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

PRO TEEN

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About CAAH and Pro-Teen?

The Canadian Association for Adolescent Health (CAAH) is a non-profit organization that promotes the health and well-being of all Canadians adolescents between the ages of 12 and 19, regardless of race or social standing.
The CAAH was founded in 1993 by a group of Canadian paediatrician under the leadership of Dr Jean-Yves Frappier, paediatrician, head of adolescent medicine at CHU Sainte-Justine. The CAAH brings together professionals from various backgrounds are areas of expertise related to adolescent health and well-being. The CAAH team is based at CHU Sainte-Justine in Montreal, Québec, Canada.

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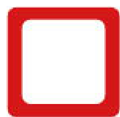

News

• A DVD with the best videos of the STI-HPV Vaccine contest

A DVD showing the winning videos and those with a special mention for the contest organized by CAAH in 2008. This DVD could be shown as a starter for discussion with groups of teens, in class or wherever appropriate. To obtain a copy, contact CAAH: acsacaah@globetrotter.net; fax (514) 345-4778.

• Trend reversing itself? B.C report suggest fewer teens are having

Daily Herald-Tribune (07.18.08): Sean Patrick Sullivan, Canadian Press

Results from the latest survey of British Columbia teenagers show the number of youths who say they have had sex dropped by a third between 1992 and 2003. Among boys, 23 percent reported sexual intercourse in 2003, down from 34 percent in 1992. Among girls, 24 percent said they had had intercourse, down from 29 percent.

The study, using data compiled by researchers from the McCreary Center Society (MCCS), a nonprofit dedicated to youth health issues, found that 87 percent of teens who reported being sexually active in 2003 used contraception, up 20 percent or so from a decade earlier.

There is a misconception on the part of parents and teens alike about how often teens are having sex, said Dr. Elizabeth Saewyc, associate professor at the University of British Columbia's school of nursing and research director at MCCS. "They all seem to think that more youth are having sex at younger and younger ages, but in fact that's not what we're finding," she said. "They're waiting longer, and when they do have sex, they're more likely to take steps to protect their health."

"Statistics Canada has been showing declining births among adolescents since 1994 and their declines match the trends that we see," Saewyc said.

In addition, concerns about younger teens lacking the maturity to engage in safe sex may be unfounded. According to the study, the youngest girls who were sexually active reported the highest prevalence of condom use.

Scientic event

Articles

• Parent-Child relationships and adjustment in adolescence

Technical Report to Division of Childhood and Adolescence, Public Health Agency of Canada

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Executive Summary

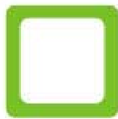
The primary focus of this project was to examine developmental changes in parent-child relationships, and their associations with child adjustment between late childhood and mid-adolescence. These questions were addressed using data from two large, nationally representative samples of Canadian children and adolescents. Recommendations for healthy parenting practices and government initiatives are summarized.

Background

Research has shown that secure attachment to parents facilitates children's adaptive adjustment. Securely attached children experience their parents as available and responsive to their needs. This security fosters adaptive exploration and buffers children from stress. In contrast, children who experience their parents as unavailable, unresponsive or rejecting become insecurely attached, and avoid relying on their parents for support. These avoidantly attached children derive little protection or guidance within their relationships with their parents. Children who experience their parents as inconsistent in their availability and responsiveness also become insecurely attached, specifically anxious or preoccupied. These anxiously attached or preoccupied children are never certain of attracting the support of their parents and tend to be dependent and clingy.

In a recent review of the published literature, Doyle and Moretti (2000) identified considerable evidence that secure attachment continues to contribute to adjustment in adolescence. For example, more positive attachment to parents among 15-year-olds has been found to be associated with fewer mental health problems such as anxiety, depression, inattention and conduct problems (Nada-Raja, McGee & Stanton, 1992). Though attachment was not specifically assessed, adolescents who report a positive relationship with their parents, and who feel comfortable turning to them for support, have been found to have a greater sense of mastery of their worlds (Paterson, Pryor & Field, 1995) and to experience less loneliness (Kerns & Stevens, 1996).

Just as parental sensitivity and responsiveness contribute to secure attachment in infancy, parental warmth/involvement, encouragement of increasing self-control and decision making, appropriate limit setting



and monitoring appear to foster secure attachment and adjustment in late childhood and early adolescence (Baumrind, 1991; Steinberg, Dornbusch & Brown, 1992; Karavasilis, Doyle & Margolese, 1999). Low warmth and low control may be particularly associated with dismissing/avoidant attachment, and low psychological autonomy granting with preoccupied attachment. Similarly, hostile punishment and coercive interactions between parents and children combined with poor parental monitoring have been found to contribute to conduct problems in preadolescence and antisocial behaviour in adolescence (Dishion, Patterson, Stoolmiller & Skinner, 1991; Conger, Patterson & Ge, 1995). Very few of the reviewed studies, however, involved families in Canada and many were based on only small samples. Moreover, Doyle and Moretti (2000) identified several gaps in the literature and unanswered key research questions to be addressed in the present project.

Data and Methodology

The Health Behaviour in School-Aged Children: A World Health Organization Cross-National Survey sample included approximately 11,000 children aged 11-15 years in 1997-98. The National Longitudinal Survey of Children and Youth Cycle 2 sample included approximately 4,000 children aged 10-13 years in 1996-97, and their mothers.

Key Findings

Findings were highly consistent across the two data sets. These findings indicated that the period of adolescence presents major developmental challenges but also new opportunities for parent-child relationships and the way these relationships can influence adolescents' developmental adjustment.

Research Question 1:

In what way do parenting and parent-child relationships differ from late childhood (age 10-11 years) through mid-adolescence (15 years)?

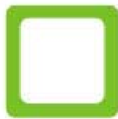
Although mothers are less involved in children's school activity as they grow older, children feel their parents continue to provide school support in other ways. Parents of older children do not report different parenting practices than parents of younger children. Nonetheless, as they grow older, children feel the quality of their relationship with parents declines. Older children report that their parents understand them less and that they argue with parents significantly more. Older children feel their parents are less warm and more rejecting, and feel less at ease confiding in their mothers and their fathers than younger children.

Research Question 2:

How do child adjustment and social relationships change over this period?

Age changes in social relationships were consistent across the two samples. Smoking, alcohol use and affiliation with peers who use drugs increase with age whereas self-esteem decreases. Older children are less likely to use helmets and seatbelts than younger children. The quality of sibling relationships remains stable, but older children have more positive relationships with friends than younger children. Older children are less victimized by others and feel safer around school than younger children.

Research Question 3:



Do parenting practices, parent-child relationships and child adjustment differ for boys and girls during this period of development?

Parents report similar practices in parenting sons and daughters. Nonetheless, girls perceive their parents as less rejecting and warmer than boys. Boys and girls are equally at ease confiding in their mothers, but girls confide less in their fathers than boys.

Research Question 4:

Do effective parenting practices contribute to a positive parent-child relationship and, in turn, to healthy child development?

Harsher parenting (more yelling and use of physical punishment, less reasoning) leads children to feel their parents are more rejecting and cold toward them. How children perceive their relationship with their parents is related to child adjustment. Children who enjoy a more positive relationship with their parents are more likely to invest in school, to use seatbelts and helmets, and to experience fewer serious injuries. They have higher self-esteem, feel less depressed and are less anxious. Children who perceive their parents as more rejecting are more likely to smoke and use alcohol; they are more aggressive, bully others more, commit more property offences and affiliate more with deviant friends. They are also more likely to be victimized by others.

Research Question 7:

Do parenting practices influence child adjustment differently for girls versus boys or for younger versus older children?

Overall, girls are less aggressive, commit fewer property offences, bully others less and are less often victimized by others than boys. Moreover, although girls have lower self-esteem and more internalizing problems, they have better relationships with friends, are more prosocial and are more involved in school than boys. Nonetheless, the impact of parenting practices on girls and boys is similar. Parenting is also associated with adjustment in younger and older children in similar ways. That is, for both girls and boys of all ages, angry, arbitrary parenting (i.e. low use of reasoning) is associated with a poorer parent-child relationship (i.e. child perceptions of parents as less warm and more rejecting) which in turn is associated with poor child adjustment.

Research Question 8:

Do the influences of parenting and/or the quality of the parent-child relationship differ in social contexts traditionally thought to put children at risk for maladjustment?

Although few social contexts (i.e. maternal education, family income, maternal employment and single-parent family) directly affect child adjustment, some influence the quality of parent-child relationships. Children of mothers with less education and children in families with lower income tend to perceive their relationships with their parents more negatively. These negative perceptions in turn are associated with poorer adjustment. Maternal employment and single-parent status do not affect child adjustment independent of parenting and the parent-child relationship.

Research Question 9:

Is there evidence that relationships with mothers and fathers differ in their contribution to adjustment?

Daughters and sons feel equally at ease confiding in their mothers, but daughters confide less in their fathers than sons. Children who feel comfortable confiding in their fathers are better adjusted in a number of ways.

Implications

Recommendations for Parents

- Parents need to recognize the continued importance of their relationship with their adolescents. Although the parent-child relationship undergoes transformation during adolescence, the adjustment of adolescents depends in good measure on the quality of their relationship with their parents.
- Children are more vulnerable to adjustment problems in adolescence than in childhood. Parents need to anticipate that their adolescent requires increased support during periods of transition, such as entry into high school.
- Adolescents need to feel that their parents are engaged and supportive of them. Adolescents are more independent than children in many aspects of their lives. Nonetheless, they require ongoing parental support in terms of parents remaining open to communication and responsive if help is needed, while, at the same time, fostering adolescent autonomy. Specific parenting skills include warmth, acceptance of individuality, active listening, behaviour monitoring, limit setting and negotiation.
- Parents need to recognize the special role of fathers in supporting the well-being of their children. Fathers' increased psychological support of daughters may be particularly beneficial to them.
- Obviously, adolescent adjustment is also determined by factors outside the family and the parent-child relationship. Even though parents may only indirectly affect how peers, romantic partners and other social influences determine the adjustment of their children, parents' support through the stressful challenges of adolescence remains important.

Recommendations for Intervention Programs

- Assisting parents in the development of parenting skills that support their relationship with their adolescents can be beneficial in ensuring attachment security and healthy development during this period.
- Public education programs should be launched to debunk the myth of adolescent detachment from parents and to enhance recognition and understanding of the importance of the parent-child relationship. Strategies to achieve this goal could include media advertising campaigns and provision of information brochures through government agencies, public health offices and schools. Appropriate speakers, as well as written and video materials, for junior high and high school parent groups, community centres, libraries, etc., would also be effective.
- Efforts should be made by appropriate agencies in conjunction with researchers to develop and evaluate programs to assist parents in developing effective skills in parenting adolescents, including skills in providing support and guidance and in negotiating limits during transition periods. This could be expediently achieved through the development of universal school and community-based programs that target parents of children entering high school and that provide education and support regarding effective parenting skills during transitions in the parent-child relationship.
- Efforts should be made to develop and evaluate targeted intervention programs that focus on

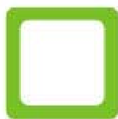
- Efforts should be made to develop and evaluate intervention programs that target attachment issues and effective parenting strategies specifically with adolescents and their families characterized by non-optimal parenting and poor parent-child relationships. A major finding of this study is the importance of these two factors in adolescent maladjustment.
- Programs should focus on fathers' as well as mothers' relationships with their adolescent children. The importance of fathers' psychological support for their daughters' well-being should be highlighted.
- Efforts should be made to advance educational training to increase the understanding and awareness of adolescent attachment issues by mental health and social service professionals, teachers, coaches, recreation and leisure leaders, front-line workers in youth-serving community organizations (e.g. Guides, Scouts, 4-H), etc.
- A coordinated referral system must be available to those working with youth and families, so families and youth in need are referred to appropriate intervention programs.

Recommendations for Research

- More research is needed to clarify the changing nature of girls' compared to boys' relationship to their fathers during adolescence, the relation of these differences to differential parental socialization and implications for adjustment.
- The above associations between variables do not identify cause and effect. Research is necessary to clarify the causal role of parenting and the parent-child relationship in child adjustment. Longitudinal analyses following the development of the NLSCY children over time will contribute to answering this question. It is also possible that both parents' and children's behaviour may be a result of another factor, such as their genetic makeup. Again, further analyses of the NLSCY data set, taking into account the shared family background of children in the same family, will provide some assessment of such contributions.
- Longitudinal analyses should continue to examine the role of social context risk factors such as inadequate income and low maternal education in the development of parenting problems and child maladjustment.
- The above findings indicate the need for additional research, using more precise and extensive measures of parents' behaviour and of the parent-child relationship than in the HBSC and NLSCY studies. Specifically, more extensive and reliable direct measures of parenting, as well as more extensive age-appropriate measures of child-parent attachment are warranted.
- Further research is required to determine whether parenting and the quality of parent-child relationships play a role in determining how other factors - such as peer influences - contribute to determining child adjustment.

Recommendations for Government Policy

- Government agencies should support the above initiatives through mental health programs, the coordination of services and further research funding.



• Aggressive girls

Aggressive Girls was prepared by Sibylle Artz and Diana Nicholson for the Family Violence Prevention Unit, Health Canada.
The opinions expressed in this document are those of the authors and do not necessarily reflect the views of Health Canada.
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Introduction

Until recently, males were believed to be more aggressive and violent than females, and therefore few studies of aggression and violence included girls and women. Lately, however, more adolescent girls have been charged with violent crimes than before, which have led to increased research on girls who use violent strategies. Nevertheless, prevention programs and intervention services often rely on research based on explanations of male behaviour. However, more recent research addresses how best to prevent and intervene in girls' use of aggression and violence.

The rate of violent crime reflected in official reports increased steadily among both male and female youth during the late 1980s and the 1990s: the rate among male youth nearly doubled, and the rate among female youth almost tripled. For example, the violent crime rate among female youth rose from 2.2 per 1,000 in 1988 to a peak of 5.6 per 1,000 in 1996, and began to decline in 1999. Two key points must be noted. First, the number of charges laid against boys is still three to four times greater than the number against girls. Second, the actual number of girls charged is small, so that a small increase in the number of charges results in a large percentage increase.

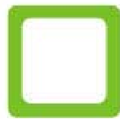
Some researchers suggest that the increase can be partly explained by the stricter approach to schoolyard fights and bullying in recent years, which has led educators, parents and police to label as "assaults" behaviours once viewed as unfortunate or "bad," but not criminal. In fact, the self-reported rates of aggressive behaviour of 10 and 11 year olds in the National Longitudinal Survey of Children and Youth were similar in the 1994/95 and 1996/97 cycles (38% and 34% respectively).10 In both cycles, girls between the ages of 12 and 13 were less likely than boys to display aggressive behaviour (29% and 56% respectively).

Terms and Definitions

Numbers by themselves do not provide insight into the dynamics of girls' participation in aggression and violence. It is helpful to start by defining the terms used to discuss the issue of aggression and violence in girls.

<u>Aggression</u>

Aggression can be defined as "a class of behaviours that have in common an intrusive, demanding, and aversive effect on others." In other words, aggressive behaviours are those that are hurtful and/ or harmful to



others. Aggression that is outwardly observable, as in name-calling, taunting, or physical intimidation and threat, is *overt*. Aggression that is not observable, as in lying or stealing, is *covert*. Aggression can also be *direct* (threatening, yelling, insulting, name-calling, teasing, hitting, shoving, pushing, kicking or destroying personal property) or *indirect* (also known as "social" or "relational" aggression, as in shunning, excluding, ignoring, gossiping, spreading false rumours or disclosing another person's secrets). Canadian reports indicate that girls demonstrate a higher level of indirect aggression at every age than do boys and that indirect aggression increases with age for both boys and girls.

Violence

Violence is distinguished from aggression by the presence of acts that involve the overt and observable use of physical force. Typically, males' aggression is overt and direct (physical), which contributes to the assumption that violence is a male behaviour. However, recent studies provide evidence of females employing both direct violence and indirect violence (using males to commit violent acts for them). If violence were assumed to be a male behaviour, female violence would be overlooked or denied. Consequently, we would fail to develop ways to prevent or intervene in violence by girls.

Bullying

Bullies use power to control others. Usually, a "dominant individual (the bully) repeatedly exhibits aggressive behaviour intended to cause distress to a less dominant individual (the victim)." Girl bullies tend to manipulate social groups by name-calling, verbal abuse and spreading rumours to damage friendships among others or to exclude selected girls from social interaction. Thus, girl bullies tend to use non-physical aggression more than physical violence. Most recently, girls are reported to be using the Internet to harass their peers. Recent research indicates that 9% of Canadian girls between the ages of 4 and 11 participate in bullying other children, and 7% are victimized by bullies; 68% of children have been observed in both roles (bully and victim). Without intervention, bullying behaviours in young children tend to persist throughout adolescence. Girls who are bullied are more likely to feel sad or miserable than to feel angry. They more often discuss their distress with their friends than with a teacher or another adult.

Conduct Disorder

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), to be diagnosed with conduct disorder a young person must have committed at least three violations in four categories of aggression (aggression toward people and animals, aggression toward property, deceit/theft and serious violations of rules) in the previous 12 months, the latest within the previous 6 months. Girls who frequently use aggression and violence may be diagnosed as "conduct disordered". These girls display a pattern of repetitive behaviours that involve violating the rights of others and other socially destructive behaviours. Only a qualified DSM-IV-trained practitioner can make a diagnosis of conduct disorder, which represents an underlying dysfunction within the individual and is distinct from behaviours that reflect reactions to social or contextual situations. Being labelled with a mental disorder represents a permanent condition and may not allow a girl to change or develop new behaviours. Therefore, labelling should be taken very seriously by anyone working with children and youth, and used only after careful consideration of its appropriateness and impact. Some research suggests that biological, genetic and medical factors are related to the occurrence of conduct disorder in some children. Environmental factors such as family, education and peer relationships also influence the development and maintenance of conduct disorder. Conduct disorder is not "oppositional disorder." Girls with oppositional disorder display patterns of negative, hostile and defiant behaviour, but their behaviours do not involve violating the rights of others.

Why Do Girls Engage in Aggression and Violence?

Some researchers think that girls resort to aggression and violence for different reasons than boys. No single factor can predict aggressive and violent behaviour. The factors that contribute to the risk of aggressive and violent behaviour among girls include both systemic (family, community and social context) and individual (personal) variables. Usually, many factors act in combination.

Family Dynamics and Parental Relationships

Evidence suggests that aggressive and violent behaviour in children is linked to family and social factors, such as social and financial deprivation; harsh and inconsistent parenting; parents' marital problems; family violence, whether between parents, by parents toward children or between siblings; poor parental mental health; physical and sexual abuse; and alcoholism, drug dependency or other substance misuse by parents or other family members. In addition, many aggressive and violent girls have poorly developed connections to their mothers.

School Difficulties

Girls who experience difficulties at school, like social rejection by peers and low connectedness to school, are often more likely to be absent and to drop out eventually. These girls are also more likely to use aggression and violence. Problems at home and learning disabilities are also interconnected with difficulties at school.

Gender Issues

Aggressive and violent girls often see male control and domination over females as normal. They may hold views similar to those that support male violence towards females in that they tend to believe girls and women have less value and importance than boys and men. Aggressive and violent girls tend to attack other girls who are perceived as competing with them for male attention, and they tend to maintain social connections with peers who are perceived as helping them win in that competition.

Boredom and Attention-seeking Behaviour

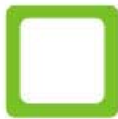
Girls who engage in relational aggression and bullying suggest that they often do so to alleviate boredom, by creating excitement, finding out gossip, seeking attention/importance and seeking validation from a group that excludes others.

Connections to Delinquent Peers

Girls are more likely than boys to be rejected by their peers for engaging in outward (overt and direct) aggression and violence. However, gang membership can appeal to girls when they are seeking to escape economically disadvantaged homes, improve their self-esteem, increase their feelings of belonging, or seek revenge and protection. Association with delinquent peers increases girls' opportunities to engage in aggressive and violent behaviours.

Experiences with Abuse

Aggressive and violent girls often report having been victimized by others. These girls are more likely than non-



violent girls and both violent and non-violent boys to have been attacked while going to or from school, physically abused at home, sexually abused or coerced into sexual relations. In their relationships with adults, aggressive and violent girls have often learned that relationships involve one person dominating and abusing another.

Drug Involvement

The abuse of alcohol and drugs contributes to aggression and violence in both adolescent girls and boys. However, chronic use of drugs seems to be especially strongly related to girls' ongoing participation in violence.

Atypical Physiological Responses

Girls who externalize (openly show) aggression and anger very often have family histories that involved repeated exposure to negative events during which they could neither fight nor flee (e.g. being abused as a child or being exposed to the abuse of a parent and/or sibling). As a result, these girls tend to be less responsive than other girls when exposed to threatening or stressful situations. They tend not to avoid situations that others would deem risky or dangerous and so are more likely to become involved with violence.

Personality Factors and Mental Illness

Although conduct disorder occurs in only 2% of the female youth population, close to 90% of aggressive and violent girls are given a diagnosis of conduct disorder, and 31% have a diagnosis of major depression. Aggressive and violent girls are also known to suffer from anxiety and attachment disorders (difficulties creating and sustaining affectionate social and personal bonds). With the onset of puberty, girls are typically three times as likely as boys to suffer from depression due to low self-esteem, negative body image, feelings of helplessness and hopelessness, and stress. If they are also exposed to abuse or neglect at home, they are at increased risk of becoming involved with violence.

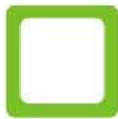
Delayed Cognitive, Moral and Social Development

The use of aggression and violence may be more likely if girls believe that other people's attitudes toward them are negative. Aggressive and violent girls may also have poor self-representations or self-images, based on negative beliefs about themselves or on negative perceptions they believe parents and peers have of them. Girls who experience delayed cognitive, moral or social development are more likely to experience school difficulties and social rejection, and are therefore at an increased risk of resorting to aggressive and violent behaviour.

Myths and Realities About Violent Girls

Myths abound about the reasons for aggression and violence in girls. The reality about what drives girls to become aggressive or violent becomes clear when we examine their experiences and beliefs. Table 1 outlines the myths and realities of what contributes to aggressive and violent behaviour in girls.

What Factors Can Prevent Girls From Engaging in Aggression and Violence?



Various protective factors can help girls at risk to avoid exhibiting aggressive and violent behaviour.

Individual protective factors: An intelligent girl with solid self-esteem, who believes that she is a capable person and who is able to take on age-appropriate social and personal responsibilities, is not likely to become aggressive or violent.

Family protective factors: Within the family, variables that support girls' use of assertive rather than aggressive behaviour include positive exposure to social situations; the presence of at least one caring and supportive adult; positive relationships with parents, especially mothers; and effective, non-authoritarian parenting.

School/community protective factors: At the school and neighbourhood level, variables that help to prevent or counter aggression and violence in girls include opportunities for education, achievement, personal growth and employment, as well as feelings of connectedness to the local community.

Efforts to prevent or counter girls' aggression and violence should be directed toward individual, family and community levels.

• Study identifies three effective treatments for childhood anxiety disorders

Walkup JT, Albano AM, Piacentini J, Birmaher B, Compton SN, Sherrill J, Ginsburg GS, Rynn MA, McCracken J, Waslick B, Iyengar S, March JS, Kendall PC. Cognitive-behavioral therapy, sertraline and their combination for children and adolescents with anxiety disorders: acute phase efficacy and safety. "New England Journal of Medicine."

U.S. Department of Health and Human Services
NATIONAL INSTITUTES OF HEALTH NIH News
National Institute of Mental Health (NIMH) http://www.nimh.nih.gov/

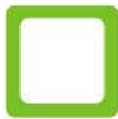
Treatment that combines a certain type of psychotherapy with an antidepressant medication is most likely to help children with anxiety disorders, but each of the treatments alone are also effective, according to a new study funded by the National Institute's of Health's National Institute of Mental Health (NIMH) The study was published online Oct. 30, in the "New England Journal of Medicine."

"Anxiety disorders are among the most common mental disorders affecting children and adolescents. Untreated anxiety can undermine a child's success in school, jeopardize his or her relationships with family, and inhibit social functioning," said NIMH Director Thomas R. Insel, M.D. "This study provides strong evidence and reassurance to parents that a well-designed, two-pronged treatment approach is the gold standard, while a single line of treatment is still effective."

The Child/Adolescent Anxiety Multimodal Study (CAMS) randomly assigned 488 children ages 7 years to 17 years to one of four treatment options for a 12-week period:

- Cognitive behavioral therapy (CBT), a specific type of therapy that, for this study, taught children about anxiety and helped them face and master their fears by guiding them through structured tasks;
- The antidepressant sertraline (Zoloft), a selective serotonin reuptake inhibitor (SSRI);
- CBT combined with sertraline;
- pill placebo (sugar pill).

The children, recruited from six regionally dispersed sites throughout the United States, all had moderate to



severe separation anxiety disorder, generalized anxiety disorder or social phobia. Many also had coexisting disorders, including other anxiety disorders, attention deficit hyperactivity disorder, and behavior problems.

John Walkup, M.D., of Johns Hopkins Medical Institutions, and colleagues found that among those in combination treatment, 81 percent improved. Sixty percent in the CBT-only group improved, and 55 percent in the sertraline-only group improved. Among those on placebo, 24 percent improved. A second phase of the study will monitor the children for an additional six months.

"CAMS clearly showed that combination treatment is the most effective for these children. But sertraline alone or CBT alone showed a good response rate as well. This suggests that clinicians and families have three good options to consider for young people with anxiety disorders, depending on treatment availability and costs," said Walkup.

Results also showed that the treatments were safe. Children taking sertraline alone showed no more side effects than the children taking the placebo and few children discontinued the trial due to side effects. In addition, no child attempted suicide, a rare side effect sometimes associated with antidepressant medications in children.

CAMS findings echo previous studies in which sertraline and other SSRIs were found to be effective in treating childhood anxiety disorder. The study's results also add more evidence that high-quality CBT, with or without medication, can effectively treat anxiety disorders in children, according to the researchers.

"Further analyses of the CAMS data may help us predict who is most likely to respond to which treatment, and develop more personalized treatment approaches for children with anxiety disorders," concluded Philip C. Kendall, Ph.D., of Temple University, a senior investigator of the study. "But in the meantime, we can be assured that we already have good treatments at our disposal."

The six CAMS sites were Duke University; Columbia University/New York University; Johns Hopkins University; Temple University/University of Pennsylvania; University of California, Los Angeles; and the Western Psychiatric Institute and Clinic/University of Pittsburgh Medical Center.

The National Institute of Mental Health (NIMH) mission is to reduce the burden of mental and behavioral disorders through research on mind, brain, and behavior. More information is available at the NIMH website (www.nimh.nih.gov). The National Institutes of Health (NIH) -- The Nation's Medical Research Agency -- includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. It is the primary federal agency for conducting and supporting basic, clinical and translational medical research, and it investigates the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit: www.nih.gov.

This NIH News Release is available online at:
http://www.nih.gov/news/health/oct2008/nimh-30.htm

Publications, web sites

• Be PINK adolescent breast health resource package: for high school and community health educators

The Be PINK Adolescent Breast Health Resource Package is a school and community groups educational resource for adolescent girls that addresses breast health. The resource provides ready-to-use, interactive, age appropriate activities, educational materials and lessons that reflect current, evidence-based core messages around issues of breast cancer, genetics, physical activity, nutrition, alcohol, tobacco use, information gathering/myth busting, breast anatomy and development, breast and body familiarity and healthy decision-making. The resource encourages youth to "be 'P.I.N.K.'": to Practice what they already know about healthy living, to Investigate the information so they can decipher fact from fiction, to know what is Normal for their body and breasts, and to know that Knowledge is power. Games, class discussions, quizzes, power-point presentations and more are all used to facilitate the learning outcomes for each lesson.

This resource is availabe online: http://www.cancercare.mb.ca/abhr/

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• Healthy Canada

Healthy Canadians is a Web site developed to provide Canadians easy access to Government of Canada health-related promotional campaigns. It will be updated regularly as new campaigns are launched. This is a shared initiative led by Health Canada and the Public Health Agency of Canada.

http://www.healthycanadians.ca/index_e.html

• Translated versions of the Canadian food guide

Eating Well with Canada's Food Guide has been translated into 10 different languages in addition to English and French! Learning more about Canada's Food Guide will help you and your family know how much food you need, what types of foods are better for you, and the importance of physical activity in your day.

http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/order-commander/guide_trans-trad-eng.php

• BC provincial pilot of an alcohol and drug monitoring and surveillance plan

McCreary (BC) is part of a collaboration of organizations on a pilot project coordinated by the Centre for Addictions Research BC, to develop a national alcohol and other drug monitoring system. Participating organizations include the Vancouver Coastal Health Authority, the BC Centre for Excellence in HIV/AIDS, the BC Centre for Disease Control, the Centre for Social Responsibility, the East Kootenay Addiction Services

Society, the Canadian Centre on Substance Abuse in Ottawa, and the Centre on Addictions and Mental Health in Toronto. McCreary is assisting in developing national guidelines on standard questions for school surveys, and will also be piloting new questions this spring to be included in the 2008 Adolescent Health Survey (AHS). The overall objective of this initiative is to create a monitoring system, inclusive of the whole country, for all populations (including adults and youth) on alcohol and drug use. The aim is to provide data for the implementation of Canada's drug strategy by identifying emerging trends in substance use. For more information about the AHS, how the information has been used, and to see a variety of reports using AHS data.

http://www.mcs.bc.ca/rs_ahs.htm

• Winter Active, a national initiative to help Canadians improve their quality of life through physical activity and healthy eating.

From the Alberta Centre for Active Living. Visit the centre's website for information and links related to physical activity and different populations (e.g., children and youth, people with disabilities, women), in various settings (e.g., workplaces, schools), and chronic diseases (e.g., heart disease, diabetes, cancer) and other topics (e.g., walking/pedometers, mental health).

http://www.centre4activeliving.ca/

• McCreary Centre Society, BC: Fitness Challenge Video

It is with great pleasure that I share with you a video of our Fitness Challenge 2008. This was such a fabulous day and I am so pleased to be able to share highlights with you all. A very special thanks to Jules Wilson for taking the photos and videos and spending the hours editing and creating this fabulous video.
http://www.youtube.com/watch?v=2jSUViefWIk