



# PRO TEEN

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## Scientific Events

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IAAH's World Congress

## Articles

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Young people in Canada: their health and well-being

Bullying in Canada

Dieting in adolescence

Dieting information for parent, teachers and coaches

## Publications

Voices of Youth in Care (VOYCE)

Health initiatives can help peace bringing in the Middle East



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# News from the Association

## President's Report 2004

The state of membership in December 2004 is as described in the tables below.

In 2004, This year, even if it shows that 54% of the members have renewed, in reality, it is a bigger percentages who have paid some dues because many members from 1999 to 2002 have renewed. The members of 1999 and 2000 will probably not renew their membership but many members from 2001 and 2002 will renew in 2004 after several reminders. Sending three reminders per year has proved to be rewarding in terms of membership renewal. Our membership is stable as compare to last year.

We are loosing and gaining members each year. Many retire or are not working with adolescents anymore. Also, many organizations were taking a membership for many professionals and are renewing for one only.

There are more members in Québec and Ontario since CAAH is better promoted in those provinces with National and Regional meetings.

81% of members are women and 19% are men; 58% of members receive our publication in French, 34% in English and 8% in both languages.

25% of the members have a single membership and 75% are in a group membership (this includes members who have an institutional membership).

### Meetings

The 2004 CAAH National Meeting was organized in conjunction with the Adolescent Medicine Division of Ste-Justine Hospital and of the Montreal children's Hospital. Under the theme of "Adolescence, body, heart and mind" it was attended by an overwhelming number of 410 participants.

1999 - 2000	121 (15%)
2001	58 (7%)
2002	111 (13%)
2003	70 (8%)
2004	450 (54%)
2005 (paid subscription since 2004)	26 (3%)
<b>TOTAL</b>	<b>836</b>

### Website

CAAH website has two main sections, the new one in Flash is designed for expert web users while the old but updated Html version is still available. Numerous articles from our publication Pro Ado and Pro Teen are frequentle added along with new ressources and links.

The website is visited by an average of more than 900 persons per week, of which about 130 accessed directly through our home page while others indirectly from external links. There are usually more than 5000 hits per week on the site. The time

spent is interesting since it is above 5 minutes in average.

**PRO-TEEN, PRO-ADO**

Few articles have been submitted to us this year. It becomes increasingly difficult to deliver the publication on time under such condition. We encourage different groupes and organizations in adolescence health to share this task by contributing more articles.

**Canadian Health Network**

CAAH is part of a consortium of affiliated partner in charge to develop an adolescence center for the Canadian Health Network, a leading health

information web site. Since July 2003, CAAH is the coordinator of the consortium,. We submitted and obtained, in March 2004, the 2004-2006 contract. It is an annual contract of 250,000\$, divided between 6 members of the consortium. Our goal is to develop a new section designed for teenagers, with teenagers. This new section will be functional in 2005. Our task with CHN is to revise its adolescent related collection of articles and to maintain the website with selected canadian content. We also do promotional work and develop marketing tools for this purpose.

**Sections**

In the constitution, the ACSA was to develop sections in each province and area. This was not possible and this concept should be re-examined.

**Committee**

Defense of the rights and services. This committee is no longer functional, due to lack of mean and availability of key players.

**Finances**

We are making up gradually for our deficit. The sums due since April 2000 will be paid by Santé Canada at the end of 2004 or in early 2005.

**Future actions**

We must reconsider the structure of our organization, like financing. The sections will be difficult to develop in a near future. Our attempts to attract western provinces interest do not harvest any result.

We are looking forward to meetings and contacts of the board of directors in the next few months to re-examine all our operation. There are potentials for development, but we need human and financial resources which are missing in our canadian healthcare system.

Jean Yves Frappier  
President

<b>Topic of Interest (more than one choice)</b>	
Parents-adolescents relationships	78%
Behavior problems	66%
Sexuality, pregnancy	74%
Handicaps, chronic diseases	37%
Sexual abuse	62%
Anorexia nervosa and bulimia	67%
Suicide, suicide attempt, depression	73%
STD, AIDS	61%
Drug abuse	67%
General health: growth, dermato, ortho, sports	43%
Rights and Laws	44%
Adolescent development	65%
Learning disorders	43%
Violence	51%
Nutrition and obesity	51%
Psychosomatic complaints	49%

Workplace (more than one choice)	
CLSC	40%
Private Office	9%
School	32%
Public Health	14%
City Health Department	1%
Hospital	18%
University	5%
Community Organization	8%
Youth Centres	6%
Children Aid Society (Youth protection)	3%
Custodial Facilities	3%
Government, Ministries, Governmental Organizations	4%
School Board	2%
Others	4%

Type of work (more than one choice)	
Clinical Intervention	71%
Teaching	38%
Prevention, Promotional Activities	64%
Health Education	44%
Clinical Coordination	13%
Group's animation	28%
Community Work	19%
Public Health	23%
Research	11%
Administration	12%
Documentation, Library	4%
Volunteers	3%
Media	3%
Street work	3%
Program development	17%
Others	4%

Profession of Members			
Nurse	36%	Family Doctor	11%
Social Worker	14%	Paediatrician	6%
Psychologist	8%	Gynecologist	1%
Teacher	2%	Other medical specialties	2%
School Counselor	3%	Librarian, Documentalist	2%
Child Life Worker, Occupational Therapist	5%	Nutritionist	2%
Community Worker, Street Worker	2%	Administrator	2%
Sexologist	1%	Others	9%
Coordinator	6%		

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## Scientific Events

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### I•A•A•H World Congress

## Positive Youth Development: Empowering Youth in a World in Transition

Lisbon, Portugal  
May 11-14th 2005

The 8th IAAH World Congress will take place in Lisbon, Portugal, 11-14th May 2005, entitled "Positive Youth Development: Empowering Youth in a World in Transition"

This meeting promises to be the most exciting event in the world of Adolescent Health so far. Over the four days from the 11th - 14th May 2005 many people from around the world will be gathered to discuss ways in which they can empower young people to achieve healthy development in a changing world.

Much has been researched about the concepts of "Risk and Resiliency". This meeting will be examining how those concepts can be applied in the context of health development in a young person's environments of home, school and community. This may be from the view of a health clinician, a teacher, a young person, a counsellor, a policy maker or a social worker. All these people are involved in empowering young people and we hope this will be the time and place for all those people to meet, exchange ideas for research, programmes, policy and practice.

You cannot miss out on this opportunity to be inspired, energised, informed and up skilled in your task of assisting young people to develop in the most optimal way for them, wherever you are in the world.

Six plenary sessions will focus on the following topics given by reknown speakers and Youth :

- Youth Development in a Time of Global Transition
- Individual Influences on Healthy Development
- Creating Connections in Families Across Cultures
- Engaging Youth in School
- Opportunities for Engagement: Capturing Creativity and Energy
- Setting the Course for National Youth Policies:

Symposiums (3hrs) will be held on : Male Health, Advocacy, Obesity, Mental Health, Gynecology

More than 55 workshops will be proposed on various topics : transition to adult health services, history

and culture in adolescent health, Creative arts in positive youth development, Health and gender equity for young men, boundaries in therapeutic relations, influence of parental models in early adolescence, effective interviewing, motivational intervention, accident and violence prevention, fitting services provision with needs, youth participation in disabling health conditions, Teen pregnancy, depression, resilience and stigma in Gay and lesbian youth, Eating disorders, sexuality, school health, Tobacco cessation, Media technology for partnering with youth, impact of media on youth, sexual abuse of boys, family intervention, conflict resolution, HIV prevention, adolescent who don't ask, psychotherapeutic intervention, migrants youth, program and policy

There will also be more than 75 short oral presentation and 190 Posters on various topics and from more than 25 countries

Online registration is available now via [www.mundiconvenius.pt](http://www.mundiconvenius.pt).

Whether you are a young person under 25, a researcher, a policy maker, a doctor, nurse, counsellor or social worker or any other profession that tries to assist young people - plan to be in Lisbon Portugal 11th -14th May 2005.

Sue Bagshaw, President IAAH

Helena Fonseca, President of Organizing Committee

Linda H. Bearinger, President of Scientific Committee

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## Articles

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### Young People in Canada: Their Health and Well-being

Public Health Agency of Canada

The Health Behaviour in School Aged Children (HBSC) survey has been carried out in Canada every four years since 1990 by the Social Program Evaluation Group at Queen's University in partnership with Health Canada. The HBSC study is sponsored by the World Health Organization, and includes research teams from 35 countries in Europe and North America.

The HBSC 2001-2002 survey uses the population health framework, promoted by Health Canada, and recognizes the broad sets of determinants of health and health behaviours in children and youth. Three age groups (11-, 13-, and 15-year-olds) are included as being representative of critical periods of early adolescent development. More than 7000 students from five grades (6, 7, 8, 9, and 10) were selected to represent these age groups across Canada. The main purpose of the HBSC study was to examine patterns in the determinants of health of these age groups as well as selected trends in their health behaviours and attitudes. The main findings are summarized below.

#### Socio-economic Inequalities

Socio-economic inequalities are related to a variety of health outcomes in Canadian youth.

Social inequalities are associated with a variety of indicators including perceived health, mortality, morbidity, and psychosomatic illness (Machenbach, Kunst and Cavelaars, 1997; Kennedy, Kawachi, and Prothrow-Stith, 1998). Some inequalities, such as gender, race, and disability, represent basic life conditions and disparities in life chances.

Socio-economic inequalities are increasing throughout the world (Atkinson, Rainwater, and Smeeding, 1995) and include factors such as income, wealth, education, and prestige (Currie, Samdal, Boyce, and Smith, 2001). Although these socio-economic aspects have been associated with the well-being of children and adults, their impact on adolescents has been controversial (Bergman and Scott, 2001). For example, the relationship between socioeconomic variables and family functioning has demonstrated varying results (Baer, 1999), as is shown in Chapter 3 (The Home) of this report.

Within the HBSC study, measures of socioeconomic status (SES) comprised parent occupation and family income as measured by material wealth, perceived family wealth, and poverty (in the form of hunger). The family affluence scale (FAS) was used as a measure to capture students' reports of their families' assets and material wealth (Currie, Todd, and Platt, 1997; Mullan and Currie, 2000).

In the HBSC sample, over half of the students surveyed indicated that their families were well off, although this decreased for students in the older grades. At the same time, on average, 13 percent of students reported at least sometimes going to bed hungry because of lack of food at home. Students whose families were relatively affluent or very affluent also reported that they were healthy and satisfied with their lives, which emphasizes the link between socio-economic factors, self-reported health, and life satisfaction among youth.

### The Home

Adolescents who have a good relationship with their parents demonstrate positive psychosocial functioning and less involvement in risk taking.

Adolescence is a period during which connectedness, or a strong sense of closeness, to the family decreases (Resnick, 2000) and attachment to peers increases (Collins and Russel, 1991; Larson and Richards, 1991; Fulgini, Eccles, Barber, and Clements, 2001). However, support from parents remains vital to the positive development of adolescents (Nada-Raja, McGee, and Stanton, 1992) and is an essential protective factor against anti-social behaviour and delinquency (Hawkins, Catalano, and Miller, 1992; Nada-Raja et al., 1992; Dornbusch, Erickson, Laird, and Wong, 2001). Such support consists of a warm and nurturing relationship, positive bonding, and parental monitoring of adolescent activities (Dekovic, 1999).

There were clear gender differences in students' relationships with their parents. Girls reported more strains in these relationships than did boys. For example, older girls reported more difficulties talking to their fathers, felt less understood by their parents, and were less satisfied with their home life than both boys their age and younger girls. Girls also reported that they had more arguments with their parents and a greater desire to leave home. Having a good relationship with parents was related to higher life satisfaction in both genders and served as a protective factor against involvement in risk-taking behaviours, such as smoking, getting drunk, and using marijuana. In addition, students with middle or high family affluence not only felt that their parents provided them with the support they needed at school but also reported being highly satisfied with their home life.

### The Peer Group

Having friends is fundamental to adolescent development.

The establishment of friendships is fundamental to adolescent development. The transition from preadolescence to adolescence brings about a change in the nature of relationships with peers. To address

their changing social needs, friendships become more intimate in nature and friends become close confidants (Buhrmester, 1996). Intimacy can be described here in terms of the ease of communication within peer relationships, as well as comfort in disclosing problems and worries with others. Having close friends is associated with positive emotional health and social adjustment. Children with close friends demonstrate better academic performance, lower rates of juvenile delinquency, and lower dropout rates, compared with children who do not have friends as sources of intimacy and social support (Parker and Asher, 1987).

The type of peer relationships, number of friends, and extent of involvement in a peer group evolve over adolescence and may influence the degree to which adolescents become involved in health-promoting or health-compromising behaviours (Sieving, Perry, and Williams, 2000).

Boys, especially in the lower grades, found it harder to communicate or discuss their troubles with same-sex friends than did girls. The HBSC data show that younger boys and girls were less comfortable in opposite-sex interactions than in same-sex friendships. The ease of communication with members of the opposite sex improved for older students as they gained more confidence. Time spent with friends is a good indicator of adolescents' involvement with their friends. Boys tended to spend more time with peers, both after school and in the evenings, than did girls.

Students who were well integrated socially and had positive peer influence reported higher life satisfaction and fewer risk-taking behaviours than did students who had poor social integration and negative peer influence. Sexual behaviour occurred more in youth with negative peer influences, regardless of whether they were well integrated socially or not.

### The School Experience

A large portion of Canadian adolescents' lives are spent in schools interacting with teachers and peers. Adolescents spend a substantial portion of their lives in school settings. Their experiences in such settings strongly influence their social and emotional health and their development, both positively and

negatively (Wells, 2000). Specifically, students' health behaviours and their views of themselves are related to their lives in school (Anderman, 1999). In addition to the direct teaching of academic skills, schools provide opportunities for adolescents to develop social connections that often have lasting impacts on their lives. For the majority of adolescents, schools provide positive experiences with teachers and peers, helping them to develop strong emotional bonds and self-confidence. However, for some young people, school is a threatening and uninviting place. Adolescents who feel isolated or rejected in school or believe that their school's expectations are too high tend to disengage from school life. These young people are prone to becoming involved with peers sharing similar negative attitudes, which can ultimately result in increased health-risk behaviours (Connop and King, 1999).

In Canada, education falls under provincial and territorial jurisdiction, with each province and territory establishing its own curriculum, general structure, and organization (Figure 5.1). Although a single national education system does not exist, there have been some attempts to create common curricula across jurisdictions – for example, the Western Protocol for Collaboration in Basic Education (WCP). With few exceptions, the formal education in most provinces occurs from kindergarten to Grade 12 and is separated into elementary and secondary programs. In Alberta and Ontario, kindergarten is optional; further, Ontario has a two-year kindergarten program. In Quebec, the final year of formal public education ends in Grade 11. Ontario phased out its Grade 13 year in June 2003. Provinces and territories also vary in their funding of alternative educational programs. Public education is generally considered non-denominational. However, Roman Catholic education boards are fully funded in some jurisdictions (e.g., Alberta and Ontario), partially funded in others (e.g., British Columbia), or not funded at all (e.g., the Atlantic Provinces). Newfoundland recently required all schools to be non-denominational, although religion courses are offered at all grade levels in the public system.

In elementary education, students have primarily one teacher for all of their school subjects for the entire year. Although the elementary panel includes Grade 6 in each province or territory, the final year of

elementary education varies from Grades 6 to 8. In the secondary panel, students complete separate classes under the guidance of subject specialist teachers; thus, students have several teachers over the year. The secondary panel is formally or informally divided into junior and senior secondary programs. Individual school districts use different variations in order to maximize the use of buildings or to address a specific educational philosophy. It is not uncommon, therefore, to see different panels, or portions of a panel, occurring in the same building. For example, the junior secondary panel can be housed with either the elementary or the senior secondary panel. In terms of student support services, elementary schools often share counselling services with other nearby elementary schools. Some limited learning support is generally available in the school, although many of these services are provided by itinerant staff. Secondary schools are more likely to have counselling services and expanded learning support services within the school, although specialized itinerant staff may also be used. The level of such support is often related to school or district size.

Secondary panels throughout Canada offer a variety of curriculum programs, providing students with opportunities to enrol in courses in the humanities, arts, sciences, and technical strands. Most jurisdictions also provide academic and less academic programs in foundational courses (most commonly in language arts, mathematics, and science). In an attempt to introduce students to the world of work, emphasis on career exploration and workplace experiences is growing. Within and across districts and provinces, there is also some variation in the manner in which specific education programs are offered; for example, full-year or semestered programs. One growing trend in education in Canada is the use of large-scale assessments to monitor school effectiveness. The Council of Ministers of Education, Canada (CMEC), sponsors the national Student Achievement Indicators Program (SAIP). Canada also participates in international assessment programs, most notably in math and science, such as the Trends in Mathematics and Science Study (TIMSS) and the Programme for International Student Assessment (PISA). Many provinces test sufficient numbers of students with these assessments so that provincial

results can be compared directly with those from other countries.

According to the TIMSS 1999 International Math Report, Canada placed tenth on the TIMSS test of mathematical achievement for 14-year-old students in a field of 40 countries. Canada's average scale score was 531. This score was significantly higher than the international average of 487 (Mullis and colleagues, 1999). According to the TIMSS 1999 International Science Report, Canada placed fourteenth in the TIMSS test of science achievement. Again, the Canadian average score of 533 was well above the international average of 488 (Martin and colleagues, 1999). The results from the most recent administration of PISA ranked Canada highly in comparison with 31 other countries where 15-year-old students wrote the test (Human Resources Development Canada, 2002). Canadian students averaged second in reading, sixth in mathematics, and fifth in science.

Most students in the 2002 Canadian HBSC survey liked school, but after peaking in 1994, the proportion of students who liked school has dropped steadily. Secondary students' perception of school tended to be more negative than that of elementary students, and boys had more overall negative views of school than did girls.

Being happy at school was related to the perception of having good and fair teachers, supportive relationships with teachers, and an increased sense of autonomy in the classroom. However, students in higher grades felt they had less say in how class time was used. More boys than girls reported school work to be difficult, yet boys also indicated that they spent less time doing homework and that their teachers expected too much of them at school. A major finding was that students who had positive experiences at school were less likely to be involved in health risk behaviours such as smoking, drinking, and using marijuana. It is important that schools provide a supportive, interesting, and engaging environment for students within which they can feel accepted.

### **Youth Health Risk Behaviours**

Experimenting with tobacco, alcohol, and marijuana is considered normal for many adolescents.

The use of tobacco, alcohol, and other substances during adolescence is sometimes regarded as non-normative and anti-social. Yet youths' desire for independence and their curiosity to discover the world around them contribute to initial experimental use of tobacco, alcohol, and marijuana. Many do not venture beyond the experimentation phase, but others continue to be involved in a lifestyle that predisposes them to various health risks. Engaging in health risk behaviours is the primary cause of morbidity and mortality of adolescents.

These behaviours tend to occur together in youth, creating a health-compromising lifestyle with consequences for physical health (Pickett, Boyce, Garner, and King, 2002).

Some adolescents go beyond the experimentation stage to the extent that these behaviours create a health-compromising lifestyle with consequences for physical health. Health risk behaviours tend to occur together in youth and should not be addressed individually.

It is encouraging to note a decline in 2002 daily smoking rates in older girls, and also in Grade 8 students compared with previous HBSC surveys.

Experimentation with alcohol occurred in younger students in the Canadian sample, with rates of alcohol consumption increasing significantly between the ages of 12 and 14 years. Interestingly, almost as many girls as boys reported engaging in binge drinking, which indicates that excessive alcohol use may be a feature of adolescent social events. Marijuana use was still popular among adolescents in 2002 and increased in use among Grade 10 boys. Those who used marijuana were more likely to smoke, drink, engage in sexual risk taking, and report poor relationships with parents and negative feelings about school. The use of other drugs remained fairly stable among youth, except for LSD use, which decreased considerably since 1998.

Questions regarding sexual behaviour were addressed for the first time in this HBSC survey. Data show that slightly over one-quarter of students in Grade 10 have had sexual intercourse. However, only two-thirds of those sexually active students used

condoms the last time they had sexual intercourse, and just under one-half used birth control pills.

### Healthy Living

Healthy living for youth includes a wide range of behaviours, such as following a healthy diet, being involved in both organized and casual physical activities, and trying to maintain an optimum weight. Healthy eating habits, good dental hygiene, and involvement in physical activity contribute to the physical and emotional health and well-being of youth. Some of those behaviours might be compromised in adolescents, because they are less dependent on their parents for some meals, spend more time away from home, and consume greater quantities of fast foods and snacks (Neumark-Sztainer et al., 1998; 2003).

It is recognized that dietary patterns in childhood and adolescence not only influence the immediate well-being of children but may also have an impact on their long-term health. In addition, dieting behaviour may have a bearing on the health status of adolescents; widespread concern about excessive dieting among young girls in Canadian society accompanies the awareness of the effects of obesity on long-term health.

Physical activity may be defined both in terms of organized sports and pursuits, as well as unstructured activities related to active living. Active living has been described as an integrated lifestyle that brings about a general state of physical, mental, spiritual, and emotional well-being (Frankish, Milligan, and Reid, 1998). Under this concept, individuals interact with their environment through relatively unstructured physical activities, such as playing outdoors, skating, skiing, skateboard-ing, and bicycling (Stewart, 1995). Regular physical activity can benefit adolescents in many ways: the achievement and maintenance of a healthy weight; the promotion of skeletal health; the improvement of sleep quality; and the enhancement of self-esteem. Inappropriate physical activity may also, however, result in injuries. Lack of, or limited, physical activity is a result of more time spent in passive leisure pursuits, such as watching television or playing video games. The duration and type of sedentary leisure time influences the extent of social

integration and has been linked to some risk behaviours.

In the Canadian HBSC sample, girls ate more nutritious foods such as fruits and vegetables than did boys. However, more girls than boys skipped breakfast and reported dieting or doing something else to lose weight, especially in the higher grades. Boys, more than girls, consumed foods high in sugar, salt, and caffeine, such as soft drinks, diet soft drinks, potato chips, french fries, and cake or pastries.

Physical exercise is necessary for growth and development as well as for the promotion of self-esteem. Student levels of physical activity were encouraging, although surprisingly low levels of exercise were reported within schools. It is interesting to note a significant gender difference in physical activity, both in and out of school, indicating that engagement in sports is still primarily a male domain and that schools could do more to involve girls in physical activities. Younger girls seemed to participate more in clubs or organizations, although the gender difference disappeared in Grades 9 and 10. Levels of television watching can be an indication of a sedentary lifestyle. A high proportion of students reported that they watched several hours or more of television each day. Recreational computer use was also quite high, with more than two-thirds of older students stating that they spent at least one hour each weekday playing computer games.

### Bullying and Fighting

Bullying takes many forms, including verbal harassment, teasing, spreading rumours or lies, and excluding others, in addition to physical bullying such as pushing or kicking. Bullying most frequently happens at school and under conditions where there is little adult supervision. In the HBSC sample, over 20 percent of students reported that they were both bullies and victims of bullying, although more students reported being bullied compared with those who reported bullying others. This difference indicates that young people who are victimized experience aggression differently than do bullies. Therefore, educational programs should explain the different forms of aggression and their harmful consequences. HBSC data show that sexual harassment reported by girls increased with age and peaked in Grade 9. Harassment because of race,

ethnicity, and religion is a form of bullying that was reported by more boys than girls. Also, boys reported more physical fighting, and frequent fighting, than did girls, and this peaked in Grade 7. Boys most often fought with friends or acquaintances, while girls were equally likely to fight with their siblings.

### **Injuries**

Injuries are among the most important health problems that young people face during their school-aged years.

Injuries are one of the most important health problems that youth face during their school-aged years. They are the leading cause of death among young people (Institute of Medicine Committee on Injury Prevention and Control, 1999), and approximately one hospitalization in six experienced by young people can be attributed to an injury (Lescohier and Scavo-Gallagher, 1996). Non-fatal injuries occur at least 1,000 times more often than fatal injuries (Lescohier and Scavo-Gallagher, 1996), and their impacts in terms of treatment, rehabilitation, and ongoing disability are of huge importance (Rivara, Grossman, and Cummings, 1987).

Various strategies have been developed to prevent injuries to youth, including those aimed at reducing risk-taking and promoting safety-oriented behaviours. Multi-faceted bicycle helmet campaigns that combine regulation with educational efforts provide good examples of such strategies (Henderson, 1995; Irvine, Rowe, and Sahai, 2002). Other ongoing strategies include: enforcement of rules and regulations around motor vehicle use, such as seat belt campaigns and RIDE programs aimed at drinking and driving (Grossman and Garcia, 1999; Evans et al., 2001); and engineering strategies that involve making youth environments as safe as possible, such as playground equipment standards (Canadian Standards Association, 1990). While all of these strategies can be effective in practice, basic information about the nature of youth injury problems assists in the planning and evaluation of the effects of interventions.

Injuries to young people should not be viewed as “accidents.” They are both predictable and preventable. By examining circumstances associated with injury events that happen over and over again,

their predictability can be demonstrated and potential opportunities to intervene can be identified. This chapter shows that some young people are more at risk for injury than others. It also profiles certain factors that are common to injury events. All of this information can contribute to the development of effective injury prevention programs.

As many as 50 percent of Canadian students reported having had an injury requiring medical attention during the past year. These injuries ranged from sprains and strains to lacerations, bruises, fractures, and head injuries. Boys consistently experienced more injuries than did girls, and the incidence of injuries peaked for both in Grade 8.

The HBSC study examined the circumstances surrounding youth injuries. The vast majority of sports and other types of injuries happened in controlled environments, including the home, school, or sports facilities. Interestingly, the percentage of injuries that occurred during organized activities increased substantially in the older grades. Strategies to prevent injuries should combine regulations and ongoing educational campaigns to ensure that the message is consistent.

### **Emotional Health**

The majority of students in the survey reported good emotional health.

Emotional health should be of concern to all Canadians. Approximately 20 percent of the Canadian population will have some sort of mental health condition during their lifetime (depression, schizophrenia, psychosis, etc.). An estimated 2.5 million Canadians over the age of 18 will experience a depressive disorder (Canadian Mental Health Association, 2002). Additionally, a high proportion (66 percent) of Canada’s homelessness (Canadian Mental Health Association, 2002) and suicides (Moscicki, 1999) are related to poor emotional health. Even such high numbers may underestimate the true extent of the problem, given that people may not always be willing to admit they are suffering from emotional health difficulties. This relatively high percentage of persons suffering from emotional health problems has both financial and societal costs. A recent report indicated that \$14.4 billion is spent annually on treating mental illness in Canada (Joubert

and Stephens, 2001), with this amount expected to increase to the point that mental illness will represent the leading health cost in the country by 2020 (Canadian Psychiatric Association, 2001).

Emotional health problems that arise in adolescents need not continue throughout their lifespan (Elder and Crosnoe, 2002). With proper treatment, such as personal and/or group counselling or medication, most individuals can lead healthy and productive lives (Diverty and Beaudet, 1997). Therefore, it is essential that we gain an understanding of the extent of emotional health problems among Canadian adolescents and what contributes to them so that they can be treated appropriately.

The 2002 HBSC survey measured emotional health across Grades 6 to 10 in two ways: symptomatically and globally. At a symptomatic level, an eight-item checklist of psychosomatic complaints was used. The scale had four items measuring psychological indicators of emotional health (feeling depressed or low, irritability or bad mood, feeling nervous, feeling dizzy) and four items measuring somatic factors (headache, stomach ache, backache, difficulties getting to sleep). The scale is flexible in that both summary scores (Haugland, Wold, Stevenson, AarØ, and Woynarowska, 2001) and individual item scores (Torsheim and Wold, 2001) are meaningful. For each of these emotional health indicators, adolescents were asked how often they had experienced the complaint in the past six months (“about every day,” “more than once a week,” “about every week,” “about every month,” and “rarely or never”).

Two global questions were also used to ask students how they viewed their health. The first item on life satisfaction asked students to rate their life on an 11-point ladder scale, with “10” representing the best possible life and “0” the worst possible life. This life satisfaction ladder has been shown to be a valid instrument in judging life satisfaction in adults (Cantril, 1965), although it has yet to be validated as a measure of adolescent life satisfaction. A second question on perceived health simply asked youth to indicate whether their health was “excellent,” “good,” “fair,” or “poor;” this item has been a useful measure of emotional health in large epidemiological surveys (Idler and Benyamini, 1997).

However, between 20 percent and 30 percent of students said that they had some form of emotional or physical (psychosomatic) complaint. Girls, compared with boys, reported higher levels of depression and headaches, which increased with age. Backaches and irritability were similar between the genders. On all measures, emotional health tended to worsen with age. An especially critical point for girls’ emotional health appeared by Grade 7, at which time they may require additional support to cope with life and body changes. In general, students who reported fewer psychosomatic symptoms were more satisfied with their lives.

Parents may be the best defence against poor emotional health. Adolescents with strong parental support were happier with their lives and reported being healthier. Having a strong network of peers contributed to better emotional health, but not as much as parental support did.

### Implications

From a population health perspective, the most powerful determinants of youth physical and emotional health evident from the 2002 HBSC survey were gender, family affluence, school conditions, and the influence of peers on risk taking.

Clearly, broad policy responses to this range of potential determinants will be required. Federal, provincial, territorial, municipal, professional, and business sectors need to discuss the health of the next generation openly with youth themselves. Youth have had insufficient attention among these sectors, in part because of the transitional character and independence-seeking nature of adolescence. When initiatives are focused on adolescents, efforts to engage youth in policy and program development need to be strengthened. The development of an inclusive, cross-sectoral “Middle Childhood and Adolescent Agenda” in Canada would contribute to the visibility and viability of policy initiatives and may also earn widespread youth approval and participation.

## Bullying in Canada

### National Strategy on Community Safety and Crime Prevention

Canadians are concerned with the level of violence in today's society, the safety of their communities, and the welfare of their children. As we know, too many children are victims of violence and aggression in the schoolyard, the playground and elsewhere. Some studies indicate that violent behaviour of young people is increasing, that the violence is directed at other young people, and that the violence is committed by younger people than was the case in the past. To prevent youth violence and reduce the rate of violent crime, research indicates that focusing on the early signs of antisocial behaviour is effective. Bullying is one phenomenon that contributes to the development of such behaviour patterns.

Bullying is a serious problem for those who engage in it, for its victims, and for the communities in which it takes place. It is not a normal part of growing up. It can make children feel frightened, sick, lonely and unhappy. Unfortunately, these childhood bullies are also more likely to develop anti-social behaviours (Farrington, 1993). Studies indicate that 30% to 40% of children with aggression problems grow up to have problems with violence as adults (Public Legal Education and Information Service of New Brunswick).

Bullying changes its form with age:

- Younger children's playground bullying often involves pushing, shoving, name calling teasing and isolation;
- Teenage bullying may begin to include sexual harassment, gang attacks, dating violence; and
- Adult bullying may become assaults, marital violence, child abuse, workplace harassment, and senior abuse (Public Legal Education and Information Service of New Brunswick).

For victims, repeated bullying can cause psychological distress and many related difficulties (Besag, 1989; Olweus, 1993). The impact of bullying extends beyond the bully and victim to the peer group, school, and community as a whole. It is important to stop bullying

at a young age and strive to create a safe and peaceful environment for everyone.

With an understanding of factors related to bullying, we can design prevention and intervention efforts that decrease bullying and increase the likelihood that teachers, parents and other children will intervene when it does occur.

The National Strategy endeavours to intervene early in the lives of our young people, addressing issues of antisocial behaviour before they become more serious problems. Building resiliency and healthy environments for children and youth today will reap benefits far into the future. The Strategy supports communities and schools - working with students, parents, educators, and practitioners, and others in developing, and sharing, grass-roots initiatives to combat bullying.

#### What is Bullying?

Bullying is the assertion of power through aggression. Bullies acquire power over their victims physically, emotionally and socially. This can be done in many ways: by physical size and strength, by status within the peer group, by knowing the victim's weaknesses or by recruiting support from other children, as in group bullying. Emotional and social bullying may perhaps be the most frequent and harmful forms. Bullying can be physical or verbal. It can be direct (face-to-face) or indirect (gossip or exclusion) (Olweus, 1991). With repeated bullying, the bully's dominance over the victim is established and the victim becomes increasingly distressed and fearful.

#### How Widespread Is Bullying?

A 1997 survey of Canadians revealed that 6% of children admitted bullying others "more than once or twice" over a six-week span and 15% of children reported that they had been victimized at the same rate (Pepler, et al.). Researchers' observations of children on playgrounds and in classrooms confirm that bullying occurs frequently: once every 7 minutes on the

playground and once every 25 minutes in class (Craig and Pepler, 1997). To understand the problem of bullying, we must consider the characteristics of everyone involved in the bullying scenario: the bully, the victim and the bystander. We must also examine the social contexts in which bullying occurs, such as the family, peer group, school, and community.

### Who are the Bullies?

Children bully in many different ways—there is not a single type of bully. The following characteristics have been identified primarily through research on boys who bully.

- Gender: Both boys and girls are involved in bullying as either bullies, victims or bystanders at approximately the same rate, although each gender expresses bullying in different ways. More boys report their bullying than girls; boys report more physical forms of bullying, while girls report indirect forms of bullying, such as gossiping and excluding (Craig and Pepler, 1997)
- Age: Ages 4-10, aggression is mainly confined to same-sex peers, whereas ages 11-18 expand their aggression to involve opposite-sex peers as well. In addition, 11 to 12-year-old students reported bullying others more than did younger or older student groups (Pepler, et al.).
- Temperament: Bullies tend to be hyperactive, disruptive, and impulsive (Lowenstein, 1978; Olweus, 1987).
- Aggression: Bullies are generally aggressive toward their peers, teachers, parents, and siblings, and others (Olweus, 1991). Bullies tend to be assertive and easily provoked. They are attracted to situations with aggressive content and have positive attitudes about aggression (Stephenson and Smith, 1989).
- Physical Strength: Boys who bully are physically stronger and have a need to dominate others (Olweus, 1987).
- Lack of Empathy: Bullies have little empathy for their victims and show little or no remorse for bullying (Olweus, 1987).

### Who are the Victims?

Children become victimized for many different reasons - there is not a single victim type. For some children, the following characteristics are present before bullying occurs; for others, they develop as a result of bullying.

**Gender:** Boys and girls are equally likely to report being victimized (Charach et al., 1995; Pepler et al., 1977).

**Age:** Victimization decreases across grade levels: 26% of children in Grades 1-3 report victimization compared to 15% in Grades 4-6 and 12% in Grades 7-8 (Pepler et al.). Children in lower grades are more likely to be victims of older bullies, whereas children in higher grades are more likely to be victims of same-age bullies. Younger students experience more direct bullying, whereas older students experience more indirect bullying (Olweus, 1993).

**Temperament:** Victimized children have a tendency to be anxious and withdrawn. There is more evidence of this among preschool children than among school-aged children.

**Physical Appearance:** Research has not supported the popular stereotype that victims have unusual physical traits (Olweus, 1991).

**Self-Esteem:** Victims often report low self-esteem, likely because of repeated exposure to victimization (Besag, 1989).

**Depression:** Both boys and girls who are victimized report symptoms of depression, such as sadness, and loss of interest in activities (Slee, 1995; Craig, 1997).

**Anxiety:** Boys and girls who are victims report symptoms of anxiety, such as tension, fears and worries (Neary and Joseph, 1994; Slee, 1995).

### What Role Do Peers Play?

Bullying usually involves more than the bully and victim-85% of bullying episodes occur in the context of a peer group (Atlas and Pepler, 1997; Craig and Pepler, 1997). Although 83% of students indicate that watching bullying makes them feel uncomfortable (Pepler et al., 1997), observations indicate that peers assume many roles in the bullying episode: joining in, cheering, passively watching and occasionally intervening.

- Peers tend to give positive attention to the bully, rather than the victim. Their reinforcement of the bully may serve to maintain the bully's power over the victim and within the peer group. The bully may also affect the peers who are watching.
- Peers who watch bullying may become excited and more likely to join in.
- Compared to girls, boys are more likely to be actively drawn into bullying episodes (Craig and Pepler, 1997; Salmivalli et al., 1996).
- In playground observations, peers intervened in significantly more episodes than did adults: 11% of episodes versus 4% (Craig and Pepler, 1997).

### What Role Does the Family Play?

Children's behaviour patterns are first established at home. It is important that parents create a home environment that discourages bullying behaviour and supports children who are victimized.

- Bullies often come from homes that are neglectful, hostile and that use harsh punishment (Olweus, 1993). Bullying may be learned by observing conflict between parents. Care needs to be taken by parents so that they do not model bullying for their children.
- Fighting amongst siblings to solve problems can inadvertently support bullying when it is accepted as a normal part of growing up.
- Victims often keep their problems a secret because they feel that they should handle bullying themselves. Often they worry about

the bully's revenge or other children's disapproval, and/or they think adults can do little to help them (Garfalo et al., 1987; Olweus, 1991).

- When they are courageous enough to tell, victims talk more often to parents than to teachers. As their children's most important advocates, parents must support their victimized children by working with the school to ensure their children's safety.

### What Role Does the School Play?

Schools play an important role in shaping children's development. As with families, schools must strike a balance between clear, consistent discipline and warm, supportive relationships.

- **Principals:** Principals set the tone for their schools. Bullying is reduced if the principal is committed to addressing bullying (Charach et al., 1995). Strategies used by principals include: consistent and formative consequences for bullies; an open-door policy for victims, with empathetic responses to their concerns; and working together with teachers on classroom management, and strategies for troubled children.
- **Student-Staff Relations:** Bullying is less prevalent in schools where there are supportive relations among school staff, warm relations between staff and students, shared decision-making among staff and students, and where the adults do not model bullying for the students (Olweus, 1987).
- **School Policy:** They key to reducing bullying in schools is a clear policy regarding bullying with consistently applied consequences (Olweus, 1991).
- **School Organization:** Schools which emphasize academic success without respecting children's individual strengths and weaknesses tend to have more bullying (Tattum, 1982).
- **Playground Supervision:** Students report that the majority of bullying occurs on the

playground (Olweus, 1991; Pepler et al., 1997). Bullying occurs where there is little supervision or when large groups of children engage in rough-and-tumble play or competitive sports (Murphy et al., 1983).

### What Role Does Broader Society Play?

Bullying problems may reflect Canada's cultural tolerance of aggression. Much of this tolerance is created through the popular media, including television, movies, music and video games. The consistent message presented by these media is that aggression is an effective solution to social problems. Aggressive children are more likely than non-aggressive children to be drawn to and imitate media violence (Huesmann et al., 1984).

Because Canada is culturally diverse, children may be bullied due to their race or ethnicity. Within schools, anti-racism and anti-sexism initiatives are often considered together with anti-bullying programs to promote positive social behaviour.

As children enter adolescence, bullying declines somewhat and sexual harassment, both between boys and girls and within same-gender groups, increases. Unwanted sexual harassment, including comments, looks, gestures, and name-calling, is reported by 48% of 12-year-old children (McMaster et al., 1997). Although equal numbers of boys and girls report experiencing this form of bullying, more boys than girls acknowledge that they have sexually harassed other students.

### What Can We Do To Reduce Bullying?

To be effective, bullying interventions must focus beyond the aggressive child and the victim to include peers, school staff, parents and the broader community. Although there are substantial differences among schools, comprehensive anti-bullying initiatives can help reduce occurrences of bullying (Olweus, 1991; Pepler et al., 1996). The central feature of the intervention must be a clearly stated code of behaviour, such as respect for one another, and enforced by consistent and supportive follow-through. It takes considerable time to bring about both attitudinal and behavioural changes among the staff, students, and parents in the school community.

The following sections provide a brief overview of components of an anti-bullying program.

- **School Staff:** Motivation and support from the school staff are essential. All school staff should be included in educational sessions. Staff, together with parent and student representatives, should be responsible for updating the code of behaviour and its consequences. Teachers' attitudes are reflected in their behaviour. When adults recognize the problem of bullying and their central role in reducing it, they supervise actively and intervene to stop bullying.
- **Parents:** Parent meetings and newsletters should inform parents about the problems of bullying. Parents should talk to their children about bullying and be aware of signs of potential victimization. Communication between parents and the school is essential, as parents are often the first to know that their children are being victimized.
- **Peers:** Peers play a critical role in bullying. Interventions must aim to change attitudes, behaviours and norms around bullying for all children in a school. Under teachers' guidance, students can recognize the problem of bullying and their potential contributions. With teachers' support, they can develop strategies for intervening themselves, or seeking adult assistance to stop bullying. Promoting attitudes in the peer group which support empathy for the victim and condemn aggression will reduce bullying.
- **Bullies and Victims:** Children involved as bullies or victims require individual attention. Talks with bullies should emphasize that bullying is not acceptable and point out the consequences established in the code of behaviour. If a group of children is involved in bullying, the bully and bystanders are made to understand their role and responsibility. Talks with victims encourage them to speak up and confirm the school's intention to ensure that they are protected from further harassment. Talks with parents inform them of their children's difficulties.

and enlist their cooperation in disciplining bullying behaviour and/or monitoring for further occurrences of bullying or victimization.

## Conclusion

This review is not a comprehensive description of all factors related to bullying and victimization, but it does attempt to capture those most frequently addressed in the literature. Children involved in bullying, whether as bullies or victims, may have negative attitudes, poor social skills and emotional difficulties which begin at home. These problems are transferred to the school and peer contexts, where they may be reinforced. The development of antisocial behaviour problems depends on the interaction of individual characteristics and exposure to risk factors at critical developmental periods.

The National Strategy on Community Safety and Crime Prevention supports community initiatives that strive to create better opportunities for children. High-quality and consistent nurturing, combined with a secure, physically and emotionally safe environment through childhood will improve each child's prospects of success in life and make it less likely that they will later be victimized or become offenders. Programs that teach children resilience, empathy and social skills can help protect children from negative experiences.

Interventions for the issue of bullying should extend to all those involved: bullies, victims, peers, school staff, parents, and the broader community. We all have a role to play in declaring bullying is not a rite of passage for Canadian children.

This fact sheet was developed by the National Strategy on Community Safety and Crime Prevention in cooperation with Debra J. Pepler of the LaMarsh Centre for Research on Violence and Conflict Resolution and Department of Psychology, York University, and Wendy M. Craig of the Department of Psychology, Queen's University.

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# Dieting in Adolescence

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## Introduction

Concern with weight and shape is extremely common during the adolescent years. In addition to being exposed to the very real health risks of obesity and poor nutrition, teenagers are being exposed to the unrealistically thin beauty ideal that is portrayed in the media (1). Unfortunately, this overemphasis on the importance of being thin is internalized by youth who equate thinness with beauty, success and health. Through media exposure, teenagers are also exposed to a number of ways to lose weight and achieve this thin ideal. The sources of information available on health and nutrition are often dubious and unreliable, motivated less by scientific evidence than by fad trends and financial incentives. The net result is that many teenagers feel the cultural pressure to be thinner than is required for good health, and may try to achieve this goal through poor and sometimes dangerous nutritional choices.

Recent Canadian data demonstrate that nearly one-half of Ontario teenagers (12 to 18 years) attending public school feel unhappy about their weight (2). Even among preadolescents, a significant number of children have a desire to be thinner (3-5). It is not surprising, therefore, that strategies aimed at changing one's weight and shape are also extremely prevalent. Canadian cross-sectional data suggest that more than one in five teenage girls are 'on a diet' at any given time (2). American (5-10), Australian (11-13) and British (14) data also suggest similar high rates of attempted weight loss among adolescents. A recent review (15) of adolescent dieting indicated that 41% to 66% of teenage girls and 20% to 31% of teenage boys have attempted weight loss at some time in the past.

## Definition of dieting

Teenagers' reasons for dieting are varied, but body image dissatisfaction and a desire to be thinner is the motivating factor behind the majority (16). Attempts to lose weight can be associated with different behavioural changes such as alterations in eating habits and/or exercise frequency. Dieting is a poorly defined

behaviour that undoubtedly has various meanings to patients and professionals alike, but to most, it suggests an intentional, often temporary, change in eating to achieve weight loss (3,17,18). Comparing studies of dieting status and degrees of dieting are problematic due to variations in definitions; however, there is consistency in defining self-induced emesis, laxative use and diet pill use as unhealthy or extreme dieting (13,18-20). In many studies (8,10,13), chronic dieting (more than 10 diets in a year), fad dieting, fasting and skipping meals are also classified as unhealthy strategies. Many authors (8,21) refer to the use of these behaviours to achieve weight loss as disordered eating if the behaviours are not sufficiently severe to warrant a diagnosis of an eating disorder.

The spectrum of behaviours captured by dieting represents a range from healthy to unhealthy. The choices made by a teen on a diet may be consistent with recommendations for healthy living, such as increasing fruit, vegetable and whole grain intake, moderate reductions in fat intake, and increased exercise (7). However, a significant percentage of teenagers, girls in particular, engage in unhealthy behaviours to control weight. Recent Canadian data reported that 8.2% of Ontario girls aged 12 to 18 years and 4% of British Columbian girls reported self-induced vomiting as a weight control strategy (2,4). Several large cross-sectional studies have investigated the frequency of specific weight control practices (7-9,13,18,20,22). Fasting, skipping meals and using crash diets are frequent (22% to 46%). Self-induced emesis has been found to occur in 5% to 12% of adolescent girls. Laxative and diuretic use is less frequent (1% to 4%), as is diet pill use (3% to 10%). Smoking cigarettes to control weight is reported by 12% to 18% of adolescent girls. Risk factors for dieting

Determinants of dieting in teenagers are broad, therefore, identifying which teenagers are most at risk of dieting and health-compromising weight loss strategies is challenging (Table 1). In general, dieting and disordered eating behaviours in teenagers increase in frequency with age and are more prevalent among girls (8,10). Although there are some variations in

socioeconomic status and ethnic groups, it is clear that no group is immune from body dissatisfaction and weight loss behaviours (8,10,23). Not surprisingly, girls who consider themselves overweight and are dissatisfied with their bodies are more likely to diet (2,3,6,20,24) and are also more likely to engage in unhealthy weight loss behaviours (20,21). As the degree of overweight increases, so does the risk of dieting and disordered eating (11,20,25). However, despite this association, it is important to recognize the high prevalence of dieting among normal and even underweight teenagers (4,7,11,20). In one cross-sectional American study (20), 36% of normal weight girls were dieting, compared with 50% of overweight girls and 55% of obese girls. Distortion of body image is common among adolescents who frequently 'feel fat' even at a normal weight (13,26). It is clear that the perception of being overweight is a factor in a teenager's decision to attempt weight loss, regardless of whether they are actually overweight. The majority of Canadian teenagers are at a normal weight (27), and many dieting teenagers seen in a clinical setting are, in fact, in a healthy weight range.

There are many individual factors that distinguish dieters from nondieters. In several large cross-sectional studies (4,8,28-31), self-esteem was found to be a strong factor differentiating teenagers who engage in unhealthy weight control practices from those who do not, even when controlled for body mass index (BMI). These same studies report that other positive attributes, such as having a sense of control over one's life, family connectedness, having positive adult role models and positive involvement in school, protect youth from unhealthy dieting. Not surprisingly, studies (32-36) have also shown that parental criticism of a child's weight, pressure to diet and parental role modeling of dieting are associated with increased dieting rates and increase risk of extreme dieting behaviours.

Body dissatisfaction and unhealthy weight loss practices have been found to be more common in teenagers affected by a chronic illness (diabetes, asthma, attention deficit disorder and epilepsy) (37,38). Teenagers who experience significant psychiatric symptoms, particularly depression and anxiety, are more likely to engage in extreme dieting practices (11,39). A history of weight-related teasing is also predictive of body dissatisfaction, weight loss

attempts and eating disturbance (24,40). Peer group influence also has an impact because girls whose friends value thinness and engage in unhealthy weight loss strategies are also themselves more likely to engage in unhealthy weight control strategies (16,41,42). Vegetarianism in adolescence is associated with some positive nutritional choices, such as increased fruit, vegetable and fibre intake; however, girls who are vegetarians are more likely to report dieting and certain disordered eating behaviours, such as self-induced emesis and laxative use. For some teenagers, vegetarianism may occur along with unhealthy eating behaviours (22,43). Other identified risk factors include involvement in weight-related sports, such as dance and gymnastics (44), and early puberty (45).

Studies (4,18,31,46) have demonstrated that teenagers who engage in other risk activities, including substance use, unprotected sex and illegal activity, are also more likely to engage in health-compromising weight loss strategies. A prospective study (47) also found that adolescent girls who are concerned about their weight or who are dieting are more likely to initiate smoking. This evidence suggests that disordered eating in teenagers clusters with other health-compromising behaviours.

### Consequences of dieting

Although adolescent dieters may make some positive choices, changes are often temporary and we must consider possible physiological and psychological adverse effects of dieting, particularly, in light of the evidence that dieting is unlikely to be effective at achieving sustained weight loss. The majority of teenagers who diet do so without any apparent sequelae, but they may be putting themselves at risk of consequences with little chance of tangible benefit. Unfortunately, few studies have addressed possible negative consequences because most dieting in teenagers is done in an unstructured way and decisions on how to go about losing weight are haphazard and often short-lived. Several reviews (48,49) of the consequences of dieting have been undertaken, but unfortunately, the conclusions pertain to dieting adults, in whom rapid physical and psychological change is not occurring.

**TABLE 1**  
**Correlates of dieting and unhealthy weight control behaviours in teenagers**

Individual factors

- Female
- Overweight and obesity
- Body image dissatisfaction and distortion
- Low self-esteem
- Low sense of control over life
- Psychiatric symptoms: depression and anxiety
- Vegetarianism
- Early puberty

Family factors

- Low family connectedness
- Absence of positive adult role models
- Parental dieting
- Parental endorsement or encouragement to diet
- Parental criticism of child's weight

Environmental factors

- Weight-related teasing
- Poor involvement in school
- Peer group endorsement of dieting
- Involvement in weight-related sports

Other factors

- Certain chronic illnesses, especially diabetes
- Presence of other risk behaviors: smoking, substance use, unprotected sex

**Physical consequences**

Dieting is associated with potential negative physical health consequences. Nutritional deficiencies, particularly of iron and calcium, can also pose short- and long-term risks. In growing children and teenagers, even a marginal reduction in energy intake can be associated with growth deceleration (50-52). Disordered eating, even in the absence of substantial weight loss, has been found to be associated with menstrual irregularity, including secondary amenorrhea in several cross-sectional studies (53-56). The long-term risk of osteopenia and osteoporosis in dieting girls, even in the absence of amenorrhea, is of considerable concern as well (54,57). The medical

complications of any purging behaviour, such as self-induced emesis, laxative use or diuretic use, are well-established, as are the risks associated with stimulant weight loss medications.

**Psychological consequences**

The short- and long-term psychological effects of dieting and food restriction on adolescents is largely unknown. Studies (58) in adults suggest that chronic dieting is associated with a variety of symptoms including food preoccupation, distractibility, irritability, fatigue and a tendency to overeat, even binge eat. While it is not known if these effects are also true for children and youth, these symptoms could have serious implications on the immature adolescent who is undergoing rapid social and psychological development. Many lifestyle habits are established during the adolescent years and alterations in the eating habits of children and adolescents could have lifelong implications for dysfunctional eating.

It is recognized that teenagers with lower self-esteem are more likely to diet, often in an attempt to feel better about themselves if weight loss is successful. The process of dieting may make the situation worse and have a further negative impact on the young person's self-esteem because, during childhood and adolescence, self-esteem is, in part, defined by successes and failures. One study (59) examined the self-esteem of children before and after participation in a structured weight loss program and concluded that a decline in self-esteem and perception occurred. An adolescent study (60) found that self-esteem was negatively impacted by participation in a 12-week multidisciplinary weight loss program for obese teenagers. These studies were small and it is not possible to draw conclusions, but we should consider the negative impact of dieting, particularly unsuccessful dieting, on a young person's self-esteem. There are no data available on the impact of self-directed dieting on the self-esteem of youth.

One of the most worrisome issues to be considered is the relationship between dieting, disordered eating and eating disorders. Teenage dieting is the usual antecedent to anorexia and bulimia nervosa. In prospective studies (12,14), dieting has been associated with a fivefold to 18-fold increased risk of developing an eating disorder. However, it is unclear

whether dieting causes, triggers or represents the first stage (prodrome) to the illness. The relationship between dieting and binge eating is also controversial. The National Task Force on the Prevention and Treatment of Obesity concluded in 2000 that in overweight and obese adults, dieting was not associated with eating disorder symptoms including binge eating (61). The review (61) focused mainly on adults in structured weight loss programs and did not address the widespread use of self-directed dieting or the impact of dieting on children and adolescents. Several other studies (10,46,62) have documented the risk of binge eating among dieting teenagers and a review (58) of the psychological consequences of food deprivation in adults concluded that deprivation resulted in a tendency to overeat and even binge eating.

Finally, there is mounting concern that dieting in preadolescents and adolescents may have the paradoxical effect of resulting in excess weight gain over time (60,63). In a recent large-scale study (63) involving over 15,000 children (nine to 14 years old) followed over a three-year period, it was observed that dieters gained significantly more weight than matched nondieters. The authors concluded that self-directed dieting in this age group was not only ineffective, but may promote weight gain.

### Summary and recommendations to clinicians

Weight dissatisfaction is frequent for teenagers in North America. Behaviours to control weight are very common and exist on a spectrum from healthy to potentially dangerous. The most important risk factors for unhealthy weight control behaviours are dissatisfaction with weight, obesity and low self-esteem. Teenagers who engage in unhealthy dieting are at risk for other health-compromising behaviours, including substance use, smoking and unprotected sex. Most dieting in teenagers is not associated with negative consequences but we must consider the physical and psychological sequelae, including eating disorders, binge eating and low self-esteem. Teenagers who diet are at risk of excess weight gain over time.

The Canadian Paediatric Society's recommendations are as follows:

- For normal and overweight teenagers, encourage eating according to the Canada Food Guide (64). Discourage fad diets, fasting, skipping meals and dietary supplements to achieve weight loss. Advise teenagers to be wary of any weight loss scheme that tries to sell them anything, such as pills, vitamin shots or meal replacements.
- For normal and overweight teenagers, encourage age-appropriate physical activity in accordance with healthy active living guidelines (65). Teach teenagers that there are a variety of reasons to exercise, not just to control weight.
- Given the high prevalence of dieting behaviours in adolescent girls, screening should be included as part of routine health care. This screening can easily be incorporated into the frequently used adolescent Home, Education, Activities, Drugs, Dieting, Safety, Sexuality, Suicide/depression (HEADSSS) interview (66).
- Teenagers who are concerned about weight or shape should be educated about the difference between 'healthy weight' and 'cosmetically desirable weight'. For teenagers, these may be very different, because many teenagers want to be thinner than is required for good health. Teenagers should be encouraged to accept a realistic weight for themselves. Calculating BMI and comparing it with BMI percentile curves is the most reliable way to assess whether a teen is in a healthy weight range (67).
- Clinicians should be aware that many weight loss attempts in teenagers are not required or justified on the basis of improved health and may reflect other issues in the adolescent's life, such as low self-esteem, being teased about weight, family pressure to achieve a certain ideal or a serious psychiatric illness such as an eating disorder. For many dieting teenagers, the behaviour is not really about their weight.

- For teenagers engaging in more severe weight loss practices, screening for eating disorders should be done promptly and early referral made for assessment (68,69).
- Educate dieting teenagers about the health risks of self-induced vomiting, laxative and diuretic use, diet pills and crash diets.
- There is a paucity of data on effective interventions for obese adolescents; however, assessment and intervention should be undertaken in accordance with evidence-based and best practice guidelines (70-72). There is no evidence that commercial weight loss programs are safe or effective for children or teenagers. Where available, referral to a multidisciplinary paediatric obesity program may be beneficial.

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## Dieting: information for parents, teachers and coaches

Teenagers see them everywhere: media messages telling them to change themselves. They're in magazines, on the Internet, on television and at the movies. Most are ads designed to get teens to buy something, like clothes, makeup or a weight loss product.

One of the strongest messages teens get is that they need to be thin. Images and words in the media tell them that being thin means they are beautiful, happy and in control of their lives. But in real life, people who are happy and successful come in all shapes and sizes.

Along with the pressure to be thin, you hear about different ways to lose weight. When we hear about 'going on a diet', we usually think about eating less or eating differently to try to lose weight. Teens who go on a diet can make some good choices about nutrition (eating more fruit, vegetables and fibre, or cutting down on snack foods) or bad choices (skipping meals, eating too little or not eating enough variety of food).

Many teens turn to dieting to try to change their bodies and feel better about themselves. Unfortunately, it usually doesn't work. Dieting actually causes some people to gain weight.

Teens who diet are often more concerned with how they look than their health. And this can lead to weight-loss goals that are not healthy.

If you have a teenager or care about teenagers, this information sheet is for you. It has facts about dieting and teens, and suggestions on how to help if you know a teenager concerned about his or her weight.

### Did you know? Fast facts about teens and dieting

About one-half (one in every two) of teenage girls and one-quarter (one in every four) of teenage boys have tried dieting to change the shape of their bodies.

More than one in three girls (about 33%) who are actually at a healthy weight still try to diet.

Teens who diet may not be as psychologically healthy as other teens. Compared with teens who don't diet, teens who do:

- Are more unhappy with their weight;
- Tend to 'feel fat' even if they are not;
- Have lower self-esteem;
- Feel less connected to their families and schools;
- Feel less in control of their lives;
- Are more likely to engage in risky behaviours such as smoking, using drugs or having unprotected sex;
- Are more likely to engage in unhealthy weight loss behaviours such as using diet pills, laxatives or vomiting after meals; and
- Are more likely to have a parent who criticizes their weight, encourages them to diet or who is preoccupied with weight themselves.

### We hear a lot about how bad it is to be fat and about childhood obesity, so what is the problem with dieting?

If your teen wants to get to and stay at a healthy weight, going on a diet is not a good solution. It hardly ever works.

Over time, children and youth may be more likely to gain weight if they try to diet. This is probably because going without eating the foods they enjoy makes them feel deprived and sad, which may lead to overeating.

Dieting may make teens feel:

- Hungry and preoccupied with food (thinking about it all the time);
- Distracted and tired;

- Sad and unmotivated (they don't feel like doing things);
- Cold and dizzy; and deprived of foods they enjoy.

Some forms of dieting can be dangerous to the health of children and youth such as skipping meals, using weight loss pills or laxatives, going on 'crash' diets or vomiting after eating.

Teens are still growing and need the right amount of nutrients to be healthy. Eliminating entire food groups or taking in too few calories when they are still developing can have serious negative effects on their health.

### **All teens talk about their weight. Isn't it normal to worry?**

It is common for teens to feel self-conscious, but constantly feeling bad about their bodies, worrying about weight or feeling guilty when they eat is not normal or healthy. This is called having a negative body image. Teens who have a negative body image often lack confidence in other areas of their lives as well.

If you are the parent of a teen who seems excessively worried about their weight, discuss this with them. It could be a phase or you may be picking up on a more serious problem such as an eating disorder. If you are concerned, have your teen see their doctor.

Many teens who are preoccupied with their weight have a parent who is also preoccupied with their weight. Consider your own eating and weight control behaviours. What kind of role model are you? Do your attitudes about food and your body tell your teen that it's normal to worry about your weight?

Here are some suggestions for parents, teachers, coaches and other mentors to help a teen who is weight preoccupied or dieting:

- Find out why they are dieting and what effect it is having on their lives.
- Acknowledge what they feel by letting them know that you understand the pressures to be thin.

- Help teens challenge media norms about how we are supposed to look.
- Advise teens that dieting doesn't work and may lead to overeating.
- Learn to praise teens (girls especially) for qualities other than appearance.
- For coaches, be aware that your comments about weight may be very powerful. Director indirect suggestions that weight loss would enhance performance can be very damaging to young athletes. Enjoy all four food groups every day.
- Following Canada's Food Guide can be helpful
- Encourage teens to be active everyday.
- Be a positive role model by showing that you accept your own body's shape and size, as well as that of others.
- Be a positive role model by eating healthy, balanced meals and snacks, and by being physically active.

### **For more information about healthy eating and activity:**

Canada's Food Guide to Healthy Eating:  
[www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/food\\_guide\\_rainbow\\_e.html](http://www.hc-sc.gc.ca/hpfb-dgpsa/onpp-bppn/food_guide_rainbow_e.html)

Canada's Physical Activity Guides for Children and Youth:  
[www.hc-sc.gc.ca/hppb/paguide/child\\_youth/index.html](http://www.hc-sc.gc.ca/hppb/paguide/child_youth/index.html)

Canadian Paediatric Society's Healthy Active Living program: [www.cps.ca/english/proadv/HAL/index.htm](http://www.cps.ca/english/proadv/HAL/index.htm)

Dietitians of Canada: [www.dietitians.ca](http://www.dietitians.ca)

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## Publications

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### **Voices of Youth In Care (VOYCE)** in partnership with CKUT launch a new Radio Series

CKUT Radio is pleased to announce the launch of a new radio series produced by VOYCE (Voices of Youth in Care). The aim of this project is to give a voice to young people growing up in foster homes, group homes and lock-up institutions.

Five young women—all young mothers and also survivors of the child welfare system—created this dynamic series. Over the past nine months, these interns were given extensive training in radio production, journalism and working with high risk youth. The launch of the radio series, which will also be available on CD, is the culmination of their work. The CD will be made available to community radio stations, youth in care, community organizations, schools and libraries across Canada.

The radio series is a collection of voices and of stories. It features the voices of young children; adolescents; young women who grew up in care and who are now raising their own children; and the people who support and advocate for these youth. These voices speak out in many ways, from personal memoirs to documentaries examining issues that matter most to youth in care. The series also features spoken word performed and written by kids in care.

VOYCE gives youth in care the opportunity not only to speak, but also to determine the very terms of the discussion- The production of this series was entirely youth-directed. The youth decided what questions should be asked and how their stories should be told. Come and share these remarkable and brave stories with us.

For more information please contact:  
Rachel Kronick, coordinator of Voices of Youth in Care

office phone: (514) 398-6787  
on air studio: (514) 398-4616  
email: programming@ckut.ca

You can listen to all four hours of the series on the CKUT archives. [www.ckut.ca](http://www.ckut.ca)

## Health initiatives can help peace building in the Middle East

An article published online by THE LANCET today (Tuesday January 25, 2005) describes how health initiatives have led to Arab and Israeli cooperation in the Middle East.

Harvey Skinner (University of Toronto, Canada) and colleagues outline the work of the Canada International Scientific Exchange Program (CISEPO), which has successfully fostered collaborative work in the region involving Israeli, Jordanian and Palestinian health professionals since 1995.

In its first initiative CISEPO identified hearing loss as an important health issue for the region and helped broker the creation of the Middle East Association for Managing Hearing Loss (MEHA) – the first joint Arab and Israeli professional association.

The cross-border project led to Palestinian and Israeli basic science research programmes between Bethlehem University and Tel Aviv University in the genetics of hearing loss, and generated joint-publications. From this followed a project to screen and habilitate 17,000 Israeli, Jordanian and Palestinian newborns for hearing loss.

CISEPO has now expanded from its initial focus on congenital hearing loss to include activities on health of mothers and children, promotion of health in young people, nutrition and infectious diseases. Overlapping components of these projects include co-authorship of presentation and papers, joint research meetings, international exchanges and training, visiting scholars, fellowships, continuing education, and electronic distance learning.

Professor Skinner comments: “Concern is mounting about our ability to address global health issues in the 21<sup>st</sup> century in a climate of national, ethnocultural, and religious conflicts. The Middle East, in particular, presents immense challenges for improving regional disparities in health and fostering peaceful coexistence.

“Our work has shown that it is possible to bring Arabs and Israelis together to achieve common goals under very difficult circumstances. From our experience,

three essential ingredients for successful cooperation include a focus on common health needs with practical outcomes, a proactive and honest third party broker, and a critical mass of ‘bridge builders’ in the region who are prepared to get involved. The health sector provides a powerful venue for building international cooperation, trust and confidence. Our ongoing experience and model give direction for health professionals in peace building – a primary determinant of global health.”

In an accompanying commentary Samer Jabbour (American University of Beirut, Lebanon) raises the question of whether the health initiative reported by Skinner does contribute to peace.

Dr Jabbour states: “Building trust among a limited number of collaborators across lines of conflict is important. But making peace is much more than individual relations. Cooperative efforts must show a broader impact, especially when the politics of cooperation are so daunting, as in this case. A focus on the individual, rather than the collective, might be inadequate, not only in terms of impact but also participation. Although a few people can certainly change the world, only a critical mass of committed doctors with a common agenda can stand a chance in the face of the political deterioration in the Middle East.”

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# Canadian Health Network

[www.canadian-health-network.ca](http://www.canadian-health-network.ca)

CHN is a national, non-profit, bilingual web-based health information service. CHN's mandate is to help Canadians make informed decisions about their health with quality, health promotion and disease prevention information from a Canadian perspective. CHN does this through a unique collaboration - one of the most dynamic and comprehensive network of health information providers including Health Canada, national and provincial/territorial non-profit organizations, universities, hospitals, libraries and community organizations.

CHN's mission is to support Canadians in making informed choices about their health, by providing access to multiple sources of credible and practical e-health information. Some of CHN's core values are to present quality, credible, and practical information from multiple perspectives, to be socially-inclusive and respectful of diversity and to exemplify ethics and integrity. Its vision is to become "Your preferred choice in Canada for helpful, e-health information you can trust."

CHN offers:

- Links to more than 12,000 English and French Canadian web-based resources that pass a rigorous quality assurance process to ensure that the information is timely, accurate, and relevant.
- In-depth information on more than 25 key health topics and population groups (Children, Adolescents, Violence, Healthy Eating, Mental Health, etc.).
- High-quality national health information, and regional resources from Canada's provinces, territories and local communities.
- Answers to questions about Canadians' health issues

CHN offers many search choices to explore its large collection of Canadian health resources in either English or French. CHN helps users take a critical look at other health web sites, with tools to assess their relevance and possible bias.

The CHN address is [www.Canadian-health-network.ca](http://www.Canadian-health-network.ca)

## ***The Youth Section of the CHN website***

A Youth Affiliate Consortium is constantly searching out new resources and refining the CHN's collection of resources for and about youth. It also develops resources for the youth section and answers any questions from or about youth asked on the CHN. The consortium members are: the Canadian Association for Adolescent Health (CAAH) acting as the lead organization, la section de médecine de l'adolescence de l'hôpital Ste-Justine (Montreal), McCreary Center Society (Vancouver), Kids Help Phone (Toronto), the Division of Adolescent Medicine at The Hospital for Sick Children in Toronto and TeenNet project (University of Toronto).

The Youth Section of CHN is designed to meet the health information needs of adolescents, young adults, their parents and adults who work with youth. The Youth Section can be accessed from anywhere on the CHN by clicking on "youth" in the list of populations in the side navigation bar. (children, men, women, seniors, etc.).

The Youth Section of CHN offers more than 700 resources in English and 350 in French. Some are documents describing a problem or the solution to a problem, some are giving access to websites of interest, some are giving tips on the prevention of certain health conditions. You will find an "FAQ" zone with answers to questions on dating, suicide, relationships and others. In the "guided search" zone, the surfer can access the 700 resources or choose from a list of more than 15 topics and access related resources on: sexuality, active living, healthy eating, substance use, violence, injury prevention, STD, workplace, mental health and others. There is also a "keyword search" and a "quick search". By clicking on the "quick search", the surfer can choose from a list of more specific topics and access related resources on: youth and alcohol, youth and suicide, youth and handicaps, youth and puberty, etc.

## **How you can help**

**The Youth Affiliate Consortium aims to develop the CHN Youth collection and hopes to bring adolescents and young adults, their parents and professionals to consult the collection regularly. We therefore are developing a special youth portal on the CHN website specifically for youth. The present site is not appropriately adapted to youth surfers. The CHN website needs a more targeted approach for youth. This youth portal on the CHN would include resources for youth only and a youth friendly and dynamic look. We intend to launch this youth portal on CHN at the end of 2005.**

**We invite you to visit the youth section of the CHN website. Please recommend the site to your colleagues, parents, and adolescents you are working with, for school work or simply to find answers to health questions. We believe that such a website is important for youth, their parents and professionals working with youth.**

**In addition, we would like you to become our partners in promoting this website and in developing it according to the needs of youth, their parents and your own needs. If you have comments on the youth section of CHN or if youth you are working with have comments, do not hesitate to contact us by Fax (514) 345-4778, by e-mail: [acsacaah@globetrotter.net](mailto:acsacaah@globetrotter.net) or by mail: CAAH, CHUME Ste-Justine, 3175 Côte Ste-Catherine, Montréal QC H3T 1C5**