as superior to those of children and adolescents (Böök & Perälä-Littunen, 2008; Christensen, 2000). Adults are represented as undeniably competent (until proven otherwise) because of their position in the adult age group and their completed physical growth. These aspects automatically point to a representation of the intellectual and physical maturity needed to have the understanding and ability to use rationally and scientifically based knowledge and practices. Children, on the other hand, are considered "naturally" incompetent because they are immature, given their position on the path of development.

Contrary to this representation, even the new sociology of childhood, alongside other scientific approaches, has developed the idea of an existing relational embodiment that can be experienced and understood by children mainly through action, and this is also true for health- and illness-related matters (Lupton, 2012). From this perspective, embodiment is considered mainly within its own process-oriented and transformational nature, in continuous action and connection with the world of which it is a part. Experiences of illness are embodied by the person as elements structuring the person herself, on the basis of the physical, psychological, relational and contextual aspects which characterise each single episode of illness (Christensen, 2000). According to this perspective, children cannot be taken to be "mute bodies", passive objects of care, but should be understood as subjects with the capacity to understand the experience of illness and, as subjects with agency, capable of dealing with their own and others' malaise and illnesses.

Thanks to the recognition of the agency of children, this new theoretical perspective has also enabled a shift in the way child and adolescent competences are understood, including in relation to health and illness. Competence is no longer only understood as an individual psychological-

cognitive property - the set of skills that mark the stages of development and become more refined over the course of a person's growth - but also, and above all, as social skills, as a relational attribute: a set of skills that are built, negotiated and transformed through everyday interactions between adults and minors, and between peers (Hutchby & Moran-Ellis, 1998). According to this vision, competence is rooted in present life as experienced by children. Its nature is understood to be dynamic and process-based, since it takes shape in the various relational contexts in which adults and minors build and conduct their everyday interactions, including those relating to health and illness. As a consequence, it is also influenced by and transformed in relationship to the restrictions, bonds and resources that characterise such contexts. In this sense, and according to the perspective of Hutchby and Moran-Ellis (1998), each competence is a piratical achievement and, at the same time, a set of skills which children and adolescents have to enact in specific life contexts in order to possess them.

The relational and dynamic nature attributed to both embodiment and the competence of children allows us to interpret childhood experiences in general, and those related to illness in particular, as processes rooted in the present time and everyday life. This is where children negotiate with adults and with their peers and, with them, co-construct their understanding of the meanings behind their states of well-being and malaise, along with ways of communicating these meanings and of receiving help to return to a state of good health and manage the state of illness.

The competence of children and adolescents in matters relating to health and illness

Of particular interest, including in terms of the findings of the research presented here, are a number of considerations seen in empirical works available in the scientific literature. These enable us to identify a cultural framework in which we can place our thoughts on competence in general and child competence in particular, as well as the main elements characterising the content and meanings of competence in matters relating to health and illness.

Some authors say that, when children speak about their experiences of illness, they do not sectorise their experiences by focusing only on bodily

sensations and their meaning, or on experiences centred mainly on the treatments they undergo. Rather, they emphasise the “social process” of the illness (Prout & Christensen, 1996; Christensen, 1998; Backett-Milburn, 2000), in which the emotional, relational, psychological, social and physiological dimensions are mixed together. These are complete and complex experiences whereby the episodes of the illness become social events (Mayall, 1996; Diasio, 2006; Memmi, Guillo & Martin, 2009). Thanks to these, in their relationships with adults and their peers, children learn and process the meanings associated with the body and the body’s messages, and the meanings and structure of the relationships between the subjects involved in the scene of the illness. Furthermore, understanding the structure and meaning of relationships during the malaise or illness event also enables them to understand the hierarchies and power differences in the relationships between adults with their different roles—particularly mothers, fathers and paediatricians—and between children themselves and the various adults.

Hierarchies and power differentials also affect the distribution of, and the unequal legitimacy ascribed to, expert knowledge and common-sense knowledge. As mentioned earlier, an illness episode is the subject of knowledge and practices that frame the meanings which, in micro-social and macro-social contexts, enable individuals to name and attribute meaning to the very experience of health and illness. In our contemporary societies, expert knowledge from the biomedical model enjoys the greatest legitimacy in terms of dialogue and practices concerning these experiences. The importance of the biomedical model and expert knowledge is also the basis for the second consideration stemming from the study of child competence in health and illness. Some authors emphasise the fact that the existing hierarchy between, on the one hand, biomedical knowledge and practices, and on the other hand, common-sense knowledge and practices, influences the ways in which the different competences are represented between adults and children (Prout & Christensen, 1996; Christensen, 1998). Indeed the greater legitimacy ascribed to biomedical knowledge over common-sense knowledge, for defining and dealing with illness events, is linked to the greater competence attributed to the adult population over the child population, which is considered more mature and hence more capable of understanding and knowing how to handle biomedical knowledge and practices. In this way, the biomedical model and the development paradigm meet, thus legitimising a specific cultural and

generational order of society (Alanen, 2004; Kelle, 2010). In this order, rationally and scientifically based knowledge is proposed as the dominant interpretative criterion for defining and understating health and illness, and age is considered the main criterion for interpreting the competence differential between adults and minors.

In everyday practice, the hierarchisation of knowledge and attribution of competence between adults and children is visible in the use of a whole series of “mediating devices” (Christensen, 1998) used by adults to establish “scientific” criteria for the “reality” of the experience of illness had by children. Christensen uses the term “mediating devices” to refer to instruments and facts—such as the thermometer, the duration of symptoms, the possession and handling of medicines, and the identification and organisation of suitable and unsuitable spaces for treatment management—whereby the services delivered upon bodies, in the sense proposed by Foucault (1976), are honed and trained. By so doing, children and adolescents are, in a way, deprived of the power to express and, above all, see recognised a different “version of the events”, involving their subjective experience of the body and the transformations it undergoes in the transition from states of health to states of illness. Through the use of “mediating devices”, they learn progressively to understand the framework of meaning deemed appropriate by adults to name and communicate the modifying processes from states of health to states of illness.

Nevertheless, if, in terms of the practices of adults contributing to defining the meanings of child competence in health and illness matters, the attention is shifted towards what children and adolescents express, practise and negotiate during the events related to malaise and illness, it is possible to observe in a new light and thus enrich the meanings attributable to the concept of competence.

First, children internalise and process the meanings of mediating devices used by adults, whether these are family members, teachers or doctors. At the same time, they learn how using them transforms these devices into important symbolic boundary markers (Christensen, 1998) whereby they can recognise, classify and communicate the “thresholds” (Christensen, 1998) that mark the transitions between states of health and states of illness. In other words, they are “really” ill when the thermometer says so, when adults decide that they have to go to the doctor, when they take medicines, and when symptoms are shown (temperature, vomiting,

diarrhoea and so on) which in the course of daily practices they have learned to recognise as “definite” symptoms of illness.

Secondly, children and adolescents learn to select the symbolic markers considered more “reliable” and “suitable” than others to express their state of malaise and illness, and to modulate the expression of these markers according to who they are interacting with and in what context. This ability to recognise the relational quality of symbolic markers allows children and adolescents to develop competences in at least two areas. The first concerns the complex work of mediation and construction between the experience of their own bodily perceptions, the significance attributed to them socially and the identification of the ways in which to express and narrate them. The second concerns the strategic ability to use the socially-shared meanings relating to health, illness and the transitions between the two states in order to simulate malaise, so they can get out of situations or tasks that are undesirable or considered difficult to face.

A further element characterising child competence in relation to health and illness is the necessary collaboration with adults that children and adolescents are called to enact, in order to be able to go through the process of identifying the malaise, administering treatment and returning to a state of good health. The collaborative attitude, often taken for granted by adults and considered a mere fact of docility and maturity, is, on the contrary, a fundamental and complex aspect thanks to which children learn, by sharing their experience of illness with adults, important practices and meanings related to these themes. In fact, these are the outcomes of interactive practices which cement the knowledge needed not only to deal with the episode of malaise itself, but also to hone the tools for recognising it and dealing with it later or, even, passing on to others what they have learned (Christensen, 1998, Alderson, 2007).

Although, this last aspect is perhaps given the least amount of consideration when it comes to child and adolescent competence, it is the area relating to the set of social skills employed by children and adolescents to experiment with and cement their journey to autonomy. Research in this area show us that the skills acquired while managing individual states of malaise and illness are then substantially spent in relationships with peers and interactions with adults, particularly in situations where children can also take the role of caregivers (Christensen, 1998; Such & Walker, 2004; Rose & Cohen, 2010). Nevertheless, it has been shown that adults generally tend not to recognise the ability of youngsters to provide practical help in

the management of others' illnesses and tend not to recognise the skill of children and adolescents in managing the states of malaise and illness that affect them (Rose & Cohen, 2010). Cases of chronic childhood illness, involving extended periods of therapy, are the few rare occasions on which adults with different roles attribute competence to children and adolescents in taking care of themselves, especially with regard to the application or administration of medication. Nevertheless, as Christensen asserts (1998), the allocation of competence to children by adults in cases of chronic illness confirms their consideration of them as being "different" from other children, rather than an acknowledgement of the potential capacity possessed by all children and adolescents to take care of themselves and, specifically, to administer their own medication autonomously. The "bracketing" of these children, as they are different from others on account of chronic and serious illnesses, appears not to recognise this expression of competence as an aspect of childhood itself.

Objectives and methodological aspects

The main purpose of the pilot research, was to explore the competence of children and adolescents in matters relating to health and illness. Here we present results regarding competences in the management of illness conditions. Specifically, we investigated the practices that groups of children and adolescents said that they used to maintain a state of good health and to deal with states of malaise. Furthermore, we made note of the meanings ascribed to such practices and the "thresholds" that mark the transition from a state of malaise to a state of illness.

Considering the importance of the socialisation and experimentation of autonomy in educational settings outside the family, the survey was conducted in two summer camps (summer 2011) for children and teenagers from different regions of Italy. 80 minors were involved, belonging to the 8- to 9-year-old age group and the 14- to 17-year-old age group, both males and females (44 children aged between 8 and 9, including 15 females and 29 males; 36 teenagers aged between 14 and 17, including 14 females and 22 males)¹. All of the children and teenagers were in good health.

¹ The research was conducted with boys and girls taking part in a summer camp at a facility in Misano Adriatico near Forlì in Italy and with teenagers taking part in a summer camp at a

These two different age groups were considered, since we intended to highlight how transformations in health- and illness-related skills manifest during the period of development, with a particular focus on the evolution of the way in which their own states are understood, the ways in which “being unwell” is communicated, and on the emphasis placed on guidance offered by adults and peers.

Seven focus groups were conducted with children and adolescents divided according to gender and age. Focus groups were carried out by one of the authors, who spent a one-week period in each of the two summer camps. During the first days, she presented the research to educational staff, to children and teenagers. She also became acquainted with people, and gathered information on daily life in the camps.

Different investigative instruments, presented according to a predetermined sequence, were used within each focus group. First came brainstorming about the meanings and situations ascribed to “being well” and “being unwell”, leading to in-depth discussion and debate, in order to contextualise the meanings expressed by issues of well-being and malaise. Subsequently, two vignettes were presented concerning episodes of malaise in contexts with adults and between peers (“having a stomach ache” and “falling and hurting yourself while playing with your friends”). These stimuli were sufficiently undefined in order to make it possible to gather the widest variety of opinions. The vignettes were presented to delve into the meanings attributed to the conceptual pairs of well-being/malaise and health/illness, the “thresholds” that mark the transitions between these states, the representations of what “you do”, what “you can do” and what “must be done” to restore a state of good health and this also in relation to the different contexts in which episodes of malaise or illness might take place, within the family environment and at a holiday camp. Finally, relational maps were made with the children and teenager to identify the array of persons they believe are qualified to take on the key roles of caregivers in health and illness, well-being and malaise.

Materials which were collected during the focus groups were analysed by using matrices by both authors.

facility called Corte della Miniera in Urbino, Italy. The camps were organised and run by the D.O.C. Social Cooperative of Turin, which specialises in educational tourism for young people, and were attended by children of Telecom employees belonging to white-collar and management-level families. Thus, the family class origins of both sub-samples is considered to be homogeneous.

The research did not aim to produce generalisable results. Rather, it intended to find a number of reference points and test several working hypotheses to produce material for new and more extensive work on the same subject.

The experience of “being unwell”, mediating devices and identifying thresholds

When presenting the results of the research we will focus particularly on the issues of identifying illness and treatment practices, comparing the practices and competences reported by children with those reported by the adolescents taking part in the focus groups.

Generally speaking, and in line with research that has looked into similar themes, we found that the teenagers and children alike displayed broad and diffuse skills in both relational and “scientific”—that is, relating to the biomedical paradigm—sectors when it came to understanding their states of malaise and the practices needed to restore them to a state of good health.

Children and teenagers of both genders showed that they possess important skills for interpreting the messages of the body and communicating them to adults. Specifically, signs of malaise are seen in expressions of the body that cause a “break” with the daily routine, both physically and behaviourally, showing clearly that these experiences call into play the dimensions of body, emotions and relations:

(How do you know when you are unwell?) From my behaviour, when I’m unwell, my face is sad, I don’t feel like doing anything, I might not eat (Girl, 9 years old, Misano Adriatico).

In the case of the children, they were seen to have already learned and understood that recognising and being able to name a phenomenon linked to “being unwell” is the result of a complex process that takes place in their relationships with others, especially parents, and which may involve other people, depending on a timescale dictated by the severity and duration of symptoms:

(Vignette: “Waking up with a stomach ache”) I’ve got the whole story: first you try and resist, then you can’t stand it anymore so you call mum, you try and do a poo but you can’t, you take pills, but the pills don’t work, and in the end you go to the doctor (Boy, 9 years old, Misano Adriatico).

One initial fact worth noting is that most of the children taking part in the research said they considered themselves capable of starting to explore and understand autonomously what the body expresses when it feels malaise. They illustrated this statement with examples from their own experiences of malaise or illness, thereby demonstrating that they have already experienced forms of self-reflection on their own body and their own state of health:

If you have to do a poo, the bottom part hurts; if you are sick, then the top part hurts. I mean, you get a temperature and that gives you a stomach ache, but you don’t need to go to the bathroom (Girl, 9 years old, Misano Adriatico).

I touch my tummy a little, I massage it and if it doesn’t go away I tell my mum (Boy, 9 years old, Misano Adriatico)

Another interesting finding concerns the time dimension and its value as a device for evaluating a possible symptom of illness. In this sense, aspects of time (“trying to resist”) or behaviours involving processes that require time (“trying to go to the toilet”) may be a significant dimension to establishing a “threshold”. Duration, the mediating device that adults use to determine the “actual” existence of a symptom, is thus recognised by even the youngest as one of those symbolic boundary markers between the state of well-being and that of malaise, up to the definition of a symptom, thanks to which it is possible to interpret and communicate the signals of the body.

As age increases, not only does the interpretation of states of malaise become more certain, but it is expressed as being rooted to both individual perception — seen as being central and a right — and to relational life:

He goes to the toilet and, if he does not get over it, he takes some medicine (Boy, 14 years old, Corte della Miniera).

She is upset and is trying to understand the reason for it, whether it is her period or just a stomach ache (girl, 14 years, Corte della Miniera).

He is thinking about the evening with the girl he's just met (Boy, 16 years old, Corte della Miniera).

Recognition of their own interpretative skills is accompanied by an awareness of the limits of their competence. These limits are mainly signalled by the introduction of several subjects who, with differing degrees of legitimacy, are ascribed the right to transform malaise into symptoms and, therefore, to define as pathological various altered physical and psychological states. Personal perception and interpretation are replaced or indeed integrated with the knowledge and practices of adults, usually those of mothers, up to the intervention of medical knowledge called upon when parental knowledge does not seem able to restore a state of good health:

He does not say he is unwell and decides to resolve the situation alone, but gets it wrong (Boy, 15 years old, Corte della Miniera).

She tells someone straightaway to get help, maybe his mum, his dad or his sister (Girl, 16 years old, Corte della Miniera).

She stays in bed and if it does not go away, she calls her mum and her mum calls the doctor (Girl, 9 years old, Misano Adriatico).

He tells his mum straightaway and his mum takes him to the doctor to be cured (Boy, 9 years old, Misano Adriatico).

Attribution of cause: aetiology and its moral value

By defining child competence as practical achievement (Hutchby & Moran-Ellis, 1998), and as a set of skills that are constructed and negotiated in specific life contexts, we can highlight one of its main characteristics, namely that it provides the chance to configure possible scenarios, thereby stimulating hypothetical thought, the fulcrum of social life.

This characteristic is clearly visible when analysing the attributions of cause that children and teenagers find in their states of malaise and illness. Indeed, they feel competent in understanding what is happening in their body, to the point of conducting an interpretive process that also includes reflections and hypotheses on the aetiology of their malaise. These

hypotheses become useful points of reference for correctly understanding the malaise itself and transforming it, if necessary, into a symptom:

Because yesterday was her friend's birthday and she ate too much (Girl, 9 years old, Misano Adriatico).

He ate loads of sweets, too many sweets (Girl, 9 years old, Misano Adriatico).

He ate too much chocolate (Boy, 9 years old, Misano Adriatico).

He ate 18,000 cakes (Boy, 9 years old, Misano Adriatico).

He tries to go to the bathroom, but he hides his discomfort because he knows the reason for it; for example he ate too much food even though he was warned not to (Boy, 15 years old, Corte della Miniera).

She's got her period or just the flu, or she feels bad about something she's done (Girl, 16 years old, Corte della Miniera).

She's worried about her maths exam (Girl, 14 years old, Corte della Miniera).

As can be seen from these comments, the causes attributable to the malaise proposed in the cartoons entitled "having a stomach ache" can have organic as well as psychological origins. The choice of one over the other is mainly related to differences in age rather than gender.

For boys and girls in the younger group, the cause of the stomach ache is, in almost all cases, related to food and is mainly attributable to abuse, quantity, or excessive intake of foods considered "harmful". In very few cases was the attribution of cause related to an external agent, such as a virus.

Following what has already been proposed in the literature, we hypothesised that the near unanimous choice for this cause might relate to a number of specific factors that occur in child socialisation with regard to nutrition, which is a powerful tool for building rules for everyday life and relationships: that is, the transmission and learning of the moral order (James, Kjørholt & Tingstad, 2009). The first factor relates to the key role played by food as a symbolic medium around which family practices take

shape. Indeed, food is one of the main tools through which we build relationships of affection, care and well-being, and thanks to which, over the course of their development, children and teenagers learn to distinguish what is good from what is bad, what is allowed and what is prohibited. Choosing, preparing and eating food testifies to the ways in which each family context, and more general social context, builds and defines what is appropriate or harmful to well-being and health, the limitations individuals ascribe to individuals in food-related matters and the reasons for these limitations (Douglas, 1993; (James, Kjørholt & Tingstad, 2009). The second factor, which is closely linked to the previous one, concerns the moral aspects that are rooted in dietary practices (Diasio, 2006). Indeed, when children learn to distinguish what is “good” from what is “bad” for their health, they also learn which behaviours are socially appropriate and which ones are objectionable, along with the reference values. These forms of learning are steered by individuals and educational agencies who may propose different messages and even contradictory ones. An obvious example of this can be seen in the divergence in the opinions expressed by advertisements and medical knowledge with regard to the wholesomeness of snacks. The malleability of these messages forms the basis for the dietary practices of each family environment and the very way in which children understand what is and is not suitable for their health and social life (James, Kjørholt & Tingstad, 2009; Diasio, 2010).

With development comes a more complex and sophisticated picture of the aetiology of illness, and reflecting on the causes of malaise is one of the first interpretative inquiries made by teenage boys and girls when they are unwell. This reflection is also based on the awareness, acquired over the course of their experience, that the cause of their malaise may not necessarily be organic in nature:

I used to get a [stomachache] when I had a test at school; I used to wake up in the morning with a huge tummy ache from anxiety. I'd be thinking about my marks, my parents, my classmates who might tease me (Goy, 15 years old, Corte della Miniera).

I feel sick when I am nervous (Boy, 16 years old, Corte della Miniera).

Yes, me too, like when you feel guilty, about something you know you've done and you don't want to answer for it ... in the long run, it causes physical pain (Girl, 15 years old, Corte della Miniera).

Asking for adult intervention marks another important difference between the experiences and reflections given by children and those put forward by the teenagers. While for the younger group, adult intervention should be requested on most occasions, for the teenagers, intervention is considered necessary mainly when they think the cause of the illness is organic. In addition to this, it is seen that parents, and especially mothers, are directly called upon by teenagers in two particular situations: when their malaise is completely unknown, that is, they cannot relate it to past experience or known causes, whether organic (e.g. the first menstrual cycles) or psychological (e.g., disappointment in love, being “nervous” about school performance), or when they are asking to use allopathic drugs.

There is one last attribution of cause which, rather than relating to the aetiology, uses an alleged malaise as an “avoidance strategy” (Christensen, 1998) for tasks or situations considered difficult or undesirable through the “staging” of being unwell:

One day I didn't want to go to school, so I tried as hard as I could to get a stomach ache I started to tremble, to get under and out from the blankets, to act like I had a cold and then I managed to get myself to vomit (Boy, 9 years old, Misano Adriatico).

At home, if I say “Mum, my stomach really hurts, can I stay home from school?”, my mum says, “No, you're going because you have to go”, but then I tell the teacher and they let me go home” (Boy, 9 years old, Misano Adriatico).

It is a real social skill in the meaning described above, namely a set of varied skills fundamental to instrumentally manipulating their social context: the ability to learn to recognise, differentiate and select the most appropriate behaviour for expressing a state of malaise or illness; knowing how to identify which of these behaviours is the most suitable for the situation in order to achieve the intended purpose, according to the relational contexts in which they find themselves and the adults present; and lastly, having a sufficiently clear measure of the malaise that must be expressed in order to be convincing.

The “uncertain ages” of competence

Increased age appears to bring an increased level of skills relating to the biomedical paradigm.

These skills work alongside and complement the previous skills concerning physical, psychological, relational and contextual aspects of the experience of illness, introducing forms of interpretation and reflection that are more easily communicable to the adult world. Alongside this extension of the interpretive tools of their own states of health and illness, and those of others, comes a kind of disavowal of the competence of those who are younger than themselves. Indeed, neither the children, nor, to an even greater extent, the teenagers, recognised in younger subjects the existence of skills similar to those possessed by themselves and by their age peers regarding the process of understanding and coping with the experience of “being unwell” and attributing causes. So, for the children and teenagers taking part in our research, age determines forms of incompetence *a priori*, and legitimises adult intervention as necessary, in order to correctly decipher the signals of the body and appropriately set up the practices required to restore a state of good health. This concept of suitability points to the key role of the biomedical paradigm for interpreting the experience of illness and to the construct of childhood as an age of incompetence and the need for care and protection.

Which remedies and how much autonomy in treatment?

In the reflections of the children and teenagers taking part in the research, treatment practices have two important characteristics. Firstly, they are considered and used as an instrument with a strong interpretative value, thanks to which it is possible to understand the degree of severity of a disease. Secondly, children and teenagers appear to place ordered therapies in a hierarchy related to behaviours considered appropriate to resolve the experience of being unwell. In other words, as they learn the treatment hierarchy in relation to the hierarchy of the severity of illnesses, children and teenagers learn what is good and allowed, or what is discouraged and prohibited, with respect to the practices of “being well” and “being unwell”.

An analysis of the responses of the children and teenagers of both genders and age groups to the vignettes, enabled us first of all to identify two macro-categories of remedy, already very clear to even the youngest, relating to the well-known distinction between biomedical remedies and common-sense knowledge remedies. Secondly, it allowed us to identify the awareness, already possessed by even the youngest children, of the hierarchical difference existing between the two different types of knowledge (Prout & Christensen, 1996). Lastly, it showed three prevailing modes of administration-assumption considered the most legitimate for restoring a state of good health: taking allopathic medicines only, reserved particularly for more serious illnesses; choosing mostly common-sense knowledge remedies, for simpler cases; and a combination of the two forms:

If he's really ill, he goes to the doctor who'll give him some medicine (Girl, 9 years old, Misano Adriatico).

He goes to the bathroom and throws up, then his mum gives him some chamomile tea (Girl, 9 years old, Misano Adriatico).

He tries to find a solution, maybe sleep a little, or some chamomile tea or lemonade (Boy, 15 years old, Corte della Miniera).

She takes some medicine, she covers up well so she doesn't catch cold and tries not to think about it (Girl, 16 years old, Corte della Miniera).

She relaxes, has something warm to drink, lies down and rests. If that doesn't work she'll take any medicine (Girl, 16 years old, Corte della Miniera).

In terms of the autonomy that children and teenagers claim to possess for taking medicines and remedies, generally speaking – and consistent with what we said earlier about their interpretative skills concerning malaise and illness – age remains the main variable. What differentiates the experience of the youngest from that of the older group is the greater degree of autonomy that the latter claim to have in adopting a remedy, whether it is an allopathic drug or another remedy, without necessarily requiring adult intervention.

Taking medicines autonomously seems to be a more established practice, especially when the experience of malaise is customary, as in the case of the menstrual cycle, or when it involves a chronic illness (in our sample, only cases of allergies were reported, requiring the use of antihistamines). These are situations where the established routine of taking medicines is based on family practices, which confer a greater degree of responsibility on minors in both age groups, contrary to considerations of age-related incapacity.

Who provides care? Who is authorised to provide care? The division of caregiving

The answers to the situations presented in the cartoons, asking which subjects were more entitled to intervene in a case of stomach ache or in a case of “hurting yourself while playing with yourself friends”, allowed us to understand the key importance of the gender variable in structuring the skills, practices and knowledge of children and teenagers in health matters.

We will mention two of the main elements that emerged from the research.

The first concerns “taking care” and “providing care”. Generally, children and teenagers recognise the importance of adult intervention, giving mothers greater, sometimes almost exclusive, competence in matters of health and illness². They thus demonstrate that they have identified the most common foundations of the division of care between parents and within the family in our society, which assign to mothers the most prevalent role of “parent who provides care” and “parent who takes care” (Ehrich, 2003; Lee, 2007; Lupton, 2011, 2012; Favretto & Zaltron, 2013). Furthermore, they not only ascribe different tasks to mothers and fathers, but they also have different expectations of them based on their gender:

² The central role of mothers as care-givers was confirmed by the analysis of the brainstorming and of relational maps. In such maps, children were asked to indicate those people who would help in case of malaise, illness or minor injuries which might occur while plying alone or with friends. Although several figures were mentioned, mothers were constantly identified. Children mentioned more often mothers as the sole resources, especially in case of malaise. Adolescents mentioned mothers as the first resources, even in situations where help was required from friends.

When I am physically ill, I ask both my parents for help. My dad can help me with the right remedies, for example, he knows when and when not to use Lanosil, but he does not actually put it on.... My dad helps me mentally and my mum helps me physically (Boy, 14 years old, Corte della Miniera).

The second element concerns the behavioural expectations during illness and accidents, which change according to gender. The youngsters in both age groups had different perceptions of themselves depending on their gender. These were not so much related to illness and health, with the exception of malaise connected to the reproductive sphere or with sexual connotations as mentioned by the girls, but rather to reactions that boys and girls "*can/should/are expected*" to have. Indeed girls are expected to have better relational skills even in matters relating to well-being/malaise and health/illness, as illustrated in the following statement:

(in the event of an accident) "If you're hurt, go and comfort her immediately, give her a bit of psychological help, calm her down ...except if it's a boy, then maybe he might fall and get up again without saying anything (Girl, 15 years old, Corte della Miniera).

Boys do not want to show their feelings; we girls are more extroverted, we care more (Girl, 15 years old, Corte della Miniera).

Girls are also expected to be more fragile, more sensitive to pain, confirming the widespread stereotypes about greater female sensitivity and fragility:

They get their mum to cuddle them immediately; boys do not because they are braver (Boy, 9 years old, Misano Adriatico).

If she is unwell, she will cry, she gets downhearted and goes straight to her mum (Boy, 14 years old, Corte della Miniera).

Conversely, boys are expected to bravely resist pain and be indifferent to their own and others' states of malaise:

If it's not serious and you don't get up, your friends will make fun of you because you're a wimp (Boy, 16 years old, Corte della Miniera).

In educational settings outside of the family, like the holiday camps where the focus groups were conducted, comparison between peers encourages self-reflection on their own health and their ability to protect and recover it. This is stimulated by the constant proximity with their peers, whose skills and reactions to “unsettling events” such as physical illness can be observed:

(in the event of illness during a holiday camp) “We don’t think about it much, we try and keep ourselves distracted and that’s also because we try and put all the bad stuff to one side during the holiday. I left home with a stomach ache, and we were actually an hour late; when I got here I was as fit as a fiddle (Boy, 15 years old, Corte della Miniera).

As Christensen notes (2000), this is a constant process of socialisation and learning among peers, involving both embodiment and the operations of the body itself, recognition of major changes, and their skill at coping with unsettling events. Indeed, an analysis of the material collected in the focus groups shows that, for the boys taking part in the research, life outside of the family context and with their peers allows them to put their minor malaises into perspective, as shown in the above testimony. It confirms their self-esteem, and this is true whether they are able to deal with the unsettling event autonomously, or whether they know when to ask for peer or adult intervention. Also, it enables them to compare their own cognitive skills with those of other boys in real contexts, thus increasing their cultural baggage concerning individual health and illness, and their perception of themselves as active and competent agents. This finding recalls the work of Christensen (1998; 2000), which highlighted the intense day-to-day work whereby children build a kind of collective bricolage of information and knowledge, which they use to create a mutual understanding of their own experiences, the “geography” (rudimentary anatomy) of their bodies and how they work (to try and understand physiology).

Interaction with peers outside of the family context is thus an important opportunity for socialisation, for autonomy, and even for health and illness matters, with effects that can be seen in the acquisition of new coping strategies.

Conclusion

To conclude, we will briefly summarise some of the points which are worthy of further study, owing to their implications for the development of educational and therapeutic relationships based on recognition of child and adolescent competences, and the active involvement of children and teenagers in the healthcare paths that affect them.

Our research has shown, first and foremost, that our understanding of states of health, malaise and illness develops within a process that combines physical, psychological, and relational experiences of well-being and malaise with a growing interpretation of the self as a healthy body and diseased body, and with the discovery of the possibility and the opportunity of submitting it to treatments of different types, imparted by different actors. This interpretation is made possible, on the one hand, by references to forms of care belonging to common-sense knowledge, learned from adults and peers and processed personally (especially when daily routines are broken due to illness). It may also stem from references to the biomedical paradigm, whose rudiments are learned in interactions with adults, particularly during episodes of personal illness or as experienced through the illnesses of other “significant” people.

Another interesting finding of our work involves the competence children and teenagers showed in recognising the relational, and not merely the physical, qualities of the symbolic markers and thresholds that mark the transition from a state of malaise to a state of illness. This is a skill that enables children and teenagers to develop skills for the complex task of integrating the experience of their bodily perceptions with the meaning attributed to them socially, and identifying ways to express and talk about them. These skills are also important in view of the fact that they form the basis of coping strategies (Pierret, 2003) for dealing with states of illness.

Gender was another key element in the construction of representations and practices relating to well-being and malaise, health and disease. What we have illustrated in our sample is confirmation of what is seen in the scientific literature (Johnson, 1995; Ehrich, 2003; Lee, 2007; Lupton, 2011, 2012; Favretto & Zaltron, 2013). Similarly to their observations of the adult world, children and teenagers believe there is a “natural” division of family and social labour. Girls are preparing for the “natural” duties of care, by expressing their emotions, pains, malaise and being actively and empathetically interested in the well-being of others who are suffering, as

mothers do and in line with what is expected of them. Boys, on the other hand, albeit with a certain degree of doubt and wavering, are learning that they are required to show resistance to pain, hide when they are upset, to be rational rather than emotional when appealing for treatment and to react in the face of difficult situations. It should be said, however, that during the focus groups, the older boys and older girls in particular, expressed some doubts about the strength of these stereotypes.

Lastly, we would like to put forward a final element regarding the perception of how their own and others' skills develop in relation to age. As we have already stated, an increase in competences, skills and understanding of one's own states of well-being and malaise, health and illness based on the biomedical paradigm, comes with disparagement for the skills of those who are younger in age, whatever their age may be. This is because they are considered to be inadequate, not only because they are less complete and less informed scientifically, but also because they are childish, and thus considered incomplete and inadequate by their very nature.

In summary, the children and teenagers people who took part in the research seem to reflect the representation of childhood and adolescence as stages of life that are characterised by an inability to understand, weak interpretative skills, and the need for care and attention. At the same time, the same children and young people emphasise the existence of their competence, abilities, interpretive skills, and their increasing suitability to handle with partial autonomy the administration of remedies and medication. In this contradiction, they are clearly children of our time, an era when children and teenagers are considered to be the active holders of due rights and, at the same time, the object of protection and special care, on account of their incomplete development. They are subjects with the right to choose and the right to speech, yet also "mute bodies" to take care of, rather than to listen to.

This contradiction, and the balance between the right of children and adolescents to be involved in their own treatment processes on the one hand, and their right to protection on the other, should form the basis for therapeutic relationships that respect the competences, skills and points of view of even the very youngest, to ensure both protection and care.

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