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Pro Teen

CANADIAN ASSOCIATION FOR ADOLESCENT HEALTH



Our website for youth is now online. Check it out at:
www.youngandhealthy.ca

PRO-TEEN

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News from the Association

Report of the President

Membership

We had 782 members in December 2006. 48% of our members have paid their dues in 2006. The members are mainly from Québec and Ontario (90%). 51% are in a group membership. 75% have their dues paid by their institution or organization. 78% of members are women; 59% of members receive their mailing in French, 33% in English and 8% in both language. Obviously, many members distribute the journal to colleagues and from some members, the journal is left in the Library of their institution (CLSC, neighbourhood clinics, public health, etc.)

Scientific Meetings

The 2006 annual national meeting was held on November 3rd and organized by the Adolescent Clinic of the Children's Hospital of Eastern Ontario. Dr Steve Feder and Dr Mark Norris offered a diverse and interesting scientific program under the theme: "Investing in the Health of our Youth. What are Today's Youth Coping with? How can you Help?" The 130 participants, according to their evaluation of the day, were pleased by the speakers and motivating workshops. Many thanks to the CHEO team in charge of that meeting.

Web Site

In February 2006, CAAH launched its website for youth www.youngandhealthy.ca. The website was launched at the same time as a big media campaign for the release of the results of the CAAH-IPSOS online survey of

sexuality of Adolescents in Canada. The site includes resources on sexuality, communication with health care providers and professionals, and a section on body and mind. The work on the website is now near completed with a quiz on STI and the Picture of health section, where youth can post their artwork about being an adolescent in this century. Questions are asked by teens on the website at an increasing rate.

The CAAH website, www.acsa-caah.ca has also been redesigned.

We acknowledge the contribution of all those who work on the two websites:

André Malo, coordination, CAAH
 Dr Jean-Yves Frappier, Editor, CAAH
 Mathieu Lampron, illustrator
 Étienne Richard, web conceptor, Adéquation
 Yvan Richard, web consultant
 Catherine Breton, script writer
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 John Duong, story board, technical assistance
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 Kamal Arora, consultant, McCreary Center Society
 Anil Rawal, consultant, McCreary Center Society
 Jennifer Cameron, consultant, McCreary Center Society
 Dr. Afsoon Fathollahzadeh, ressources, Toronto

Journal

The journal is popular. Many of our new members become members to receive the journal. Publishing the Journal is time consuming. This year, we had two issues of the Journal. We dedicated a fair amount of time for the issue presenting the results of the IPSOS-CAAH online survey of sexuality in Canadian youth.

Projects

Canadian Health Network. Since July 2003, CAAH is the coordinator of the consortium who acts as youth affiliate of the Canadian Health Network, an health promotion website at www.canadian-health-network.ca. Since two years, we have worked on a special youth portal. The CHN special youth area should be functional in 2007. It was developed with the help of McCreary Centre Society and other consortium members.

Projects carried with an unrestricted funds from Merck Frosst Co. In March 2005, CAAH had unrestricted funds from Merck Frosst. In 2006, additional funds were provided to finalize two CAAH projects: 1) analysis of the on-line survey of youth and mothers of youth on issues around sexuality. 2) completing the youth portal and engaging in marketing activities.

- *Survey of sexuality of Canadian youth and perception of their mothers.* The survey was released end of February 2006 with a media campaign. Dr Jean-Frappier (Montreal), Dr Franziska Baltzer (Montreal), Dr Jorge Pinzon (Vancouver), Dr April Elliot

(Calgary) and Dr Miriam Kaufman (Toronto) were the spoke-persons for the release. Altogether, they participated in more than 110 interviews in their respective cities or on the phone for media from other provinces. The media campaign, TV – radio – journals, account for a total audience of 30 millions. The results of the survey are being analyzed more in depth and will be published in scientific journals.

- *Marketing activities for the Youth portal www.youngandhealthy.ca.* A video clip was created in English and French to announce the CAAH youth portal. This clip can serve for viral marketing and for presentation in school health activities. If you want an electronic copy of the clip to distribute through e-mail, let us know. Also bookmarks were designed and a brochure to be sent to schools, clinics, etc.

Finances

Membership dues account for only a small fraction of our income. And only a percentage of the members pay their dues. The financial status of CAAH is precarious.

Future Actions

To review the structure, financial status and some of the by-laws of CAAH.

Jean Yves Frappier
President

Scientific Events

Adolescent Sexuality: from Fun to Preoccupation

13th Annual National Conference

Canadian Association for Adolescent Health

Montreal, November 8-9th 2007

This Conference is organized by the Adolescent Division and the Gynecology Department of CHU Sainte-Justine along with other partners: the Adolescent Medicine Program of the Montreal Children's Hospital, the Sexology dept of UQAM. It will be an occasion to celebrate the 100th anniversary of Ste-Justine Hospital, 100 years of healthcare for adolescents and 32 years of specialized adolescent health services offered by "la section de médecine de l'adolescence" within the hospital and the community.

Adolescent sexuality is often discussed but it seems there is a need to further debate around the topic, perhaps with a different perspective. Despite all media prevention campaign, STI are on the rise and messages don't seem to get across. Schools reorganize their approach to sex education in some provinces. Ethical issues force us to rethink some paradigms. Age of sexual consent is on the political agenda. Adolescents change but laws do not always follow. Contraception and STI treatment are offering new perspectives. And what about parents, professionals and all those involved with youth health, wellbeing and education?

A Conference aimed at nurses, physicians, social workers, psychologist and other professionals from the health sector, public health, schools and also health workers from community or non profit organizations. As usual, there will be a concurrent French and English program. Guest speakers and workshops animators will share thoughts and a new look at an old behavior. Different topics will be covered during the plenary and workshop sessions among which:

- Why messages do not get across
- Ethics and intervention

- The law
- Psychosexual development of adolescent
- Hypersexuality: myth or reality
- The need to perform
- Boys : how to reach them
- Abstinence: challenge and understanding
- The new Québec school program
- Exotic and esoteric approaches: what to think about them?
- What role for parents?
- What role for professionals?
- Adolescent: what do they expect from us?
- The first encounter with a professional: how to address the issue
- Common sexuality problems in youth
- Gynecological problems
- Contraception: what's new?
- STI: What's new
- Human Papilloma virus and vaccine against HPV

To submit a topic for a workshop or a poster, before April 6th 2007: acsacaah@globetrotter.net

For more information on the Conference and to follow the development of the program, visit regularly CAAH website: www.acsa-caah.ca

or contact:

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Human rights and Sexual Health: Implications for Education and Service

29th Annual Guelph Sexuality Conference
Guelph, Ontario, June 18-20th 2007

This yearly event will cover topics such as: sexuality and the law, gender identity, equity, discrimination, policy, minorities, sexual rights, harassment, the internet, and others.

For information: www.open.uguelph.ca/sexconf

Re-Thinking Risk in Adolescence

McCreary Youth Foundation's Annual Conference
Vancouver, April 27-28, 2007

McCreary Youth Foundation's annual conference will explore the theme of "Rethinking Risk" and will challenge conference participants on concepts of risk and to consider both the positive and negative aspects of the risky and risk-taking behaviours of adolescents.

A growing body of research and academic work argues in favour of rethinking our ideas about the importance of measuring at-risk, risky, and risk-taking behaviours of adolescents. It is becoming apparent that documenting risk behaviours does not necessarily change it and that resilience and capacity building in young people; enhancement of protective factors within individuals; and the introduction and evaluation of harm reduction models might be more beneficial.

The goal of this year's conference is to focus our attention on the nature of risk and to understand risk from a young person's perspective. We can then start to address some of the challenges and ways in which we can work to minimize some of the negative impacts of risk and to ensure that the required supports and protective factors are there for young people.

The program is intended for a multidisciplinary audience of academics, youth serving professionals and young people.

Confirmed speakers include:

- Opening remarks by Bob Lenarduzzi
- Keynote address by David A. Wolfe, Ph.D., RBC Chair in Children's Mental Health, Director, CAMH Centre for Prevention Science, Professor of Psychology & Psychiatry, University of Toronto
- Closing remarks by Ian Manion, Ph.D., C.Psych., Executive Director, Operations The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO

For a full conference description, visit: <http://www.myfoundation.ca/conference-description.html> or contact Sarah Day or Kathy Powelson at 604-299-1609 or email: info@myfoundation.ca

1st Canadian National Transcultural Health Conference

May 10 and 11, 2007, Montréal

A skilled multidisciplinary group of healthcare professionals, administrators, educators and community representatives from across Canada will host the conference. Here, you will learn of updates and changes in knowledge on culturally sensitive healthcare practices and policies, as well as engage in reflection on future directions. This event is designed for paediatricians, family physicians, social workers, psychiatrists, psychologists, and educators interested in culture and diversity. It is of equal value to health and social services policy makers and administrators, in addition to front-line community workers and advocates. Throughout the conference, presentations will encourage interactive discussions among participants from across Canada. Since registration is limited, an early response is advised. On behalf of The Montreal Children's Hospital of the MUHC and partners, we welcome you to Montréal for your input in what promises to be a vibrant and ground-breaking meeting. Klaus Minde, MD, FRCP(C) and Marie Serdyska, BSW are the Conference Co-Chair.

Conference Goals & Objectives

- Highlight good practices in the areas of intercultural, transcultural and diversity services and to develop national priorities for future actions
- Explore impacts of different approaches/philosophies of addressing culture and diversity in healthcare, the effectiveness, and the implications of these interventions for future directions
- Promote and strengthen networks of intercultural, transcultural and diversity expertise and collaboration

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Exploring Mental Health in Adolescents

Society for Adolescent Medicine Annual Meeting
Denver, Colorado, March 28-31 2007

You will find the program book on the SAM Web Site www.adolescenthealth.org at Annual Meeting. Along with program book content, you will see a hotel reservation form, a paper copy of the SAM registration form, and a link to the new online Registration Form.

The Program Committee have provided very interesting educational venues this year. Main speakers will address "the teen brain" and "mental health services for adoles-

cents: delivering results". A panel will discuss "serving the mental health of adolescents in schools". The international symposium will offer an "International perspectives on adolescent mental health: from policy to practice". There are 5 platform research presentations, 3 Research Symposium, two separate poster sessions and more than 100 workshops, dialogues or special interest groups.

International Conference on Physical Activity & Obesity in Children

Toronto, Ontario
June 24-27, 2007

The Canadian Fitness and Lifestyle Research Institute (CFLRI) is pleased to invite you to attend this Conference. This intensive, content-rich, four-day program is the perfect opportunity for any professional involved in promoting children's physical activity to access the latest leading edge science related to childhood obesity. You will have the opportunity to hear and interact with the world's leading experts in the field of childhood obesity research.

Some of the scientific activities and topics presented by speakers from around the world.

A Worldwide Perspective on Obesity in Children

The Causes of the Obesity Epidemic in Children

Are children/youth more/less active than previous generations?

- What is the physical inactivity and physical activity level of children and youth?
- Has there been a change in the level of sedentarism and the pattern of physical activity of children over time?
- What are the determinants of physical activity and inactivity in children and youth?

Is physical inactivity contributing to obesity in children and youth?

- What are the factors contributing to the obesity epidemic among children?
- Is there a biological basis for the obesity epidemic?
- Is physical inactivity a contributing factor to the epidemic?

What are the practical implications of the physical activity deficit?

- Whose responsibility is it — parents and/or children?
- Can we modify the social environment of children/youth to overcome the physical activity deficit?

What are the public policy and public health implications of the physical activity deficit?

- Can the physical activity deficit be addressed through legislation?
- Can the physical activity deficit be addressed through public health and formal education approaches?
- Can the physical activity deficit be addressed by the private sector?

Are there successful, innovative community-based physical activity interventions? A presentation of programs from around the world

- Reducing obesity and related chronic disease risk in children and youth: a synthesis of evidence with "best practice" recommendations.
- CAPS, a 4-year physical activity promotion study in French adolescents.
- Promoting physical activity and reducing sedentary behaviour in Australian children.
- Obesity and physical activity interventions in Latin American children.

2007 report card on physical activity for children and youth, Active Healthy Kids Canada.

Conference Secretariat & Registration contact: Canadian Fitness and Lifestyle Research Institute 201-185 Somerset St. West, Ottawa, Ontario K2P 0J2. Tel: (613) 233-5528; Fax: (613) 233-5536; e-mail: mcosta@cflri.ca

From Adolescence to Adulthood: Sharing Approaches and Throwing Passageways Between Two Worlds

7th International Congress of ISAPP

Montreal, July 4 - 7th 2007

The **International Society of Adolescent Psychiatry and Psychology** will hold its Seventh Congress in Montreal from July 4th to July 7th 2007 with the special participation of the Quebec Order of Psychologists, Sainte-Justine Hospital and Philippe Pinel Institute in association with the University of Montreal.

Our next meeting should focus on the transition from adolescence to adulthood, a complex period for care holders where major changes and transformations are needed with regard to practices as several theoretical and clinical issues ask for attention and revision in the distribution of services.

When considering this critical period, recent research data and clinical experimentations will be shared and new evidence provided on adolescent vulnerabilities and pathological traits with their linkage to adult psychiatric conditions. Which should bring to the question: What adult psychiatry might teach to and what should it learn from adolescent psychiatry when confronted to the past history of adult patients or to emerging pathological conditions in adolescents, and sometimes even in young children?

Distinguished guest speakers, presenters and participants should explore longitudinal patterns of various clinical conditions, such as mood and anxiety disorders, psychotic and severe personality disorders, conduct

or eating disorders, as well as several issues raised by diagnosis and detection strategies at an early age. Discussion on these topics amongst experts from various milieux and communities should consider actual controversies and hopefully propose new directions.

On a cultural and social standpoint, the 2007 Congress will take place during the much acclaimed Montreal International Jazz Festival, a major cultural event that spreads a unique spirit to the streets of Montreal where a host of renowned performers and musicians from all over the world perform from June 28th to July 8th.

The International Society for Adolescent Psychiatry and Psychology (ISAPP) is an organization composed of mental health professionals - psychiatrists, psychologists and social workers - working with troubled adolescents in several parts of the world. The organization was established in 1984 as an international professional society to fill a void in the mental health arena. It is the only psychiatric institution at the international level to be exclusively devoted to the mental health of adolescents. Modelled on an American precursor, the American Society for Adolescent Psychiatry, it seeks to provide a forum for intellectual exchange among professionals concerned with troubled adolescents.

Official WebSite: <http://www.isapp2007.org>

Articles

Human Papillomavirus -The Popular Virus Nowadays What you Need to Know about HPV and the Vaccine

What is HPV?

The Human Papillomavirus (HPV) is one of the most common families of viruses in the world and is also the world's leading sexually transmitted infection.

In 2000, Weinstock studied the prevalence and incidence of STI in the 15-24 years old age group in USA. Although it is difficult to have good reliable data on all STI, he estimates that the incidence of HPV (number of new cases in a year) was way above the incidence of all other STI; as an example, 3 times the incidence of Chlamydia, 2.5 times the incidence of Trichomonas, 7.5 times the incidence of Herpes.

How many types of HPV are there?

There are over 100 different types of HPV known to infect humans with about 40 that are specific to anogenital tract infections. This Q&A concerns only anogenital specific HPV.

The anogenital specific HPV are classified as high risk, because they are mostly associated with cervical cancer, or low risk, because they are mostly associated with genital warts.

High risk types: 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68, 82, and probably a few others. The types of HPV in decreasing order of frequency found in a large study of women with cervical cancer are: 16, 18, 45, 31, 33, 52, 58, and 35.

Low risk types: 6, 11, 40, 42, 43, 44, 54, 61, 70, 72, 81. The low risk types are less commonly considered carcinogenic and if they are, it is to other sites than the cervix: penis, vulva, anus, and larynx.

How is it transmitted?

Anogenital specific HPV are transmitted by skin-to-skin contact with the penis, scrotum, vagina, vulva, or anus of an infected person. Although less common, HPV can be transmitted through non penetrative contact and oral sex. Kissing or touching a partner's genitals with the mouth can also transmit HPV. HPV is not transmitted by blood.

Can same sex partners get infected?

Men having sex with men and women having sex with women can also be infected. In a study, HPV DNA has been detected in over 50% of men having sex with men.

Can a teen be infected with more than one type?

Yes, a teen can be infected with more than one type of HPV, both high risk and/or low risk types. In fact, between 5-30% of those infected are infected with more than one HPV type. Being infected with one HPV type does not decrease the risk of acquiring others.

What are the chances of being infected?

It is estimated that 75% of all sexually active Canadians will have at least one HPV infection in their lifetime. In Canada, HPV infects more than 500,000 persons annually.

The Canadian prevalence for cancer-causing types of HPV in different groups of females ranges from 10.8 to 29%.

The highest rates of infection are found in people under the age of 25. It is estimated, like for many other com-

mon STI, that over 70% of HPV infections are among the 15-24 y.o. age group. In a study from Ontario of women visiting their family physicians for a Pap test, the rate for the cancer-causing types of HPV in the 15-19 year olds was 15.7%. The same study shows a 25% acquisition rate over 14 months. In another study in British Columbia, 26% of those under 20 years old were infected.

At any one point in time, 1% of sexually active adults will have visible genital warts. In the Ontario Study, 1.1% presented with genital warts. Most people (66%) who have sexual contact with a partner infected by genital warts will develop warts themselves usually within three months of contact.

What is the incubation period?

It can take weeks to months before the lesion caused by an HPV infection appears or are detected.

What diseases are caused by HPV?

HPV infects the skin, lining of the mouth, tongue, throat, tonsils, vagina, penis, cervix and anus.

Different HPV types are related to different diseases.

Low risk types cause genital warts or condyloma. HPV types 6 and 11 cause 90% of genital warts. Respiratory papillomatosis is seen in one in 400 children born to mothers infected with HPV 6 and 11. From 10-25% of abnormal Pap smears (low grade, ASCUS, LSIL) are associated with low risk HPV types.

High risk types are associated with cancer. HPV types 16 and 18 are associated with 70% of cervical cancer. HPV infection is necessary for the development of cervical cancer but most infections do not result in cancer because the woman is able to clear the virus from her body. High risk types are also associated with 20-50% of vulvar cancer, especially in young women. They are associated with 40% of vaginal cancer and 95% of anal cancer in women and 83% of anal cancer in men. Penile cancers are rare but 40-50% of cases are linked to HPV. About 20% of oropharyngeal cancers are attributable to HPV. High risk types also cause flat warts; they are seen on the skin of the genitals as slightly raised, papular or

macular lesions with brown/grey/bluish pigmentation.

Is cervical cancer frequent?

Cervical cancer is the third most frequent cancer in women between the ages of 20 and 34. In Canada, 8.9/100,000 women will develop the cancer with a mortality rate of 2.5/100,000. In 2006, an estimated 1,350 Canadian women were expected to be diagnosed with invasive cervical cancer and another 390 were expected to die because of it. However, cervical cancer in adolescents is very rare.

What proportion of cervical cancer is attributable to HPV?

Most if not all cervical cancer cases are attributable to HPV infection. The attributable proportion is a little higher for HPV and cervical cancer than for smoking and lung cancer and much higher than for alcohol and oral cancer.

Any risk factors or predictors associated with HPV?

Risk factors associated with HPV acquisition include:

- Young age (<25 years)
- Increasing number of sexual partners
- First sexual intercourse at an early age (< 16 years)
- Male partner has had or has multiple sex partners
- Previous infection with an STI, specifically Chlamydia and Herpes simplex
- Use of oral contraceptives is controversial as an associated factor

Any risk factors for failure to detect or progression of Cervical Cancer?

Risk factors for HPV persistence and progression to cervical cancer include:

- Has never been screened for cervical cancer (close to 50% of women with cervical cancer)
- HIV infection or a weakened immune system from any cause
- Cigarette smoking

How long can the infection last?

Most HPV infections are transient. About 70% will be HPV DNA negative after one year and 91% after 2 years. High risk types take longer to clear than low risk types. However, it is unclear if it is eliminated or if it stays dormant and then reactivates years after.

Genital warts seem to clear within an average of 18-24 months in most infected persons.

Are there signs and symptoms?

Many teens with HPV infection don't know they have it. However, they are contagious.

In cases of genital warts, cauliflower-like growths appear and symptoms can include itching, burning and, in anal warts, occasional bleeding as a result of anal sex or a bowel movement.

Lesions of the cervix (cervical intraepithelial lesions or neoplasia) rarely have noticeable signs or symptoms.

How are HPV related diseases diagnosed?

Genital warts are usually easy to identify upon clinical examination.

Pap tests (also called a Pap smear) for women are used to examine cells collected from the cervix to help identify abnormal cell changes before cancer develops or cervical cancer. The limitation of Pap testing is the high rate of false-negative results - the estimated range is 5% to 20% with about one third of false-negative diagnoses attributable to slide interpretation errors and two thirds to poor sample collection and slide preparation. Pap tests are more accurate when high grade cervical lesions are present.

Cervical lesions are classified by severity using a system known as 'CIN' (cervical intraepithelial neoplasia): stage 1 lesions are considered low grade and can clear up on their own whereas stages 2 and 3 are considered high grade and are pre-cursors to cervical cancer. Many women infected by HPV develop atypical squamous cells of undetermined significance (ASC-US) or low grade squamous intraepithelial lesions (LSIL).

When a Pap smear is abnormal, it is possible that a colposcopy will be recommended. A colposcopy is done during a regular gynaecologic examination where the colposcope, a type of binocular with magnifying lenses is used to find areas of abnormality on the cervix and then proceed to a biopsy.

There is no culture for HPV. Screening for HPV using an HPV DNA test is not widely available and is expensive; one test detects high risk types and does not identify which type is detected; another test can detect low risk types. A biopsy can be performed for genital warts but is not indicated in most cases. A serology test is available only for research purposes; many infected persons do not have detectable antibodies. Other tests exist but are mainly used in research.

In men, apart from an examination for genital warts, there is no recommended test to detect HPV.

What about treatment?

There is currently no medical cure to eliminate HPV infection.

Those with cell changes on the cervix are followed and treatment offered before the cells evolve either to a higher grade or to cancer. Follow-up is according to guidelines for PAP testing, HPV testing and the results of these tests (low grade or high grade changes).

Depending on the stage of cervical cancer, there are treatment options.

Genital warts can be removed by laser therapy, chemical treatments or immunotherapy but they can reappear.

Can HPV infection be prevented?

A vaccine is now available that protects against 4 types of HPV. Condoms do not offer 100% protection but are still indicated, if not for the prevention of other STIs. Reducing the number of partners and monogamy are somewhat effective approaches.

What is the story on condoms?

Condoms have not been shown to offer 100% protection

or prevention of HPV infection possibly because the virus can be on uncovered areas of the skin. However, recent studies have shown some benefit if a condom is always used, including: regression of cervical lesions (CIN), clearance of HPV in women and men (penile lesions), acquisition of HPV (up to 70% reduction in transmission).

What is the vaccine against HPV?

A quadrivalent vaccine is available in Canada since July 2006. It immunizes against HPV types 6, 11, 16, 18. Thus the vaccine protects against 70% of the types causing cervical cancer and 90% of the types causing genital warts. The vaccine contains virus like particles and is thus not a live or attenuated virus vaccine and contains no viral DNA. It induces immunity, but not infection. Another vaccine, bivalent (type 16, 18) has not yet been approved.

What is the quadrivalent vaccine efficacy?

At this time, 5-years data shows 96% protection against HPV infection. No cases of cervical intraepithelial neoplasia (CIN) caused by HPV type 16 or 18 or genital warts caused by HPV type 6 or 11 were found.

Who Should Get the Vaccine Against HPV in Canada?

The recommendations of the national advisory committee on immunization for the quadrivalent vaccine are (Statement on human papillomavirus vaccine. An Advisory Committee Statement (ACS), National advisory committee on immunization. Can Commun Dis Rep. 2007;33(ACS-2):1-32):

1. "Females between 9 and 13 years of age. Gardasil TM is recommended for females between 9 and 13 years of age, as this is before the onset of sexual intercourse for most females in Canada, and the efficacy would be greatest. While efficacy of the vaccine in this age group has not been demonstrated, the immunogenicity bridging data implies that efficacy would be high.
2. Females between the ages of 14 and 26 years would benefit from Gardasil TM, even if they are already sexually active, as they may not yet have HPV infection and are very unlikely to have been infected with all four HPV types in the vaccine. It is therefore recommended that females in this age group receive the vaccine. However, women who are already sexually active may be infected with an HPV type contained in the vaccine, and there is no readily available screening method to determine this. Therefore, these women need to be aware of the possibility that they are already infected.
3. Females between the ages of 14 and 26 years who have had previous Pap abnormalities, including cervical cancer, or have had genital warts or known HPV infection would still benefit from Gardasil TM. These women may not have had infection with the HPV types included in the vaccine and are very unlikely to have been infected with all four HPV types contained therein. It is therefore recommended that these women receive the vaccine. However, they should be advised that there are no data to suggest that the vaccine will have any therapeutic effect on existing cervical lesions.
4. Females > 26 years. Studies of Gardasil TM vaccine use in women > 26 years are ongoing. No recommendations can be made for the use of the vaccine in this age group at this time, although its use can be considered in individual circumstances.
5. Females < 9 years of age. Immunogenicity or efficacy is not known for females < 9 years of age nor is the duration of protection from this vaccine. The vaccine is not recommended for this age group.
6. Males. While immunogenicity data are available for boys and men, the efficacy of Gardasil TM vaccine in males is as yet unknown. The vaccine cannot be recommended for males at this time.
7. Immunocompromised persons. Because Gardasil TM is a subunit vaccine, it can be administered to persons who are immunosuppressed as a result of disease or medications; however, the immunogenicity and efficacy in this population are not known, and individuals should be aware that immune response to the vaccine might be less than in persons who are immunocompetent.
8. Pregnancy. Gardasil TM vaccine is not recommended for use in pregnancy. Although the vaccine has not been causally associated with adverse outcomes of pregnancy or adverse events to the developing fetus, the data on vaccination in pregnancy are limited. Until further information is available,

initiation of the vaccine series should be delayed until after completion of the pregnancy. If a woman is found to be pregnant after initiating the vaccination series, completion of the three-dose regimen should be delayed until after pregnancy. If a vaccine dose has been administered during pregnancy, there is no indication for any intervention”.

In Canada, it is estimated that the mean age at first intercourse is 15 years old in sexually active teenagers. Over 45% of teenage girls are sexually active by the age of 17 years old. These figures are probably much higher for adolescents presenting with social, familial or behavioural problems.

Can teenage boys get the vaccine?

Studies in males are underway. At this time, there is no published data on the efficacy of the vaccine in men. However, other countries like Australia, Mexico and European Union have approved the vaccine for men, based on good immunogenicity and safety data. It is probable that the efficacy will also be high in males. Results of studies should be available in 2008-09.

If a girl is already sexually active, is the vaccine recommended?

A girl who is sexually active may not be infected with any or all of the four types against which the vaccine protects. So immunization of sexually active girls is recommended. Obviously, it is better to immunize before the onset of sexual contact.

There are no reliable tests or tests used other than for research purposes that would determine with certainty if a girl is already infected and with what HPV type. The vaccine has no proven therapeutic effect.

If a teenage girl is already infected with one of the HPV types in the Vaccine or has cervical cells changes, can the vaccine cure the infection and is the vaccine indicated?

The vaccine is prophylactic, it is not therapeutic. Up to now, no study has proven any efficacy for those already infected. But she can be protected against the other HPV types in the vaccine and there is no contraindication to

vaccination. However, she still should be monitored according to standard practices for the cells changes.

How is the vaccine administered?

The vaccine is administered intramuscularly in 3 doses at 0; 2; 6 months. The second dose could be given a month after the first one and the third at least three months after the second.

The 3 doses are recommended and it is not known what immunity the girl would get from only one or 2 doses.

The vaccine should be kept at a temperature of 2-8 degrees Celsius and it cannot be kept in a home refrigerator but in an office refrigerator with temperature logs.

If a girl is sick, can she be vaccinated?

The vaccine can be administered to girl who presents with minor illnesses like mild gastro-enteritis or a cold.

How long will the protection last?

The current studies show that vaccinated persons are protected up to 5 years and there is no evidence of waning immunity during that time period. Studies are being carried on to evaluate longer term efficacy.

What are the side effects?

The vaccine has been tested in over 25,000 women (9-26 y.o.) in 33 different countries. There were no serious side effects. Administration of the vaccine can cause soreness at the injection site.

Is it dangerous if the vaccine is given during pregnancy?

Based on the data, there were not more congenital anomalies overall in the pregnant women who receive the vaccine versus the placebo group. A non significant difference was found in the group of females whose estimated onset of pregnancy was within 30 days of receiving the vaccine. However, the vaccine is not recommended during pregnancy or for girls whose intention is to get pregnant. If a teen becomes pregnant during the vaccination series, the remaining vaccinations should

be postponed until she is postpartum. A pregnant teen who receives a vaccination should be reported to the company's pregnancy registry for follow-up (800 986-8999).

Does a vaccinated girl still need Pap smear control?

Yes, if she is sexually active. The vaccine protects against type 16 and 18, associated with 70% of cervical cancer. There are still the other types not covered by the vaccine and that can cause cervical cancer. Also, it is possible that she was already infected when she got the vaccine. The Pap test should be done according to standard of care for that age group.

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- Human Papilloma virus: HPV information for clinicians. 2006. This brochure is available online at www.cdc.gov/std/HPV/hpv-clinicians-brochure.htm. It can also be accessed from www.cdc.gov/std/hpv. This brochure covers the natural history, risk factors, transmission, prevention and management of HPV infection and associated conditions, including new technologies and guidelines for the prevention, screening and management of cervical cancer. Also posted is four sets of counseling messages, developed to facilitate provider-patient communication about HPV and associated diseases. These will include messages for (1) prospective vaccine recipients, (2) women receiving the HPV DNA test with Pap for cervical cancer screening, (3) women with a high-risk HPV DNA test result, and (4) patients with genital warts. Finally, for those interested, you can now register for email notifications whenever updates are made to CDC's HPV page. To do this, click on the new link at the top of our HPV page (www.cdc.gov/std/hpv), called Email updates.

Health Canada, Population and Public Health Branch, Bureau of HIV/AIDS, STD and TB, What you need to know about human papillomavirus (HPV) web page (<http://www.phac-aspc.gc.ca/std-mts/pdf/hpv-e.pdf>)

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Vaccines History Is Instructive

David Oshinsky

In 1796, an English country doctor named Edward Jenner successfully immunized a child against smallpox, the world's deadliest infectious disease. His experiment, "An Inquiry Into the Causes and Effects of the Variolae Vaccinae" (or "smallpox of the cow") added the word "vaccination" to our vocabulary. News of Jenner's stunning achievement led millions throughout Europe to roll up their sleeves. Napoleon, Britain's mortal enemy, had his troops vaccinated before taking the field. "Ah, Jenner," he supposedly said after freeing two English prisoners at the doctor's request, "I can withhold nothing from that man."

Yet, as Arthur Allen makes clear in "Vaccine", a timely, fair-minded and crisply written account of "medicine's greatest lifesaver," not everyone welcomed Jenner's feat. Criticism came quickly, often in apocalyptic terms. The economist Thomas Malthus wrote that vaccination might lead to dangerous population increases. Ministers warned against interfering with the Lord's grand design. Others, meanwhile, objected to a process that injected foreign, perhaps poisonous, matter into the body. What possible good could come from polluting the bloodstream of a child?

For vaccine supporters, the answer was simple. Vaccination saved lives by stimulating the immune system to create protective antibodies against disease. The process wasn't foolproof, they agreed, and the hazards were real. Vaccines could be contaminated with deadly bacteria; some were too weak to be effective, others so strong they could kill. Yet in a world where millions were dying needlessly from smallpox, this seemed a small price to pay. Vaccination, like other great discoveries, involved risk and reward.

Antivaccine sentiment found fertile soil in the United States, where the ethos of individual responsibility often clashed with public health programs based on collective norms. As Allen notes, Americans remained suspicious of calls for mandatory vaccination. Indeed, one of the potent symbols of the early antivaccine movement was the limp "Raggedy Ann" doll, created in 1915 by a man whose daughter had died shortly after being vaccinated

at school without parental consent. Authorities blamed a heart defect; her parents blamed the shot.

What kept vaccine opponents on the defensive, however, were the rapid breakthroughs in medicine and public health. Jenner's triumph was followed by a procession of other vaccines, for rabies, tetanus, yellow fever, diphtheria and more. A healthier diet, advances in sanitation and surgery, the development of antibiotics and DDT - all combined to increase the average American life expectancy to 70 years from 47 between 1900 and 1955.

Allen sees two events in these years as crucial to the growing public acceptance of vaccines. When America went to war in 1941 following Pearl Harbor, the health of the troops became a primary concern. Determined to prevent the medical casualties of World War I, where the number of American soldiers killed by influenza (44,000) almost matched the number lost in battle (50,000), military officials made vaccination mandatory. "Yes, the shots hurt and even caused illness sometimes, but the soldier survived," Allen writes. "Returning from the war he wanted his children to have the same protection."

World War II made vaccination fashionable. Polio turned it into a national crusade. No disease drew as much attention in postwar America, or created as much fear. Primarily striking children, polio killed some of its victims and paralyzed others, leaving behind vivid reminders for all to see: wheelchairs, leg braces, iron lungs, deformed limbs. The quest for a means of prevention led to the largest public health experiment in American history, involving nearly two million school-age volunteers. When Jonas Salk's killed-virus polio vaccine was declared "safe, effective and potent" in 1955, the nation celebrated as if a war had ended - and, indeed, one had. At a White House ceremony, President Eisenhower choked back tears as he told the young researcher: "I have no words to thank you. I am very, very happy."

The polio vaccines of Salk and Albert Sabin marked a special moment in medical history. As late as the 1950s, parents had been encouraged to expose their children to

diseases like measles, mumps and chicken pox in order to get them over with before adulthood, when the dangers increased. Now, there were vaccines for all these illnesses, and more were on the way. Some researchers spoke openly of a future without infectious disease. “Will such a world exist?” a scientist asked. “We believe so.”

In our current age of AIDS, Ebola and avian flu, one marvels at the arrogance of these words. Nature remains a full step ahead. For Allen, growing fears of vaccination in the decades after Salk’s triumph are partly a function of these heightened expectations. But more important, he thinks, was the general fallout from catastrophes like Watergate and Vietnam, which undermined institutional authority across the board. By 1980, the days of deferring to the expertise of doctors and researchers, pharmaceutical companies and federal bureaucrats, were long gone in the United States - and unlikely to return. The public’s portrait of a medical researcher had turned from the selfless and independent Salk working on behalf of children to that of a lab-coated lackey from a drug giant conspiring to hide the dangers of products that are slickly marketed and wildly overpriced.

In terms of vaccination, the Watergate moment occurred in 1982, when a television station in Washington, D.C., broadcast an ominous documentary about the dangers of D.T.P., a standard childhood shot for diphtheria, tetanus and pertussis (whooping cough). Titled “Vaccine Roulette,” it was, Allen notes, a story “waiting to be told.” The pertussis component had proved extremely effective against a wretched, life-threatening disease. But side effects, including convulsions and brain damage, were reported in a tiny percentage of those who received it. By playing up the perils of D.T.P., while minimizing the seriousness of pertussis, the documentary ignited a grass-roots movement of alarmed parents - some suspecting that their children had been damaged by D.T.P., others concerned by the ever growing number of vaccines being recommended by their pediatricians. For Allen, this was a signal opportunity - a chance to educate the public about the process of vaccination. But

little positive came of it, beyond a national compensation program in 1986 that allowed families claiming vaccine-injury to file for government payments.

Allen is sympathetic to parental fears regarding the dangers of various vaccines, though he remains skeptical that scientific studies of these dangers, no matter how rigorous, will open many minds. At this point, he writes, much of the “antivaccinist” leadership is composed of countercultural types who view life through the prism of conspiracy theory: the government lies, the drug companies are evil, the medical profession is corrupt; trust the Internet instead. A fair number oppose traditional medicine in favor of homeopathy, believing that vaccines weaken the immune system and that sickness is a natural part of life. “We treat our children like machines that are never supposed to slow down or let us miss a day of work,” a mother told Allen. “We never allow them the soulfulness of being ill.”

To a large extent, says Allen, this antivaccination impulse is fueled by an ignorance of the past. Vaccines have done their job so well that most parents today are blissfully unaware of the diseases their children are being inoculated against. The end result is a culture that has become increasingly risk-averse regarding vaccination because people have greater trouble grasping the reward.

The problem appears to be growing. As more children go unvaccinated in the United States, there has been a rise in vaccine-preventable diseases. Meanwhile, fewer pharmaceutical companies are now producing vaccines, citing the high cost of testing, diminishing markets and a fear of litigation. For Allen, a reversal of these trends will require something long overdue: a frank national discussion about the risks and benefits of vaccination. His splendid book is a smart place to begin.

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Gun Control: the Fight for a Safe Law Goes on

The Government has proposed to change the Canada's Gun Control Law, eliminating registration of Rifles. Our Association has been part of the process to bring this law. It is important to remind some facts.

Canada Is Safer Today than In 1991

Statistics Canada released data showing gun death in Canada is the lowest it has been in 30 years. In 2003, 792 Canadians were killed with firearms compared to 1132 in 1995 (the year Bill C-68 passed) and 1444 in 1991. Declines are most pronounced in suicides, homicides with rifles and shotguns, homicides of women.

In spite of the increase in gang violence with illegal handguns, homicides with firearms are down from 271 in 1991 to 175 in 2004. This law protects women. Since 1991, murders of women with guns have fallen by two-thirds. Meanwhile, the number of murders of women without firearms has gone down only 10%. 77% of spouses of firearms owners support the legislation. The new system is working. License screening has prevented 7,000 potentially dangerous people from owning guns.

Police access the gun registration database 5000 times a day and use it to remove guns from people who pose a threat. It supports investigations - more than 3000 court cases used data from the registry in 2005 alone. The new firearms registry has been a success: 90% of all firearms' owners are now licensed. 90% of all firearms are now registered.

The Supreme Court of Canada unanimously ruled that registration and licensing are linked and that it is not reasonable to have one without the other. Most industrialized countries license gun owners and register guns.

Our gun laws may not be perfect and there have been problems with costs and management, but the fundamental question is: should we make it easier or harder for criminals to get firearms?

Licensing gun owners and registering firearms are the foundation of community safety. Stronger firearms' laws over 15 years have contributed to a decrease in deaths

and injuries from homicide, suicide and accidents. All illegal guns begin as legal guns. Without strong controls over firearms we cannot keep guns out of the wrong hands. Public safety not gun owner interests must be the priority. The powerful NRA (National Rifle Association, USA) has been in Canada supporting the Canadian gun lobby. But most Canadians support strong gun laws and want more not less gun control.

Controls on ALL Guns Are Needed

Rifles and shotguns in the wrong hands are just as deadly as handguns. Half the police officers killed in recent years have been killed with rifles and shotguns. They are the weapons of choice in domestic violence and suicide. They are also often confiscated from gangs. Six inquests recommended licensing and registration because they are essential to preventing tragedies. While half the handguns recovered in crime originate in the US, the other half come from Canadian sources.

Screening and licensing gun owners is fundamental to any system of firearms control. In 1995 a comprehensive licensing system was introduced which required anyone who owned a gun to have a valid license, renewed every 5 years. Previously a firearms acquisition certificate (FAC) was required to ACQUIRE firearms not to possess them. As a result only 1/3 of gun owners had valid FACs. Most Canadian gun owners, almost 2 million, obtained their licenses in 2000 and the initial renewal cycle was extended over 4 years (2005-2009). Many gun owners now need to renew their licenses at a cost of \$60 for 5 years, regardless of the number of firearms they own.

The Controversy over the Costs of Gun Control in Canada

The "Billion Dollar Gun Registry" is misleading. The total cost to set up a brand new program, license most owners, and register most guns has averaged \$96 million per year, most of it on screening and licensing gun owners NOT registering firearms.

"The registry" has become short for the entire firearms

licensing and registration program in Canada and much confusion exists regarding its costs and operations. In 2005/6 the entire program cost less than \$83 million, most of it – \$62.8 million – spent on licensing gun owners. Only \$15.7 million has been budgeted for the registration of ALL guns, a fraction of that – about \$10 million - is spent on registering rifles and shotguns. Claims that huge savings will come from eliminating the registration of rifles and shotguns that can be reinvested in policing are not based on fact. Registration is one time only – 7 million rifles and shotguns have been registered. The only guns which need to be registered now are those being acquired or transferred, about 400,000 per year which is why the ongoing costs.

In May 2006, the Auditor General's Report provided no basis for dismantling gun control. 1) In spite of the claims that secret spending would drive the costs of the firearms "registry" up to two billion or more, the auditor general confirmed that the costs over 10 years were slightly under the \$1 billion projected - \$946 million over 10 years. 2) The auditor general did criticize the government for accounting and management practices, for example, expenses were not claimed in 2003/4 that should have been, instead they were claimed in 2004/5. While this did not affect the overall costs of the registry she noted that it was an attempt to mislead parliament by not showing the cost over-runs in the year they occurred. 3) The auditor general also indicated that improvements have been made and the system seems to be well-managed now. 4) She identified areas for improvement including better management of the verification of registration data (currently firearms registration information is verified by a network of volunteers with little

control and potential errors, the government has refused to pay for verification or charge fees to gun owners to cover the costs of verification).

In May 2006, the International Action Network on Small Arms noted that Canada would be swimming against international trends to strengthen controls on guns in order to fight the illegal trade in guns. Ontario's Attorney General and the Mayor of Toronto have also said it would be a mistake to relax the laws. Polls show that 2/3 of Canadians support the basic principles of the law, while support is highest in Ontario and Quebec, even in Alberta it is 50%.

Major Policing and Public Safety Groups Maintain that we Need the Law.

- Canadian Association of Chiefs of Police
- Canadian Professional Police Association more than 40 women's organizations from across the country including virtually every province
- Centre of Suicide Prevention
- Canadian Paediatric Society
- Canadian Association for Adolescent Health
- Canadian Association of Emergency Physicians
- Quebec Public Health Association

Adapted from Coalition for Gun Control Documents
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Helping Children and Adolescents Cope with Violence and Disasters

The National Institute of Mental Health, National Institute of Health, USA

Helping young people avoid or overcome emotional problems in the wake of violence or disaster is one of the most important challenges a parent, teacher, or mental health professional can face. The National Institute of Mental Health and other Federal agencies are working to address the issue of assisting children and adolescents who have been victims of or witnesses to violent and/or catastrophic events. The purpose of this fact sheet is to tell what is known about the impact of violence and disasters on children and adolescents and suggest steps to minimize long-term emotional harm.

In the aftermath of the terrorist attacks on New York City and Washington, D.C., both adults and children are struggling with the emotional impact of such large-scale damage and losses of life. Other major acts of violence that have been felt across the country include the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City and the 1999 shootings at Columbine High School in Littleton, Colorado. While these disastrous events have caught the Nation's attention, they are only a fraction of the many tragic episodes that affect children's lives. Each year many children and adolescents sustain injuries from violence, lose friends or family members, or are adversely affected by witnessing a violent or catastrophic event. Each situation is unique, whether it centers upon a plane crash where many people are killed, automobile accidents involving friends or family members, or natural disasters such as the Northridge, California Earthquake (1994) or Hurricane Floyd (1999) where deaths occur and homes are lost—but these events have similarities as well, and cause similar reactions in children. Even in the course of everyday life, exposure to violence in the home or on the streets can lead to emotional harm.

Research has shown that both adults and children who experience catastrophic events show a wide range of reactions (1, 2). Some suffer only worries and bad memories that fade with emotional support and the passage of time. Others are more deeply affected and experience long-term problems. Research on post-traumatic stress disorder (PTSD) shows that some soldiers, survivors of criminal victimization, torture and other violence, and

survivors of natural and man-made catastrophes suffer long-term effects from their experiences. Children who have witnessed violence in their families, schools, or communities are also vulnerable to serious long-term problems. Their emotional reactions, including fear, depression, withdrawal or anger, can occur immediately or some time after the tragic event. Youngsters who have experienced a catastrophic event often need support from parents and teachers to avoid long-term emotional harm. Most will recover in a short time, but the few who develop PTSD or other persistent problems need treatment.

Trauma, what Is It?

“Trauma” has both a medical and a psychiatric definition. Medically, “trauma” refers to a serious or critical bodily injury, wound, or shock. This definition is often associated with trauma medicine practiced in emergency rooms and represents a popular view of the term. Psychiatrically, “trauma” has assumed a different meaning and refers to an experience that is emotionally painful, distressful, or shocking, which often results in lasting mental and physical effects.

Psychiatric trauma, or emotional harm, is essentially a normal response to an extreme event. It involves the creation of emotional memories about the distressful event that are stored in structures deep within the brain. In general, it is believed that the more direct the exposure to the traumatic event, the higher the risk for emotional harm (3). Thus in a school shooting, for example, the student who is injured probably will be most severely affected emotionally; and the student who sees a classmate shot, even killed, is likely to be more emotionally affected than the student who was in another part of the school when the violence occurred. But even second-hand exposure to violence can be traumatic. For this reason, all children and adolescents exposed to violence or a disaster, even if only through graphic media reports, should be watched for signs of emotional distress.

How Children and Adolescents React to Trauma?

Reactions to trauma may appear immediately after the traumatic event or days and even weeks later. Loss of trust in adults and fear of the event occurring again are responses seen in many children and adolescents who have been exposed to traumatic events. Other reactions vary according to age (4-7)

For children 5 years of age and younger, typical reactions can include a fear of being separated from the parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions and excessive clinging. Parents may also notice children returning to behaviors exhibited at earlier ages (these are called regressive behaviors), such as thumb-sucking, bedwetting, and fear of darkness. Children in this age bracket tend to be strongly affected by the parents' reactions to the traumatic event.

Children 6 to 11 years old may show extreme withdrawal, disruptive behavior, and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and fighting are also common in traumatized children of this age. Also the child may complain of stomachaches or other bodily symptoms that have no medical basis. Schoolwork often suffers. Depression, anxiety, feelings of guilt and emotional numbing or "flatness" are often present as well.

Adolescents 12 to 17 years old may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, and anti-social behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, and confusion. The adolescent may feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery from the trauma.

Some youngsters are more vulnerable to trauma than others, for reasons scientists don't fully understand. It has been shown that the impact of a traumatic event is likely to be greatest in the child or adolescent who previously has been the victim of child abuse or some other

form of trauma, or who already had a mental health problem (8-11). And the youngster who lacks family support is more at risk for a poor recovery (12).

Helping the Child or Adolescent Trauma Survivor

Early intervention to help children and adolescents who have suffered trauma from violence or a disaster is critical. Parents, teachers and mental health professionals can do a great deal to help these youngsters recover. Help should begin at the scene of the traumatic event.

According to the National Center for Post-Traumatic Stress Disorder of the Department of Veterans Affairs, workers in charge of a disaster scene should:

- Find ways to protect children from further harm and from further exposure to traumatic stimuli. If possible, create a safe haven for them. Protect children from onlookers and the media covering the story.
- When possible, direct children who are able to walk away from the site of violence or destruction, away from severely injured survivors, and away from continuing danger. Kind but firm direction is needed.
- Identify children in acute distress and stay with them until initial stabilization occurs. Acute distress includes panic (marked by trembling, agitation, rambling speech, becoming mute, or erratic behavior) and intense grief (signs include loud crying, rage, or immobility).
- Use a supportive and compassionate verbal or non-verbal exchange (such as a hug, if appropriate) with the child to help him or her feel safe. However brief the exchange, or however temporary, such reassurances are important to children.

After violence or a disaster occurs, the family is the first-line resource for helping. Among the things that parents and other caring adults can do are:

- Explain the episode of violence or disaster as well as you are able.
- Encourage the children to express their feelings

and listen without passing judgment. Help younger children learn to use words that express their feelings. However, do not force discussion of the traumatic event.

- Let children and adolescents know that it is normal to feel upset after something bad happens.
- Allow time for the youngsters to experience and talk about their feelings. At home, however, a gradual return to routine can be reassuring to the child.
- If your children are fearful, reassure them that you love them and will take care of them. Stay together as a family as much as possible.
- If behavior at bedtime is a problem, give the child extra time and reassurance. Let him or her sleep with a light on or in your room for a limited time if necessary.
- Reassure children and adolescents that the traumatic event was not their fault.
- Do not criticize regressive behavior or shame the child with words like “babyish.”
- Allow children to cry or be sad. Don’t expect them to be brave or tough.
- Encourage children and adolescents to feel in control. Let them make some decisions about meals, what to wear, etc.
- Take care of yourself so you can take care of the children.

When violence or disaster affects a whole school or community, teachers and school administrators can play a major role in the healing process. Some of the things educators can do are:

- If possible, give yourself a bit of time to come to terms with the event before you attempt to reassure the children. This may not be possible in the case of a violent episode that occurs at school, but sometimes in a natural disaster there will be several days before schools reopen and teachers can take

the time to prepare themselves emotionally.

- Don’t try to rush back to ordinary school routines too soon. Give the children or adolescents time to talk over the traumatic event and express their feelings about it.
- Respect the preferences of children who do not want to participate in class discussions about the traumatic event. Do not force discussion or repeatedly bring up the catastrophic event; doing so may re-traumatize children.
- Hold in-school sessions with entire classes, with smaller groups of students, or with individual students. These sessions can be very useful in letting students know that their fears and concerns are normal reactions. Many counties and school districts have teams that will go into schools to hold such sessions after a disaster or episode of violence. Involve mental health professionals in these activities if possible.
- Offer art and play therapy for young children in school.
- Be sensitive to cultural differences among the children. In some cultures, for example, it is not acceptable to express negative emotions. Also, the child who is reluctant to make eye contact with a teacher may not be depressed, but may simply be exhibiting behavior appropriate to his or her culture.
- Encourage children to develop coping and problem-solving skills and age-appropriate methods for managing anxiety.
- Hold meetings for parents to discuss the traumatic event, their children’s response to it, and how they and you can help. Involve mental health professionals in these meetings if possible.

Most children and adolescents, if given support such as that described above, will recover almost completely from the fear and anxiety caused by a traumatic experience within a few weeks. However, some children and adolescents will need more help perhaps over a longer period of time in order to heal. Grief over the loss of a

loved one, teacher, friend, or pet may take months to resolve, and may be reawakened by reminders such as media reports or the anniversary of the death.

In the immediate aftermath of a traumatic event, and in the weeks following, it is important to identify the youngsters who are in need of more intensive support and therapy because of profound grief or some other extreme emotion. Children and adolescents who may require the help of a mental health professional include those who show avoidance behavior, such as resisting or refusing to go places that remind them of the place where the traumatic event occurred, and emotional numbing, a diminished emotional response or lack of feeling toward the event. Youngsters who have more common reactions including re-experiencing the trauma, or reliving it in the form of nightmares and disturbing recollections during the day, and hyperarousal, including sleep disturbances and a tendency to be easily startled, may respond well to supportive reassurance from parents and teachers.

Post-traumatic Stress Disorder

As mentioned earlier, some children and adolescents will have prolonged problems after a traumatic event. These potentially chronic conditions include depression and prolonged grief. Another serious and potentially long-lasting problem is post-traumatic stress disorder (PTSD). This condition is diagnosed when the following symptoms have been present for longer than one month:

- Re-experiencing the event through play or in trauma-specific nightmares or flashbacks, or distress over events that resemble or symbolize the trauma.
- Routine avoidance of reminders of the event or a general lack of responsiveness (e.g., diminished interests or a sense of having a foreshortened future).
- Increased sleep disturbances, irritability, poor concentration, startle reaction and regressive behavior.

Rates of PTSD identified in child and adult survivors of violence and disasters vary widely. For example, estimates range from 2 percent after a natural disaster

(tornado), 28 percent after an episode of terrorism (mass shooting), and 29 percent after a plane crash (13).

The disorder may arise weeks or months after the traumatic event. PTSD may resolve without treatment, but some form of therapy by a mental health professional is often required in order for healing to occur. Fortunately, it is more common for traumatized individuals to have some of the symptoms of PTSD than to develop the full-blown disorder (14).

As noted above, people differ in their vulnerability to PTSD, and the source of this difference is not known in its entirety. Researchers have identified factors that interact to influence vulnerability to developing PTSD. These factors include: characteristics of the trauma exposure itself (e.g., proximity to trauma, severity, and duration), characteristics of the individual (e.g., prior trauma exposures, family history/prior psychiatric illness, gender—women are at greatest risk for many of the most common assaultive traumas), and post-trauma factors (e.g., availability of social support, emergence of avoidance/numbing, hyperarousal and re-experiencing symptoms).

Research has shown that PTSD clearly alters a number of fundamental brain mechanisms. Abnormal levels of brain chemicals that affect coping behavior, learning, and memory have been detected among people with the disorder. In addition, recent imaging studies have discovered altered metabolism and blood flow in the brain as well as structural brain changes in people with PTSD (15-19).

Treatment of PTSD

People with PTSD are treated with specialized forms of psychotherapy and sometimes with medications or a combination of the two. One of the forms of psychotherapy shown to be effective is cognitive behavioral therapy, or CBT. In CBT, the patient is taught methods of overcoming anxiety or depression and modifying undesirable behaviors such as avoidance of reminders of the traumatic event. The therapist helps the patient examine and re-evaluate beliefs that are interfering with healing, such as the belief that the traumatic event will happen again. Children who undergo CBT are taught to avoid “catastrophizing.” For example, they are reas-

sured that dark clouds do not necessarily mean another hurricane, that the fact that someone is angry doesn't necessarily mean that another shooting is imminent, etc. Play therapy and art therapy also can help younger children to remember the traumatic event safely and express their feelings about it. Other forms of psychotherapy that have been found to help persons with PTSD include group and exposure therapy. A reasonable period of time for treatment of PTSD is 6 to 12 weeks with occasional follow-up sessions, but treatment may be longer depending on a patient's particular circumstances. Research has shown that support from family and friends can be an important part of recovery.

There has been a good deal of research on the use of medications for adults with PTSD, including research on the formation of emotionally charged memories and medications that may help block the development of symptoms (20-22). Medications appear to be useful in reducing overwhelming symptoms of arousal (such as sleep disturbances and an exaggerated startle reflex), intrusive thoughts, and avoidance; reducing accompanying conditions such as depression and panic; and improving impulse control and related behavioral problems. Research is just beginning on the use of medications to treat PTSD in children and adolescents.

There is accumulating empirical evidence that trauma/grief-focused psychotherapy and selected pharmacologic interventions can be effective in alleviating PTSD symptoms and in addressing co-occurring depression (23-26). However, more medication treatment research is needed.

A mental health professional with special expertise in the area of child and adolescent trauma is the best person to help a youngster with PTSD. Organizations on the accompanying resource list may help you to find such a specialist in your geographical area.

What are Scientists Learning about Trauma in Children and Adolescents?

The National Institute of Mental Health (NIMH), a part of the Federal Government's National Institutes of Health, supports research on the brain and a wide range of mental disorders, including PTSD and related conditions. The Department of Veterans Affairs also conducts

research in this area with adults and their family members.

Recent research findings include:

Some studies show that counseling children very soon after a catastrophic event may reduce some of the symptoms of PTSD. A study of trauma/grief-focused psychotherapy among early adolescents exposed to an earthquake found that brief psychotherapy was effective in alleviating PTSD symptoms and preventing the worsening of co-occurring depression (27).

Parents' responses to a violent event or disaster strongly influence their children's ability to recover. This is particularly true for mothers of young children. If the mother is depressed or highly anxious, she may need to get emotional support or counseling in order to be able to help her child (28-30).

Either being exposed to violence within the home for an extended period of time or exposure to a one-time event like an attack by a dog can cause PTSD in a child.

Community violence can have a profound effect on teachers as well as students. One study of Head Start teachers who lived through the 1992 Los Angeles riots showed that 7 percent had severe post-traumatic stress symptoms, and 29 percent had moderate symptoms. Children also were acutely affected by the violence and anxiety around them. They were more aggressive and noisy and less likely to be obedient or get along with each other (31).

Research has demonstrated that PTSD after exposure to a variety of traumatic events (family violence, child abuse, disasters, and community violence) is often accompanied by depression (3, 32035). Depression must be treated along with PTSD, and early treatment is best.

Inner-city children experience the greatest exposure to violence. A study of young adolescent boys from inner-city Chicago showed that 68 percent had seen someone beaten up and 22.5 percent had seen someone shot or killed. Youngsters who had been exposed to community violence were more likely to exhibit aggressive behavior or depression within the following year (36, 37).

NIMH-supported scientists are continuing to conduct research into the impact of violence and disaster on children and adolescents. For example, one study will follow 6,000 Chicago children from 80 different neighborhoods over a period of several years (38).

It will examine the emotional, social, and academic effects of exposure to violence. In some of the children, the researchers will look at the role of stress hormones in a child or adolescent's response to traumatic experiences. Another study will deal specifically with the victims of school violence, attempting to determine what places children at risk for victimization at school and what factors protect them (39).

It is particularly important to conduct research to discover which individual, family, school and community interventions work best for children and adolescents exposed to violence or disaster, and to find out whether a well-intended but ill-designed intervention could set the youngsters back by keeping the trauma alive in their minds. Through research, NIMH hopes to gain knowledge to lessen the suffering that violence and disasters impose on children and adolescents and their families.

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The General Public can obtain publications about PTSD and other anxiety disorders by calling NIMH's toll-free information service, 1-888-ANXIETY, or calling the Institute's public inquiries office at (301) 443-4513. Information is also available online from NIMH's website: <http://www.nimh.nih.gov/healthinformation/anxietymenu.cfm>.

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Gender, Age, and Behavior Differences in Early Adolescent Worry

Brown SL, Teufel JA, Birch DA, et al. 2006. Gender, age, and behaviour differences in early adolescent worry. *Journal of School Health* 76(8):430-437.

“Consistently, early adolescents worry more as they age. They also appear more likely to keep worries to themselves as they go through this stage of development,” state the authors of an article published in the October 2006 issue of the *Journal of School Health*. Research has shown that adolescent worry has been associated with several important behavioral and health outcomes. Additionally, studies have shown that adolescents exhibit age- and gender-related patterns with regard to the type and number of reported worries, that the types of worries reported by adolescents vary across time, and that certain worries seem to remain stable and highly ranked by adolescents. The article presents findings from a study to examine the issues early adolescents worry about most frequently and whether gender or age predicts early adolescents’ worries. Findings from this study are compared to those of other studies focusing on school, friends, family, appearance, and the future. The study did not address fear or the processes associated with stress; the focus was on perceived situational demands as sources of worry or stress.

Data were collected from 1,004 adolescents (ages 9-13) who attended programs at 10 health-education centers in seven states (Illinois, Indiana, Michigan, North Carolina, Ohio, Pennsylvania, and Wisconsin). Students were asked to respond to two demographic questions (age and gender), eight questions asking how often they experience various worries, and two questions about their behaviors and their preferred information sources when worried. Individual data were obtained via computer systems that combine data from multiple students responding with individual, electronic keypads. The analysis calculated proportions for each demographic, worry behavior, and worry experience; evaluated differences in frequency of each worry by gender and age; and calculated the number of frequent worries. The analysis also examined associations between predictor variables (gender, age, and worry behaviors) and risk for frequent worry. The authors found that * Adoles-

cents worried weekly most about school grades and least about their friends’ problems. There were no significant age or gender differences for total weekly worrying. * Compared to boys, girls worried weekly more about fitting in at school and about being out of shape or overweight, whereas boys were more likely than girls to have weekly worries about their futures. * Older students had more weekly worries than younger students about looks or appearance and about being out of shape or overweight. Compared to the youngest students (age 9), the oldest students (age 13) also were more likely to worry about problems at home and about their friends.* Adolescents who primarily talk to a parent when they are worried were significantly less likely to worry about being liked or fitting in. Those who said they usually keep their worries to themselves were at greater risk than the referent category for weekly worries about grades. Compared to those who turn to parents, those who turn to friends were more likely to have weekly worries about their friends and about being a failure or disappointing loved ones. Those who preferred the Internet for information about what is worrying them were at greater risk for weekly worries about their future but were less likely to worry weekly about grades than those who turned to parents.

The authors conclude that “this study highlights the need to pay more attention to the ways students attempt to cope with their worries.... [and] points to an opportunity to investigate the link between types of adolescent worries and primary sources of worry information utilized by early adolescents.”

More information about adolescent mental health is available from the Bright Futures Web site at <http://www.brightfutures.org/mentalhealth/index.html>; and from the MCH Library’s knowledge path at http://www.mchlibrary.info/KnowledgePaths/kp_mentalhealth.html

Community Belonging and Self-Perceived Health

Canadian Community Health Survey (CCHS) - (January to June 2005)

Statistics Canada

Over the past 25 years, research has clearly established a causal association between social relationships and health (1-4). People who are socially isolated and have few ties to other individuals are more likely to suffer from poor physical and mental health and are more likely to die prematurely.

More recently, the notion of “social capital” has received increasing attention in health research (5-8). Social capital is generally defined as aspects of social organization, such as civic participation and trust in others, that facilitate cooperation among community member(s) (9). High levels of social capital have been linked to lower mortality rates, lower rates of crime and increased perceptions of positive health (8-12).

There is, however, some debate about whether social capital benefits the community at large or individual residents--who profit directly from feelings of connectedness to the community. A recent study suggests that the association between social capital and positive perceptions of health is more important at the individual level (12). It is hypothesized that feeling “connected” to one’s community promotes health because such ties promote mutual respect, and thereby increase self-esteem. Another possibility is that interaction among community members results in the transmission of social norms related to health-promoting behaviours such as physical activity and refraining from smoking (1-4).

Since its inception in 2000/01, the Canadian Community Health Survey (CCHS) has included a question on community belonging. Therefore, it is possible to track the degree to which Canadians feel connected to their local communities. An earlier paper, based on data from the 2000/01 CCHS, revealed an association between individuals’ sense of belonging and their general self-perceived health (14). Based on the first 6 months (January to June) from the 2005 CCHS, this article updates the earlier article.

Comparisons are made between community belonging rates at provincial and health region levels. Because the

2005 CCHS includes questions about self-perceived mental health as well as general health, the previous analysis can be extended by measuring associations between community belonging and mental as well as physical health.

Majority Feel Connected to Local Community

In 2005, close to two-thirds of Canadians (64%) reported a strong sense of community belonging; this included 17% who described their sense of belonging as very strong and 47% who reported it as somewhat strong. Just over a quarter (26%) reported a somewhat weak sense of community belonging; 9%, very weak.

The likelihood of reporting a strong sense of community belonging varied considerably across provinces. Approximately three-quarters of the residents of the Atlantic provinces reported a strong sense of belonging, with Newfoundlanders having the highest rate in the country at 79%. Relatively high rates were also reported in Saskatchewan (73%) and British Columbia (69%). Residents of the province of Quebec were the least likely to feel connected, with only 54% reporting a strong sense of belonging. A previous study found that Quebecers were also less likely to report a strong sense of belonging to Canada, but their sense of belonging to their province was similar to that of other Canadians (16).

The degree to which the residents of health regions within each province felt connected to their respective communities also differed widely. Health regions comprised of major urban centres tended to have the lowest rates of community belonging. For example, in Ontario, the lowest rates were among residents of the health regions of York and the City of Toronto; in Manitoba the lowest rate was for Winnipeg; for Saskatchewan, Saskatoon; for Alberta, Calgary and the Capital health region (Edmonton); and for British Columbia, Vancouver. Conversely, predominantly rural health regions had higher rates of belonging. For people living in predominately urban health regions, the average community belonging

rate was 63%. By contrast, the average for those living in health regions that were predominantly rural was 77%. The highest belonging rate in the country was 89% in the Labrador-Grenfell health region in Newfoundland and Labrador and the lowest was in the Laval health region in Quebec (44%).

Rates Increasing

Between 2000/01 and 2005, the proportion of Canadians reporting a strong sense of belonging to their local community rose from 58% to 64%. Significant increases occurred in all provinces except Newfoundland and Labrador. Community belonging increased the most in New Brunswick, where the rate rose from 62% to 73%.

Associated with Age

The proportions of men and women who reported a strong sense of community belonging did not differ. However, rates did vary by age group. A high proportion (77%) of youth aged 12 to 17 reported a strong sense of belonging, but among young adults aged 18 to 29, the figure was much lower at 55%. At older ages, the rate increased steadily from 61% among those aged 30 to 44 to 72% among seniors (65 or older).

Feeling connected to the community was less common among people who were divorced or separated (57%) or never married (54%), compared with those who were married or living common-law (65%). People living with young children were slightly more likely than those who did not have young children in their household to have a strong sense of belonging.

Modest associations were observed between community belonging and socio-economic status. People with a low household income were less likely to report a strong sense of community belonging, but there were no differences between those with lower-middle, middle, upper-middle or high household incomes. The only association with education was that postsecondary graduates were slightly less likely to feel connected, than were people who had completed only high school.

Community Belonging and Health

A relatively high proportion of people who felt con-

nected to their local community perceived their health positively. Close to two-thirds of those who felt a very strong or somewhat strong sense of community belonging reported excellent or very good general health. In contrast, only half of those with a very weak sense of belonging viewed their general health so favourably.

At the provincial level, significant associations between community belonging and self-perceived general health emerged in all provinces except Prince Edward Island and Quebec. Associations were particularly strong in British Columbia and Ontario. In British Columbia, 64% of residents with a strong sense of belonging reported excellent or very good general health compared with 51% among those with a weak sense, and in Ontario 64% versus 55%. These findings are particularly relevant in view of evidence that self-perceived general health is predictive of chronic disease incidence, use of medical services, recovery from illness, functional decline, and mortality (2,3,5,6,7,18).

The likelihood of reporting excellent or very good mental health also declined in parallel with decreases in degree of connectedness—from 81% for those with a very strong sense down to 63% for those with a very weak sense of community belonging. At the provincial level, a strong sense of community belonging was associated with an increased probability of reporting excellent or very good mental health in all provinces except Prince Edward Island.

Even after other potentially confounding factors were taken into account, sense of community belonging was strongly related to both self-perceived general and mental health. Compared with those with a weak sense of community belonging, people with a very strong sense had close to twice the odds of reporting excellent or very good general health. Similarly, those with a very strong sense of belonging had over two times the odds of excellent or very good mental health. When people are asked to rate their general health, psychological factors play a role in perceptions (17). Therefore, the degree to which physical and mental health factors contribute to associations between community connectedness and perceptions of general health is unknown. However, when the relationship between community belonging and self-perceived general health was examined in a model controlling for self-perceived mental health in

addition to other possible confounders, the odds ratios for belonging diminished but were still significant. This suggests that sense of community belonging is associated with both the physical and mental health of individuals. Although due to the cross-sectional nature of this analysis, it is not possible to determine whether it is health that influences sense of community belonging or the other way around.

Data Source

Estimates are based on data from the first 6 months of the 2005 (Cycle 3.1) Canadian Community Health Survey (CCHS), collected between January and June of that year. The CCHS covers the population aged 12 or older living in private households. It does not include residents of Indian reserves, Canadian Forces bases, or some remote areas. Although residents of the three territories are part of the CCHS sample, they are not included in this early release. The overall response rate for this first release of the 2005 CCHS was 76%; the total sample size was 67,741. Approximately 3% of this sample was excluded from this analysis because of non-response to the question on community belonging. All estimates were weighted to be representative of the household population aged 12 or older in 2005.

The questions

To measure sense of community belonging, respondents to the Canadian Community Health Survey were asked,

“How would you describe your sense of belonging to your local community? Would you say it is: very strong? somewhat strong? somewhat weak? very weak?”.

Self-perceived general health was assessed with the question, “In general, would you say your health is: excellent? very good? good? fair? poor?”

Self-perceived mental health was measured with the question, “In general, would you say your mental health is: excellent? very good? good? fair? poor?”

Household income was based on the number of people in the household and total household income from all sources in the 12 months before the interview.

*Reproduced from: Canadian Community Health Survey (CCHS) - Cycle 1.1
Statistics Canada
www.statcan.ca,*

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Investment in Physical Activity Is Critical

Compelling evidence identifies the importance of increasing Canadian physical activity levels. In response to this evidence, the Coalition for Active Living submitted a brief to the Standing Committee on Finance in November 2002. This document urged the Government of Canada to make a strategic investment of \$500 million dollars over five years (beginning in April, 2003) to enable the voluntary sector to undertake an aggressive strategy to address this national physical inactivity epidemic.

The Physical Activity Status of Canadians

Through the 1990s, research revealed that most Canadians were not active enough to receive the health-related benefits of regular physical activity. Today, the level of physical inactivity is reaching epidemic proportions.

According to the 2000/01 Canadian Community Health Survey (CCHS), half of Canadians 12 years of age and older are physically inactive. Inactive Canadians face an increased risk of chronic disease and premature death

due to physically inactive lifestyles more women (54%) than men (44%) are physically inactive above age 65, physical activity rates are the lowest (34%). Other key findings of the CCHS include the following.

- A substantial number of Canadians in every province are insufficiently active, with the highest rates of inactivity in Newfoundland and Labrador, Prince Edward Island, New Brunswick, and Manitoba, and the lowest in Ontario, Alberta, and British Columbia.
- 2.8 million Canadians aged 20 to 64 are obese (this equals 15% of the population or one in seven people).
- Although they are the most in need of physical activity, obese people are the least active (33%).

Inactive Children and Youth

The majority of Canadian children and youth, aged 12 to 17, are not active enough for optimal growth and development (according to international guidelines). Canadian girls are less active than boys, with only 12% of girls (compared with 20% of boys) considered active enough using these guidelines (Canadian Fitness and Lifestyle Research Institute).

The average Canadian child is sedentary for three to five hours a day in front of the TV. A study in the Canadian Medical Association Journal also showed that between 1981 and 1996, the prevalence of overweight boys increased from 15% to 35.4% (the prevalence of overweight girls increased from 15% to 29.2%).

During this same time, the prevalence of obesity in children tripled, from 5% to 16.6% for boys and from 5% to 14.6% for girls (Tremblay & Willms, CMAJ 2000 Canadian Medical Association Journal; 163).

The Cost of Physical Inactivity

Increased physical activity levels can save health-care dollars. \$2.1 billion, or about 2.5% of the total direct health-care costs, can be attributed to physical inactivity. This figure mirrors results reported for the United States (Katzmarzyk, Gledhill, Shepard, CMAJ 2000 November 28;163(11): 1435-1440).

Conservative estimates suggest that reducing the prevalence of physical inactivity by 10% would save \$150 million annually. This saving does not include indirect costs such as lost productivity due to illness, premature death, or a range of other health conditions, including mental illness and poor quality of life (Katzmarzyk, Gledhill, & Shephard, 2000).

Investment in Strategies to Increase Physical Activity Levels is Critical

According to the Canadian Council for Tobacco Control (www.cctc.ca), 5.4 million Canadians smoke (2001 stats). This represents 22% of the population aged 15 and over. Health Canada's Tobacco Strategy is currently investing \$480 million over five years. This strategy aims to reduce smoking from 25% to 20% of Canadians. This funding represents a cost of \$11.63 per year per smoker (or \$58 per ex-smoker per year if the strategy is successful).

According to the Canadian Diabetes Association's web site (www.diabetes.ca), 2 million Canadians have Type II diabetes, a condition that is preventable through proper exercise and diet. The federal government has invested \$115 million over five years to address this disease, representing a cost of \$13.50 per person with Type II diabetes.

Over 21 million Canadians are not active enough to benefit from a physically active lifestyle. A strategic investment of \$500 million over five years to address this physical inactivity epidemic equals a cost of less than \$5 per inactive Canadian per year (from 2001 CFLRI Physical Activity Monitor statistic that 57% of Canadian adults are insufficiently active for optimal health benefits).

Reproduced from The Coalition for Active Living. The Coalition for Active Living is a national action group of over 80 organizations advocating to ensure that the environments where Canadians live, work, learn and play support regular physical activity. The CAL is responsible for the development of the Framework for a Pan - Canadian Physical Activity Strategy and is funded by the Physical Activity Contribution Program of Health Canada.

Pathways of Alberta Youth through the Post-secondary System into the Labour Market, 1996-2003

Harvey Krahn and Julie Hudson

University of Alberta, November 2006, Canadian Policy Research Network. www.cprn.org

Pathways for Youth to the Labour Market

The CPRN “Pathways” research project is designed to profile the range of school-to-work transition (SWT) pathways taken by Canadian youth and to identify factors associated with more successful transitions into rewarding employment. This study describes pathways through the PSE system into the labour market taken by Alberta’s high school graduating “class of 1996” during the seven years following its exit from high school. Several caveats about the study’s generalizability are required. Alberta’s population (younger and somewhat more educated), labour market (stronger, and heavily energy-focused), and PSE system (arguably more extensive and integrated) are somewhat unique, so generalizations to other provinces are probably not appropriate. Even so, during the 1996-2003 period covered by this study, the Alberta economy was not as over-heated as it is today (in 2006). By 2003, when study participants were about 25 years of age, a sizeable minority had not yet left the PSE system and many had only a few years of adult labour market experience. Hence, the long-term impacts of PSE investments were not yet apparent.

Alberta’s Post-secondary Educational System

Alberta took an early lead in opening pathways between different types of PSE institutions and in situating colleges in smaller communities. Given its natural resource-focused economy, Alberta also has pursued an agenda of skills training, most noticeably via its apprenticeship programs, including youth apprenticeships. During the 1996-2003 period covered by this study, Alberta had four universities, four privately-funded university colleges that could award baccalaureate degrees, more than a dozen publicly-funded colleges that offered diploma courses (some also offered transferable university credit courses), and two large technical institutes.

The 1996-2003 Longitudinal Study of Alberta High School Graduates

This report presents findings from a seven-year lon-

gitudinal study of the Alberta high school graduating “class of 1996.” Baseline data were collected in 1996 via self-administered questionnaires from 2,681 Grade 12 students in 58 high schools across the province. In 2003, when they were about 25 years old, 1,218 of these individuals were interviewed by telephone.

Post-secondary Educational Experiences (1996-2003)

A very high proportion of respondents (88 percent) had enrolled in a post-secondary program at some point between 1996 and 2003. Sixty percent had acquired at least one PSE credential. One in three (32 percent) had obtained a university degree, 15 percent had acquired a community college diploma, and 15 percent had obtained a technical school diploma. Only 4 percent had completed an apprenticeship program. Young women were more likely to have chosen university or a community college, while young men were over-represented in technical schools and apprenticeships. Youth living in large cities were more likely to have attended university. Youth from more advantaged families (where at least one parent had a university degree) were much more likely to have received a university degree themselves. Immigrant and visible minority youth were also more likely to have acquired a PSE credential. Aboriginal youth were severely under-represented among PSE graduates.

Non-Linear Post-secondary Pathways

A large minority of study participants had deviated from a traditional “straight out of high school, into, and through college / university” educational path. One-quarter (23 percent) had returned for a second year of Grade 12 in the fall of 1996. Nineteen percent of PSE participants had transferred between institutions while completing a program. Over half of these transfers (56 percent) involved students moving from a community college that offered the first several years of a baccalaureate program into a university providing the finishing upper-year courses. Fourteen percent of PSE partici-

pants had completely discontinued (i.e., dropped out of) a program of study, 20 percent had changed a program, and 5 percent had done both.

Employment Outcomes by Age 25

When interviewed in 2003, 71 percent of study participants were employed in a single job, 14 percent were holding more than one job, 6 percent were unemployed, and 9 percent were out of the labour force. Most of the employed (63 percent), but particularly those with PSE credentials (70 percent or more), were working in managerial, professional, or skilled occupations. Part-time employment (12 percent) and self-employment (7 percent) were relatively uncommon, although one in six respondents (17 percent) were employed in temporary jobs. The median (gross) monthly income for all employed respondents was \$2,500 which translates into \$30,000 per year. Study participants with university and also trades / technical credentials earned considerably more than those without any PSE credentials, other things being equal. College credentials did not transfer into noticeably higher incomes. Women were earning, on average, only two-thirds of what men were earning. Even after statistically controlling on hours of work, type of PSE credential, and other factors, a large gender income gap remained. Just over half of employed study participants had received at least one promotion in their present job. About two-thirds reported receiving paid vacations along with medical and dental coverage, and almost as many could take paid maternity or paternity leave.

Schooling and Skills

Study participants were generally positive about the labour market value of their education. Fifty-nine percent felt that high school had helped them meet their career objectives. Eighty-five percent (85 percent) of those with PSE credentials felt that postsecondary training had helped them meet career objectives. Those who had pursued technical training, or had completed professional university programs, were most positive in their assessments. When asked to list specific employability skills obtained in high school, 2003 study participants were more likely to provide positive answers than they had back in 1996. They were also more likely to identify specific courses (e.g., Math, English) that had turned out to be useful in the workplace. Most PSE graduates could identify employability skills obtained through their programs. Compared to current (2003) assessments of high

school education, these evaluations of PSE programs were more likely to focus on analytic and computer / technical skills.

Evaluating Employment Outcomes

One-third (31 percent) of all employed respondents felt over-qualified in their current job. Almost half (47 percent) felt that they were underpaid. Six out of ten (62 percent) employed respondents said they were satisfied with their (main) job, including 21 percent who said they were “very satisfied.” This is a typical level of job satisfaction for young Canadian workers. Sample members who had acquired a PSE credential were more likely to be satisfied with their job (66 percent) compared to those without a degree or diploma (56 percent). Less than half of the complete 2003 sample (46 percent) agreed that: “My career has worked out the way I hoped it would.” Individuals employed in managerial / professional and skilled trades jobs, positions typically obtained as a result of PSE credentials, were much more likely than those working in semi-skilled or unskilled jobs to report satisfaction with their careers.

Policy Implications

This study was not designed as a program or policy evaluation, and it focuses on a somewhat unique province, but the findings still have some general policy implications. As many other studies have shown: PSE investments continue to pay off; young people who acquire PSE credentials find better jobs, earn more, and report more job satisfaction. Improving access to the PSE system by placing institutions in mid-sized communities and by implementing effective credit transfer policies appears to lead to higher PSE participation and completion rates. Even with improved access, family background continues to influence PSE outcomes. Efforts to remove systemic barriers to PSE participation, particularly for Aboriginal youth, must continue. Interrupted and non-linear PSE journeys are remarkably common. Some reflect barriers to PSE completion, but many are based on young people reconsidering their aspirations and options. Opportunities to reconsider PSE plans, and to change direction, should be maintained within the system. Employability skills of various kinds are enhanced in both the secondary and postsecondary education system. Recommendations that the balance between core curriculum and employability skill training needs to be reconsidered, with more emphasis on the latter, should be viewed with caution.

The Contribution of Abstinence and Improved Contraceptive Use to Recent Declines in Adolescent Pregnancy In USA

Santelli JS, Lindberg LD, Finer LB, et al. 2007. Explaining recent declines in adolescent pregnancy in the United States: The contribution of abstinence and improved contraceptive use. *American Journal of Public Health* 97(1):150-156.

“Our data suggest that declining adolescent pregnancy rates in the United States between 1995 and 2002 were primarily attributable to improved contraception use,” state the authors of an article published in the January 2007 issue of the *American Journal of Public Health*. Adolescent pregnancy rates in the United States declined by 27% from 1991 to 2000. In a previous analysis of nationally representative data from samples of U.S. high-school students, the authors of the article found significant increases in use of contraception among adolescents ages 15-17 between 1991 and 2001 and estimated that improved contraceptive use and delay in initiation of intercourse contributed equally to declining pregnancy rates. The article presents findings from an effort to update the study using data from the National Survey of Family Growth (NSFG), a nationally representative household survey that, relative to school surveys, provides more data on older adolescents and those who have left school and collects more detailed information about contraceptive use. The current analysis examined the roles of increased contraceptive use and delayed initiation of sexual activity in explaining changes in pregnancy risk over the period 1995-2002 among adolescents ages 15-19.

Measures for the analysis included sexual activity and contraceptive use, contraceptive failure rates, risk indices, and data on pregnancies. The two risk indices created for the study included (1) the contraceptive risk index, which summarized the overall effectiveness of a group’s contraceptive use and nonuse and (2) the overall pregnancy risk index, which summarized the risk of pregnancy among all adolescents, incorporating information about both the level of recent sexual activity and the level of contraceptive risk among those who were sexually active at the time of the study.

The authors found that:

- Rates of sexual activity did not decline significantly among adolescents ages 15-19 or among those ages 18-19; the decline in sexual activity among adolescents ages 15-17 was of borderline significance.
- The contraceptive risk index declined by 34% among adolescents ages 15-19, by 46% among those ages 15-17, and by 27% among those ages 18-19.
- Pregnancy risk declined by 38% among adolescents ages 15-19, by 55% among those ages 15-17, and by 27% among those ages 18-19.
- Fourteen percent of the change in pregnancy risk among adolescents ages 15-19 was attributable to a decrease in the percentage of sexually active young women, while 86% was attributable to changes in contraceptive method use; among adolescents ages 15-17, the corresponding percentages were 23% and 77%, respectively. All of the change in pregnancy risk among adolescents ages 18-19 was the result of increased contraceptive use.

“In comparison with our school-based study, this analysis of the NSFG showed a larger contribution of contraceptive use to declines in adolescent pregnancy rates,” state the authors. They add, “our findings raise questions about current US government policies that promote abstinence from sexual activity as the primary strategy to prevent adolescent pregnancy.”

More information is available from the MCH Library’s at <http://www.mchlibrary.info>. See knowledge path, Adolescent Pregnancy Prevention, organizations resource list, Adolescent Pregnancy and Parents.

www.acsa-caah.ca



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Publications

The Youth of British Columbia: their Past and their Future

Tonkin R, Foster L, co-editors, Western Geographical Series Vol. 39, Western Geographical Press, University of Victoria, 2005.

Book Review by Judith Hall:

For anybody interested in or working with youth, this book is a must. It is chock-full of data and information about the approaches that have been shown to work in BC. It emphasizes that youth are relatively underserved in BC and have unique needs. For those with a young

person in their family, it is a particularly good read in order to understand what that young person is exposed to and the positive approaches that seem to work at this time in life and history. (Full review in BC Medical Journal, Vol. 48 No. 9, November 2006.)

Adolescent Risk Behaviors: Why Teens Experiment and Strategies to Keep Them Safe

David A. Wolfe, Peter G. Jaffe, and Claire V. Crooks. (2006) New Haven: Yale University Press

This book focuses on the crucial role that relationships play in the lives of teenagers. The authors particularly examine the ways that healthy relationships can help teens avoid such common risk behaviors as substance abuse, dating violence, sexual assault and unsafe sexual practices.

Youth: Choices and Change, Promoting Healthy Behaviors in Adolescents

Breinbauer C, Maddeleno M. Pan American Health Organization, Washington, DC, 2005

This book outlines developing effective health promotion and prevention programs for adolescents; theories and models for health promotion and behavior change and their application to adolescents; and the importance of early intervention in adolescent developmental changes and goals:

Immunization Info in Foreign Languages

www.immunize.org/vis

You will find info for:

Asian, eastern:

Burmese, Cambodian, Chinese, Hindi, Hmong, Japanese, Korean, Ilokano (Philippines), Laotian, Marshallese, Punjabi, Samoan, Tagalog, Thai, Vietnamese

Western:

Armenian, Bosnian, Croatian, English, French, German, Italian, Polish, Portuguese, Romanian, Russian, Serbo-Croatian, Spanish

Middle-Eastern:

Arabic, Farsi, Somali, Turkish

A Health Profile of Adolescent and Young Adult Males: 2005 Brief

A brief from the National Adolescent Health Information Center (NAHIC-USA).

The transition from adolescence to young adulthood to adulthood involves changes in development and independence that have implications for health. This brief highlights priority health issues for adolescent & young adult males and identifies key gender & racial/ethnic disparities. Health topics include violence, substance use, mental health, reproductive health and healthcare access & utilization.

The National Adolescent Health Information Center (NAHIC) was established in 1993 with funding from the Maternal and Child Health Bureau (MCHB) of the U.S. Department of Health and Human Services. It is based within the University of California, San Francisco's Division of Adolescent Medicine, Department of Pediatrics and Institute for Health Policy Studies. The overall goal of NAHIC is to improve the health of adolescents by serving as a national resource for adolescent health information and research, and to assure the integration, synthesis, coordination and dissemination of adolescent health-related information. Major activities include:

- Promoting collaborative relationships with MCHB, other federal and state agencies, professional and research organizations, private foundations and advocacy groups;
- Collecting, analyzing and disseminating information through short-term and long-term analyses of new policies affecting the adolescent population; and
- Providing technical assistance, consultation and continuing education to states, communities and providers in content areas that emphasize the needs of adolescents.

Throughout its activities, NAHIC emphasizes the needs of special populations who are more adversely affected by the current changes in the social environment of youth and their families.

http://nahic.ucsf.edu/index.php/data/article/a_health_profile_of_adolescent_and_young_adult_males_2005/

Adolescent Health Curriculum: To Enhance Public Health Training

The RESOURCE Project Web site provides a range of tools for faculty from a variety of disciplines to use in enhancing the adolescent health training of public health students. The RESOURCE Project is a collaborative effort of the Public Policy Analysis and Education Center for Middle Childhood, Adolescent and Young Adult Health and the Association of Teachers of Maternal and Child Health. The Web site contains a 12-unit curriculum, which addresses the following topics: adolescent development, use of data to shape adolescent health policy, sexuality, adolescent pregnancy, sexually transmitted infections, mental health and suicide, substance abuse, violence, unintentional injuries, nutrition and physical activity, youth with special health care needs, health care services, school interventions, and community interventions.

Each unit includes a sample syllabus, recommended readings, data sources, suggested assignments, case studies, sample presentations, and links to other resources. More information is available at <http://policy.ucsf.edu/resources>.

The Public Policy Analysis and Education Center for Middle Childhood, Adolescent and Young Adult Health (Policy Center) is pleased to announce the release of the RESOURCE Project.

The RESOURCE Project is a user-friendly, educational resource designed to enhance the adolescent health training of public health students in the United States. The project adopts a developmental perspective, viewing adolescent health and well-being as closely intertwined with healthy development and environmental influences.

The curriculum is intended for faculty from public health and related disciplines. The 12 units in the curriculum address the following topics:

- adolescent development
- use of data to shape adolescent health policy
- sexuality/teen pregnancy/ sexually transmitted infections

- mental health and suicide
- substance abuse
- violence
- unintentional injuries
- nutrition and physical activity
- youth with special health care needs
- health care services
- school interventions
- community interventions

Each unit offers several easily adapted components, including: a sample syllabus, recommended readings, data sources, suggested assignments, case studies, sample presentations, and links to other useful resources.

The RESOURCE Project is a collaborative effort spearheaded by the Policy Center, with support and guidance from the Association of Teachers of Maternal and Child Health (ATMCH).

The RESOURCE Project has its own section on the Policy Center web site:
<http://policy.ucsf.edu/resources/>

Please contact the Policy Center (phone: 415-502-4856; email: policycenter@ucsf.edu), with any questions about these resources.

Jane Park & Tina Paul Mulye

Tina Paul Mulye, MPH Project Associate National Adolescent Health Information Center Public Policy Analysis and Education Center for Middle Childhood, Adolescent & Young Adult Health University of California, San Francisco Phone (415) 502-4856 Fax (415) 502-4858 NAHIC on the Web: <http://nahic.ucsf.edu/> Policy Center on the Web: <http://policy.ucsf.edu/>

The Journal of the Canadian Academy of Child and Adolescent Psychiatry

The Journal of the Canadian Academy of Child and Adolescent Psychiatry circulates to over 425 child and adolescent psychiatrists across Canada and is also available as an open access journal at www.canacad.org. The journal is focused on providing current knowledge to

help improve the understanding and practice of mental health professionals in Canada with a focus on children and youth. The journal is published 4 times a year and welcome submissions. Instructions to authors are also available on the Academy website. www.canacad.org.

The Healthy Aboriginal Network Non-profit Promotion of Health, Literacy & Wellness

A resource on suicide prevention for youth, visual learners and hard to reach populations. It's a comic book and its calls Darkness Calls. It's the story of a teenager that feels socially isolated and has difficulty at school. Even though Kyle has tremendous artistic talent and the support of a good friend he finds one day just too overwhelming and considers taking his own life. It's the story of the struggle between good and evil over the spirits of youth. The story was inspired, written and illustrated by Steve Sanderson, a professional Aboriginal youth cartoonist. The story was previewed with health professionals and youth focus groups for authentic characters and language. We released the comic in June 2006 and have already sold over 33,000 copies

across Canada and the US. We also released a comic on youth health issues and have funding to create literacy on three more subjects this winter – diabetes, staying in school and women's sexual health. Our website should be up and running. Please keep in touch with us at www.thehealthyaboriginal.net.

The Healthy Aboriginal Network
328 East Thirty Second Avenue
Vancouver, BC V5V 2Y4
P 604-876-0243 F 604-876-0248
sean@thehealthyaboriginal.net
BC incorporated non-profit Society No. S-48530

A Teen Guide to Parental Separation and Divorce

This Web site was developed by the British Columbia Ministry of Attorney General with the financial assistance of the Department of Justice, Canada. Welcome to A Teen Guide to Parental Separation and Divorce. If your parents have recently separated or divorced (or you think they may be about to), or you have a friend in that situation, this site is for you. Parental separation and divorce are hard on teens. One thing that can help is

information—about what separation and divorce mean in Canada, and how they might affect you. The purpose of this site is to provide you with that information: law, emotions, changes in youth life, strategies, resources, FAQ, etc.

http://familieschange.ca/teen/law/law_intro.htm

www.mindyourmind.ca

Our mission is to inspire youth to reach out, get help and give help. mindyourmind.ca, a youth mental health website, dedicated to promoting positive mental health and to reducing the barriers that surround reaching out for help.

Stuff for Sex – It’s not a fair trade

It’s not something that we like to talk about or even think about, but the reality is young people in our urban and rural communities are trading sexual acts for things in return. They’re doing it for a place to stay, a ride somewhere, or even a pack of smokes. It’s a reality for many young people, yet adults generally have no idea this is happening. It’s called Sexual Exploitation. This is the illegal act of luring or engaging anyone under 18 into the sex trade or pornography, with or without their consent. The person doing this is in a position of trust or authority and is taking advantage of this trust. It is a criminal offence and a form of child abuse. It is not ok.

Why is this happening? Various factors increase a youth’s vulnerability which puts them more at risk to be targeted. These could include:

- Seeking a sense of identity or belonging
- Using drugs or alcohol
- Having low self-esteem/self worth
- Survived past abuse
- Are homeless or at risk for becoming homeless
- Disconnected relationships with friends and family

RISE for Youth is a program created by Western Area Youth Services (WAYS) to reduce the Incidents of Sexual Exploitation for Youth. This program has developed youth friendly posters and booklets that provide more information on the topic, and aim to increase awareness in our communities. Mindyourmind.ca is pleased to offer 2 downloadable posters on our website and an e-booklet version of the brochure with a quiz, for online access to these resources. mindyourmind.ca and WAYS have collaborated to bring the Stuff for Sex Campaign to life. Check out the mindyourmind.ca website to see an electronic version of the Stuff for Sex brochure, an e-quiz and both posters in downloadable form.

For more information, please contact Heather Miko-Kelly, Street Team Leader at 519.858.3502 or streetteam@mindyourmind.ca

Health of the Nation: A Population Health Perspective

The Canadian Population Health Initiative (CPHI) of the Canadian Institute for Health Information is pleased to provide “Health of the Nation: A Population Health Perspective”. This e-newsletter is broadly distributed to policy and decision-makers, researchers and advocates throughout Canada. The aim of the newsletter is to ex-

pand pan-Canadian understanding of population health research, policy and knowledge exchange by promoting CPHI activities across the country. This publication is available, free of charge, at <http://secure.cihi.ca>. e-mail us at healthofthenation@cihi.ca

The Alberta Centre for Active Living

The Alberta Centre for Active Living is a key advocate of physical activity for all Albertans and a primary source of research and education on physical activity for practitioners, organizations, and decision-makers. The centre's mandate is to improve the health and quality of life of Albertans through physical activity. The centre is a member of the Coalition for Active Living and the Alberta Healthy Living Network.

Alberta Centre for Active Living Goals

- Goal 1: The Alberta Centre for Active Living is a key advocate of physical activity and physical activity expertise.
- Goal 2: The Alberta Centre for Active Living generates and transforms information and research into practical knowledge about physical activity for practitioners, organizations, communities and decision-makers.
- Goal 3: The Alberta Centre for Active Living provides information and educational opportunities for practitioners, organizations, communities and decision-makers to help people become and stay active.
- Goal 4: The Alberta Centre for Active Living applies and promotes an integrated population health approach and advocates physical activity expertise within this approach.
- Goal 5: The Alberta Centre for Active Living demonstrates optimal organizational capacity.

The Alberta Centre for Active Living defines advocacy as “actions taken to influence public opinion and government or other (e.g., organizational) policy related to physical activity, with the ultimate aim that ‘All Albertans value enjoy and benefit from a physically active way of life’.

The first goal of the centre is to be a key advocate of physical activity in Alberta and Canada. The outcomes related to this goal describe how the centre goes about its work in this area. The centre takes a leadership role in addressing issues in the field (e.g., meeting with government ministers, responding to issues surfacing in the media or organizations, developing targeted messages). Advocacy ability is increased through partnering/collaborating with other organizations (e.g., the centre participates in a large number of networks and is a member of many provincial and national coalitions and organizations). Centre advocacy influences policy related to physical activity (e.g., the centre proactively approaches decision-makers and provides support and information for policy development). A key advocacy tool used by the centre is the Pan Canadian Physical Activity Strategy developed by the Coalition for Active Living.

Center's publications

The centre's two regular newsletters, WellSpring and Research Update, our many research reports, and information about our programs are all available on the web site. Our web site also links to a wide range of resources from other organizations on many aspects of physical activity, including workplace, children and youth, older adults, and preventing chronic diseases.

The centre is funded by the Alberta Sport, Recreation, Parks & Wildlife Foundation and Alberta Tourism, Parks, Recreation and Culture. Our affiliation with the University of Alberta's Faculty of Physical Education and Recreation has led to strong ties with prominent University of Alberta researchers in epidemiology, behavioural medicine, and exercise physiology. The centre is also the Active Living Affiliate for the Canadian Health Network, which is funded by the Public Health Agency of Canada.

Alberta Centre for Active Living
Edmonton, Alberta
Tel.: 780 415-6248
www.centre4activeliving.ca

Books For Teens And Parents

Suggestions Collected by Lawrence Neinstein

Anderson A. Making weight: men's conflicts with food, weight, shape & appearance. Carlsbad, CA: Gurze Books, 2000.

Beecher M. Parents on the run: a common sense book for today's parents. New York, Calahad Books, 1974.

Bennett D, Rowe L. What to do when your children turn into teenagers. New York, NY, Doubleday division of Random House, 2003

Collins L. Eating with your anorexic: how my child recovered through family-based treatment and yours can too. New York, McGraw-Hill, 2005.

Columbia University Health Education Program. The "Go Ask Alice" book of answers: a guide to good physical, sexual and emotional health. New York: Henry Holt & Co., 1998.

Crompton V, Kessner EZ. Saving beauty from the beast: how to protect your daughter from an unhealthy relationship. Boston, Mass, Little, Brown, 2003.

De Prisco J, Riera M. Field guide to the American teenager: a parent's companion. Cambridge, Mass. Perseus Pub., 2000

Forgatch M, Patterson G. Parents and adolescents: living together. II. (2nd ed.) Champaign, Ill. Research Press, 2005.

Ginsburg KR. A Parent's Guide to Building Resilience in Children and Teens: Giving Your Child Roots and Wings Elk Grove Village, Ill. American Academy of Pediatrics, 2006.

Ginsburg K, Jones M, Jablow MM. Less stress, more success: a new approach to guiding your teen through college admissions and beyond. Elk Grove Graphics, IL, American Academy of Pediatrics, 2006.

Gordon S, Gordon J. Raising a child responsibly in a

sexually permissive world. Holbrook, Mass. Adams Media, 2000.

Haffner D. From diapers to dating: a parent's guide to raising sexually healthy children. 2nd ed. New York, Newmarket Press, 2004.

Haffner D. Beyond the big talk: every parent's guide to raising sexually healthy teens-from middle school to high school, and beyond. New York. Newmarket Press, 2001.

Harris RH, Emberley M. It's Perfectly Normal: Changing Bodies, Growing Up, Sex, and Sexual Health. Cambridge, Mass, Candlewick Publishers, 2004.

Lock J. Help your teenager beat an eating disorder. New York, NY : Guilford Press, 2005.

Madaras L. My body, my self for boys. New York: New Market Press, 1995.

Madaras L. The what's happening to my body? Book for boys: the new growing-up guide for parents and sons. 3rd ed. New York: Newmarket Press, 2001.

Madaras L. The "what's happening to my body" book for girls: the new growing-up guide for parents and daughters. 3rd ed. New York: Newmarket Press, 2001.

McCoy K. Growing and changing. New York: Berkley Pub. Group, 2003.

McCoy K, Wibbelsman C. The teenage body book. New York: Perigee, 1999.

McGraw J. Life strategies for teens. New York, Fire-side, 2000.

Middleman AB, Pfeifer KG. American Medical Association boys' guide to becoming a teen. San Francisco, CA: Jossey-Bass, 2006.

Middleman AB, Pfeifer KG. American Medical Association girl's guide to becoming a teen. San Francisco, CA: Jossey-Bass, 2006.

Panzarine S: A parent's guide to the teen years: Raising your 11 to 14 year old in the age of chat rooms and navel rings. New York Facts On File, 2000.

Pollack W. Real boys : rescuing our sons from the myths of boyhood. New York, Henry Holt & Company, 1999

Richardson J, Schuster MA. Everything you never wanted your kids to know about sex, (but were afraid they'd ask): the secrets to surviving your child's sexual development from birth to the teens. New York, Crown Publishers, 2003.

Siegel M. Surviving an eating disorder: strategies for family and friends. New York, NY: HarperPerennial, 1997.

Steinberg L The ten basic principles of good parenting. New York, Simon & Schuster, 2004.

Steinberg LD, Levine A. You and your adolescent: a parent's guide for ages 10 to 20. New York, Harper Perennial, 1997

Wolf AE. "Get out of my life, but first could you drive me and Cheryl to the mall?" A parent's guide to the new teenager. New York, Farrar, Straus and Giroux, 2002.

Practical parenting information from the Love and Logic Institute. <http://www.loveandlogic.com>

Ken Ginsburg's new book published by the AAP, "A parent's guide to raising resilient children and teens (Giving your child roots and wings)". It gives parents a lot of "news they can use."

La guia esencial sobre sexualidad" (Fairview Press-2005-Basso) which is the translated version of "The Underground Guide to Teenage Sexuality." (Fairview Press-2nd Edition-2003-Basso)

Youth Action: Next Steps Workshops

The next steps workshop is a creation of the McCreary Centre Society in British Columbia (www.mcs.bc.ca). Through workshop activities, the Next Steps makes health research relevant to young people and uses it as a springboard for creating ideas for action. The Next Steps brings research back to youth in an empowering way - by facilitating a dialogue to explore the research results and assisting youth in generating ideas for action on issues that are important to them.

The three key components to the Next Steps are:

- Bridging Research & Action - Research results are brought back to youth for them to discuss and critique.
- Positive Youth Development - The workshop process focuses on positive action and encourages ideas that build the resiliency and strengths of young people.

- Building Partnerships & Capacity - Workshops build on existing relationships and community strengths to promote the healthy development of youth and to build capacity in communities to be inclusive of all youth.

A complete toolkit is available for download from McCreary's website for anyone interested in conducting their own Next Steps. Or, for those that are curious about what youth said on health issues (or issues in general) that are important to them, McCreary has produced the Next Steps Report: BC Youths' Response to the AHS III and ideas for action . Teachers, Public Health Nurses, Recreation Program Coordinators and anyone who works with youth, will find useful and innovative ideas to engage youth in their community.

For more information or to download the Next Steps, http://www.mcs.bc.ca/ya_next-steps.htm

Take Control of Your Health!

www.youngandhealthy.ca



je suis • je veux • je peux
ma santé c'est mon affaire!

www.jeunesensante.ca

www.acsa-caah.ca



Canadian Association for Adolescent Health
Association canadienne pour la santé des adolescents