CANADIAN ASSOCIATION
FOR ADOLESCENT HEALTH

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# PRO-TEEN

Inside this issue:



## PRO-TEEN

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# News from the Association

## President's 1999 report

This year is marked by our second year with financial difficulties. Some activities were reduced. At the same time, some new projects could ensure our development.

### Management

For the journal:

We have a student in charge: writing news, scanning or searching articles on web, word processing, page setting. The journal is somewhat different in English and French; a youth is translating some article.

For membership:

The information on the members are on a Access Microsoft file. We are able to make list by province, postal code, language, status in the Association, etc. We have a student entering data on members. Communication with members by e-mail is increasing.

For the budget:

We have yet to improve the accounting system. A person competent with the special computer program will be hired on a part time basis.

For the promotional mailing list:

A student is entering organizations-professionals on our promotional list. We are constantly improving and expanding the list, at a lower pace this year.

For the meetings:

The organization of our meetings has been carried out by our staff, under the coordination of our executive secretary (writing and designing the brochures, arrangements with printers, mailing, entering the registrants on Access Microsoft file, producing the proceedings and all the logistics of the meeting...). This is cost saving.

### Members

In 1999, we have increased our membership, from **931 to 987**.

The state of membership in November 1999 is as follows :

| | |
|---|---|
| **1997** (deleted in December 1999) | 117 (12%) |
| **1998** | 257 (26%) |
| **1999** (registered and paid in 1999) | 507 (51%) |
| **2000** (registered and paid since September 1999) | 106 (11%) |
| **TOTAL** | **987** |

This year, 62% of our members have paid their dues. The 117 members of 1997 will not renew and be deleted, but 50% of the members from 1998 will probably renew in 2000 after several reminders.

We are loosing 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.

| **Members per provinces** | |
|---|---|
| Québec | 687 (69%) |
| Ontario | 196 (19%) |
| British Columbia | 44 (4.5%) |
| Nova Scotia | 13 (1%) |
| Alberta | 32 (3%) |
| Saskatchewan | 5 (0.5%) |
| Manitoba | 6 (1%) |
| Newfoundland | 2 |
| New Brunswick | 3 |
| Yukon | 1 |

There are more members in Québec because more promotion of CAAH was carried on in that province (many regional meetings). We are beginning to publicize CAAH in other provinces, with mailing lists that are being developed for that purpose.

82% of the members are women; 59% of the members want to receive their mail and journal in French, 33% in English, while 8% want both.

24% of the members have a single membership; thus 76% are in a group membership. This includes about 48% of total membership who have an institutional membership (145$ for up to 7 members). It is only 19% of the members who pay themselves their dues, the majority having their dues paid by their institution or organization.

| **Professions of members** | | | |
|---|---|---|---|
| Nurses | 315 (32%) | Coordinator | 37 (4%) |
| Social Workers | 123 (12%) | Family Medicine | 105 (11%) |
| Psychologist | 58 (6%) | Doctors : specialists | 57 (6%) |
| Teachers | 16 (2%) | Dentist | 4 (0.5%) |
| Counsellors | 28 (3%) | Librarian | 18 (2%) |
| Psycho-educator | 36 (4%) | Dietitian | 12 (1%) |
| Community Workers | 23 (2.5%) | Others | 99 (10%) |
| Sexologist | 4 (0.5%) | Not available | 35 (3.5%) |

| Fields of Interest (more than one choice) | | | |
|---|---|---|---|
| Parents/adolescents Relationships | 714 (72%) | Anorexia Nervosa, Bulimia | 512 (52%) |
| Adolescent Development | 626 (63%) | Nutrition, obesity | 365 (37%) |
| Behavior Problems | 667 (67%) | General Health: growth, skin, ortho, sport | 462 (47%) |
| Suicide, Suicide Attempt, Depression | 536 (54%) | Psychosomatic Diseases | 443 (45%) |
| Violence | 596 (60%) | Handicap, Chronic diseases | 356 (35%) |
| Drugs Use and Abuse | 643 (65%) | Learning Disorders | 465 (47%) |
| Sexuality, Pregnancy, Contraception | 615 (62%) | Rights, Laws | 425 (42%) |
| STD and AIDS | 536 (54%) | Not Available | 90 (9%) |
| Sexual Abuse | 574 (58%) | | |

| Type of Work (more than one choice) | |
|---|---|
| Clinical Intervention | 592 (60%) |
| Teaching | 282 (28%) |
| Prevention / Promotion | 532 (54%) |
| Health Education | 364 (37%) |
| Coordination | 90 (9%) |
| Group Animation | 254 (26%) |
| Community Work | 159 (16%) |
| Public Health | 162 (16%) |
| Research | 87 (9%) |
| Administration | 108 (11%) |
| Documentation, library | 30 (3%) |
| Benevolent | 23 (2%) |
| Media | 19 (2%) |
| Street Work | 11 (1%) |
| Program Development | 143 (14%) |
| Others | 27 (3%) |
| Not Available | 90 (9%) |

| Work Place (more than one choice) | |
|---|---|
| CLSC | 303 (30%) |
| Private Office | 87 (9%) |
| School | 270 (27%) |
| Public Health Department | 130 (13%) |
| District Health Services | 13 (1%) |
| Hospital | 172 (17%) |
| University | 49 (5%) |
| Community Organization | 70 (7%) |
| Youth Homes | 14 (1.5%) |
| Youth Protection (CPEJ, DPJ) | 20 (2%) |
| Custodial Facilities | 21 (2%) |
| Government Organization | 20 (2%) |
| Others | 33 (3%) |

## Meetings

Annual National Meetings

Annual national meeting Fall 1998, Montreal
"Eating Disorders in Adolescents" (305 participants)

Annual national meeting Fall 1999, Toronto
"Adolescent mental health: Practical Strategies" (100 participants)

Annual national meeting May 4-5 2000: Montreal
"Adolescent Health: update for the 3rd Millenium"

Regional Meetings

Québec Regional meeting, Montreal May 7 1999: "adolescence et pouvoir" (250 participants).

Ontario Regional meeting, Ottawa May 14 1999. "Assessment and Management of Drug Use in Adolescents" (140 participants).

For 2000:

- Regional Meeting Ontario
  Spring 2000 Ottawa ("Eating Disorders")

- Regional Meeting Maritimes
  Fall 2000 Moncton (tentative)

- Regional meeting Québec
  Fall 2000 Montreal

We should increase the number of Meetings in Ontario and the other provinces.

## Website (www.acsa-caah.ca)

We have developed our web site. It is still in an early stage but the main structure is up and running. We are now loading the site with articles that were published in the Journal or from the proceedings of our meetings.

## Journal

The journal is very popular. Many of our new members become members to receive the journal. We have to think about the orientation of this publication. Publishing the Journal is time consuming. However, it is encouraging to see that articles submitted to the journal are increasing.

## Regions and Sections

The Québec section is functioning since 2 years now. It has organized 2 regional meetings and is preparing a third meeting for the fall 2000. It is composed of about 10 members: nurses, doctors, social workers, University students.

Probably, it is more useful to have a section serving a smaller region in a province. Since travel is a problem and costly, it is more appropriate to divide the provinces in multiple sections. With this in mind, Montreal has a section and Québec City will start a section in 2000. Toronto, Ottawa and other could start sections in 2000.

## Committees

Advocacy

We have solicited members to be part of the committee. Dr. Leonard chair this Committee and was busy organizing the Fall 99 meeting. The Committee has no financial or support resources.

Nominating committee

Yet to be established

## Finances

Over the past two years, the CAAH has been experiencing financial difficulties. This is a problem that affects not only the CAAH but also many similar organizations. There are many reasons:

- Low membership fees
- Low Conferences registration fees
- Increases in operating expenses (mailing, printing, …)
- Pharmaceutical company grants are more difficult to obtain

-A limited budget that prohibits publicity.

Our financial difficulties can also be explained by the fact that only one third of our spending budget comes from membership fees (approximately $17 000). The rest comes from Conferences that, despite their success and high attendance in general, have not been profitable in the last two years. CAAH was able to survive in 1998 because of a government contract and a grant from the Merck Frost Company. **At the present time, we are in deficit.**

### Budget: Auditor Report 1998

| | |
|---|---|
| **Revenues** | |
| In bank | 2,489 |
| Membership fees | 16,150 |
| National meeting | 38,698 |
| Regional meeting Québec | 16,987 |
| Regional Meeting Ontario | 898 |
| Grant | 30,000 |
| **TOTAL revenues** | **102,733** |
| **Expenses** | |
| Aministrative support | 32,144 |
| Advertising | 2,289 |
| Secretarial | 1,116 |
| Data entry | 2,812 |
| Taxes and permits | 62 |
| Journal | 13,132 |
| Office supplies | 454 |
| Bank charges | 154 |
| Photocopies | 434 |
| Travel | 884 |
| Entertainment | 347 |
| Amortization | 738 |
| Professional fees | 750 |
| National Meeting | 33,799 |
| Regional Meeting Québec | 14,675 |
| **TOTAL expenses** | **103,790** |
| **In bank, end of year** | **1,432** |
| **Loan from another organization** | **3,000** |

| Budget for 1999 (predicted, not reviewed) | |
|---|---|
| **Revenues** | |
| In bank | 1,432 |
| Subscription 1999 | 16,744 |
| Québec Regional meeting May 99 (Montreal) | 1,000 |
| Ontario Regional meeting May 99 (Ottawa) | 500 |
| Annual Meeting October 1997(Toronto) | ..5,000 |
| Meetings 1998 and others | 2,135 |
| **TOTAL revenues** | **26,811** |
| **Expenses** | |
| Executive secretary | 28,000 |
| General Administration | 3,508 |
| Journal | 11,200 |
| Membership data and renewal | 2,360 |
| Executive and Board of Directors | 1,300 |
| **TOTAL expenses** | **46,368** |

## Subscription 2000

Registration fees to be increased, especially for institutional membership.

## Future Actions

CAAH can survive. The Association has "growing pains" but is alive and can still count on strong partnership. There are many solutions:

- Promotion to increase membership
- Solicit new contracts
- Increase membership fees, particularly for groups/institutions
- Increase Conferences registration fees and sponsorship
- Increase the number of Conferences.

The CAAH's survival depends on measures that will be established in the upcoming year and their efficiency. It also depends on each member's efforts. We have to expand in other provinces, especially Ontario. Sections must be created and more meetings organized. We need to create a base of collaborators of CAAH. About 100 members throughout Canada will be asked to become collaborators and help with the Journal, and the different activities of CAAH. Survival and development of CAAH is also dependant upon contract and promotion and upon a collective effort of its members.

Happy and productive year,

Jean-Yves Frappier
President

**It is the time to renew your membership !**

# Canadian Health Network

www.canadian-health-network.ca

The Canadian Health Network has officially been launched in November by Alan Rock, Minister of health. The Canadian Health Network (CHN) is growing to meet the health information needs of Canadian consumers and health intermediaries alike. As you may be aware, the CHN is designed to improve access to timely, relevant, and credible information related to health and well-being and to strengthen health promotion networks across Canada. While Health Canada is taking a leadership role in establishing CHN initially, the ultimate goal is to have an integrated and national health information service that is jointly managed and sustained by many partners.

Critical to the development and sustainability of CHN are partnerships with organizations across the country. **Affiliate organizations** will have content expertise in a health topic and/or target group area, ie youth. They will play a key role in supporting the CHN by providing expert advice and responding directly to any consumer inquiries. They will also be responsible for developing and supporting a network of **associate organizations** that provide content specific information. In addition, affiliates will be part of a distributed network of organizations inputting data to support the ongoing development of the CHN Web site, and provide content to operating centers to respond to complex consumer requests, for now through e-mail. Already, more than one million visits to the CHN website were registered in the first months it has been operating.

## CAAH and CHN

A consortium now act as the affiliate for the youth component of CHN. The consortium includes TEEN NET project – University of Toronto, Department of Public Health, McCreary Society (Vancouver), CAAH and la section de médecine de l'adolescence-Hôpital Ste-Justine, Kids Help Phone, Hospital for Sick Children-Adolescent Division-Toronto.

CAAH has been given the lead to review and expand the content of the youth web site, review and expand the FAQ, all this with the help of other affiliates and expert panel. CAAH will help in answering questions on specific issues and help in the development of the youth network. McCreary Centre Society has been given the lead to develop a youth network that will, among other things, support a special entry for youth on the website and the development of resources for the website.

It is possible that CAAH members be asked to participate in the development of resources for the site or to evaluate the site. Even if the site is at its early stage and we are only starting our input, why not visit the site now and provide us with constructive feedback?

CHN prototype Web site :
**www.canadian-health-network.ca**

# A New Member on the Board of Directors

**Mary Paone** has been appointed on the Board of Directors of CAAH, replacing Lise Audet. Mary Paone is a clinical nurse specialist, with a Master degree in Nursing, working in the Youth Health Program, Children's & Women's Health Centre of British Columbia in Vancouver. She is transition coordinator, transition services, British Columbia Children's Hospital. We welcome her and she will surely bring expertise and vision to our Association.

# Scientific Events

## "Adolescent Health: Updates for the 3rd Millennium"

7th Annual National Meeting of CAAH—May 4-5, 2000

The 7th Annual National Meeting of CAAH will be held May 4-5 2000 in Montreal. The program is being developed and features lectures (Visions of Adolescence in the new millennium, violence, health status in different subcultures, etc.), updates on common health issues (emergency contraception, STD, acne, allergies, menstrual problems, abdominal pain, compliance, confidentiality, anxiety disorders, school avoidance, etc.), and workshops (parent-adolescent relationships, contraception, eating disorders, etc.).

For more information:

CAAH
section médecine de l'adolescence
Hôpital Ste-Justine
3175 Côte Ste-Catherine
Montreal, QC H3T 1C5
Tel : (514) 345-9959
FAX : (514) 345-4778
e-mail : acsacaah@microtec.net

## "Eating Disorders in Adolescents"

3rd Ontario Regional Meeting of CAAH

The 3rd Ontario regional Meeting of CAAH will be held in Ottawa Friday June 2nd 2000. The Children's Hospital of Eastern Ontario has received funds for their Eating Disorders program and it will be an opportunity for a variety of professionals to get together around this important health issue in adolescents and discuss evaluation, intervention and prevention strategies. Dr. Steve Feder, Head of Adolescent Health at CHEO is in charge of the program committee.

For more information:

CAAH
section médecine de l'adolescence
Hôpital Ste-Justine
3175 Côte Ste-Catherine
Montreal, QC H3T 1C5
Tel : (514) 345-9959
FAX : (514) 345-4778
e-mail : acsacaah@microtec.net

## "Adolescents and Violence: What have we Learned; What Can we do?"

Washington March 22-26, 2000.

The Society for Adolescent Medicine presents its 32nd annual meeting. This meeting features lectures, institutes, 44 workshops, research presentations, 18 dialogues in adolescent health, many interest groups. Registration fees, before February 29, 2000, include breakfast and lunch at 575$ US for MD and 500$ US for non MD.

For more information:

SAM
1916 NW Copper Oaks Circle
Blue Springs
Missouri 64015.
Phone: 816-224-8010,
Fax: 816-224-8009.

# "Resilience 2000. Current Concepts – Practical Applications"

Washington, March 21-22, 2000

The **International Association for Adolescent Health** with the Pan American Health Organization and the Society for Adolescent Medicine is presenting this interesting Meeting to be held March 21-22, 2000 in Washington.

In keeping with current trends to move from a problem based to a development based approach to adolescent health this conference will address the theme of resilience and youth development. Delegates will be provided with a critical overview of contemporary research on resilience and the conceptual frameworks being used. Presenters will focus on the practical implications of the theoretical base for country level policy and programs and the actual application of conceptual frameworks within clinical and local program settings. The conference will also offer a youth perspective and opportunities for presentation of short papers, workshops and displays. As a multidisciplinary event, the conference will be of interest to any health professional wishing to adopt more positive, development oriented services or programs for adolescents.

Deadline for submission of abstract: January 31 2000. Registration limited to 150 (Fees: 200 $ US).

For information:

IAAH
Box 19, site 3
Gabriola Island
BC VOR 1X0
FAX: 250-247-8063
Website: www.iaah.org

# "Beyond Boundaries: Research and Action for the third Millennium"

X International Symposium on Victimology, Montreal, August 6 – 11, 2000

The start of the new millennium will mark the fifteenth anniversary of the adoption of the *Declaration of the Basic principles of Justice for Victims of Crime and Abuse of Power* by the UN. Where are we now? You are invited to embark upon a critical examination of many issues to prepare the way forward into future.

For information:

x International Symposium
on Victimology – JPdL Conventions
1555 peel St, suite 500
Montreal QC H3A 3L8
Fax: 514-287-1248
e-mail: info@victimology-2000.com

**It is the time to renew your membership ! Do it now!**

# Ninth International Conference on Eating Disorders

Evaluating the past and Envisioning the Future
May 4 – 7, 2000; New York Hilton and Towers

The Academy for Eating Disorders is preparing the Ninth International Conference on Eating Disorders that will take place in New York. They are sending a call to all who desire to give a submission for workshop, paper and poster sessions. A preliminary schedule have also been posted.

For more information please contact:

Academy for Eating Disorders
6728 Old McLean Village Drive
Mc Lean, VA 22101-3906
Tel : (703) 556-9222
Fax : (703) 556-8729
Email : aed@degnon.org
Web : www.acadeatdis.org

# Beyond 2000: Healthy Tomorrows for Children and Youth

June 14-18, 2000

The Canadian Paediatric Society, the Canadian Institute of Child Health, and the Canadian Academy of Child Psychiatry invite you to **Beyond 2000: Healthy Tomorrows for Children and Youth**, a 5-day conference to be held in Ottawa from June 14-18, 2000.

**Beyond 2000: Healthy Tomorrows for Children and Youth** will be a uniquely Canadian event that leads to the development of a vision that can be promoted and acted upon by all sectors. It will be the major gathering on child and youth health in Canada in 2000. The aims of the conference are to:

- bring together practitioners from all sectors involved in the health and well-being of children and youth;

- link prevention and health promotion with care and treatment, and provide an opportunity for research dissemination;

- articulate a vision for children and youth in Canada in the next millennium.

Through workshops, poster sessions, presentations, plenary sessions, and displays, we will explore issues around themes such as:

- determinants of health
- education and health
- access to care
- environmental influences on child and youth health and development
- children and youth with special needs

Because the scope of this conference is broad, we want to involve as many stakeholders as possible. A number of participating organizations have been instrumental in developing the scientific program, and ensuring that all the sectors involved in the health and well-being of children and youth are included.
For more information:

**Beyond 2000 Secretariat**
c/o Canadian Paediatric Society
100-2204 Walkley Road
Ottawa ON K1G 4G8
E-mail: beyond2000@cps.ca

# Articles

## Health Connections: Listening to BC Youth

### Listening to BC Youth

As 1999 draws to a close, all eyes are on the future. Healthy Connections offers a vision of that future as seen by British Columbia's young people. The Adolescent Health Survey (AHS) gives BC youth a chance to tell us about their lives today and their outlook on tomorrow as they approach adulthood in a new millennium. The nearly 26,000 students who completed the survey welcomed an opportunity to make their voices heard. Healthy Connections reports results of the second province-wide survey of adolescent health and risk behaviour conducted by The McCreary Centre Society. Combined data from the first AHS in 1992 and this 1998/99 survey represent responses from some 41,000 BC youth.

This report introduces new information about the importance of social connections in the lives of youth. The survey results offer strong evidence that involvement in school, family and community contribute to good adolescent health and protect against risks.

However, the survey findings confirm that some youth do not have equal access to opportunities to make the most of their potential. While most British Columbia youth are doing well, this study suggests that we in BC can do more to promote a non-exploitative, caring society that respects and values the contributions of youth.

### About the Survey

What is the AHS?

The McCreary Centre Society conducted the first Adolescent Health Survey (AHS I) in 1992. Nearly 16,000 BC students in Grades 7-12 participated in that survey.

AHS II was designed to track trends showing how BC students have changed since 1992, and to identify new issues facing youth today. In all, 25,838 students completed the survey in the spring or fall of 1998. Trained administrators, mostly public health nurses, conducted the survey in classrooms in Grades 7-12. Students completed the anonymous, pencil and paper questionnaire in about 45 minutes. Participation in the survey was voluntary, and parents' consent was arranged through each school district. In all, 43 of BC's 59 school districts agreed to participate in the survey.

What does the survey ask?

The 127 questionnaire items include questions on health status, health-promoting practices and risky behaviours. Questions were chosen to identify factors that influence both present and future health and well-being. Most health problems during the teenage years are caused by preventable actions, such as drinking and driving or unprotected sexual activity. Adolescence also is the time when individuals often establish life-long attitudes and habits, such as smoking, diet and exercise.

The survey also looks at factors that affect health in a broader sense, that of personal well-being and the capacity to achieve full potential in life.

Who was involved?

Classes in both public and independent schools were randomly selected to provide a representative sample of all regions of the province.

Are the results accurate?

The McCreary Centre Society has taken a number of steps to ensure that the survey results are accurate. These steps include careful attention to:
Sample size: a large number of students was surveyed.
Selection: classrooms were randomly selected

to represent all Grade 7-12 students in the province.
Confidentiality: students were assured that their participation was voluntary and anonymous.
Administration: the survey was conducted in classrooms by public health personnel following consistent guidelines.
Validity of responses: checks were in place to identify frivolous or contradictory answers; only about 1% of questionnaires were eliminated from the analysis of results for this reason or for failure to complete more than 50% of questions.

About 8% of the 316,000 students enrolled in Grades 7 through 12 across the province completed the survey. Survey data were analyzed using current statistical techniques to ensure that the results reported here accurately reflect the characteristics of all BC students in those grades.

AHS II provides information only about youth in school, representing 88% of BC youth in the study age group. McCreary plans additional studies to collect comparative data on the health status of street youth and other young people who, for whatever reason, are not enrolled in school.

What happens to the information?

The McCreary Centre Society is committed to making the survey results widely available to those working to improve the status of youth health in British Columbia, and to youth themselves. This report provides highlights for the province as a whole. Where available, comparative results of the 1992 and 1998 surveys are reported. More detailed analysis of the data, providing additional information on specific population groups and subject areas, will also be released in the future.

## Making Sense of the Data

The enormous body of data collected from AHS II confirms that BC youth are doing well. Most young people are healthy, get along with their families, enjoy school and look forward to the future. One clear finding from this latest survey is the stability of trends since 1992. Many questions on the 1992 survey were repeated word-for-word in AHS II, enabling a precise analysis of how today's young people are the same, or different, from students who answered the same questions six years ago.

The good news…

The survey delivers a message that is largely positive, refuting current public apprehensions about youth. Recent tragic events in the US and Canada have raised fears, often fed by the media, that young people are becoming more violent, more distant from their parents, less committed to education, and more influenced by television and the Internet. In contrast, results of this survey reveal a remarkable stability. On many topics, responses to the 1998 survey are exactly the same as in 1992. Those stable trends include overall physical and emotional health, suicide attempts, and attitudes and behaviour related to eating disorders. The survey results convey good news about emotional health. Contrary to popular belief, adolescence is not always an emotional roller coaster; only a small minority of BC youth report severe emotional distress. Another positive finding relates to a decline in the experience of abuse, with female youth reporting lower rates of both physical and sexual abuse than in 1992

Nearly 9 out of 10 youth enjoy good or excellent physical health. Most young people are making smart choices about their health and avoiding risky behaviours. Bicycle helmet use has increased dramatically, likely as a result of 1996 provincial legislation. Most young people do not smoke cigarettes, drink and drive, or use illegal drugs. And more BC teens are waiting longer to have sex for the first time. Most youth in the 12-18 age group have not yet become sexually active.

For those worried about youth violence, the survey offers reassurance that young people are not more inclined today than in 1992 to get involved in fights. Most youth say they have good social supports and people they trust to help with problems. Many youth are actively involved in their communities, with over 80% contributing time in volunteer activities.

And not-so-good news…

However, some findings from AHS II suggest that prevention and health promotion efforts

have not made enough of an impact on young people. Many students apparently aren't getting the message about the dangers of tobacco, as smoking in this age group has not decreased since the last survey.

More teens are delaying the start of sexual activity. However, many of those who are having sex are not protecting themselves against sexually-transmitted diseases and unwanted pregnancies. Condom use has not increased among adolescents since 1992, and many sexually-active young people do not use any form of birth control. Most injuries are preventable, yet they continue to pose a serious threat to youth health. During the previous year, 40% of students responding to the survey had received an injury serious enough to require medical attention. Many of those injuries involved some kind of sports or recreational activity. Seatbelt use has not yet reached acceptable levels and, in fact, has declined slightly since 1992. And there has been no progress in reducing the number of young people who drive after drinking or using drugs.

Illegal drug use is a reality in the lives of many BC teens. The survey results show a sharp increase in marijuana use since 1992. Over four in ten students have experimented with marijuana at least once, and about one in ten is a frequent user. A significant proportion of students has experimented with other "harder" drugs.

Rising rates of adolescent drug use are not unique to BC; similar trends have been reported in other parts of Canada.

Location matters

Regional comparisons of survey results show striking differences on some topics among various parts of the province. The Greater Vancouver region has lower rates of cigarette smoking, sexually-active teens, drinking and driving, suicide attempts and overall injuries, but higher rates of sports injuries and racial discrimination than most other regions. The Northwest region has relatively higher rates of suicide attempts, racial discrimination and smoking. The Interior and Kootenay regions report higher rates of drinking and driving in this age group, and the Kootenay region has the highest injury rates.

Connections count

A new series of questions, added to the 1998 Adolescent Health Survey, sheds light on factors that appear to protect young people against risks that are harmful to their health. These questions, derived from groundbreaking studies in the United States, look at how youth feel about their relationships at home and at school. The questions gauge the student's level of "connectedness" with parents, family, teachers and classmates.

This part of the Adolescent Health Survey charts important new ground. The findings show clearly that families continue to be key in influencing choices and actions that impact on youth health. Students who report being strongly connected to their families seem less likely to engage in risky behaviours such as early sexual intercourse and use of illegal drugs. Young people with strong family connections are less likely to experience emotional distress or to attempt suicide.

School is another important influence on youth behaviour. Students with a sense of belonging and involvement with school report higher educational expectations and appear less likely to make choices that are dangerous to their health. Most teens say they have someone in their lives who can help with personal problems. For most problems, female students rely on friends, while males are more likely to turn to parents. Students were less likely to ask teachers or health professionals for help.

A special focus

The "Special Focus" section of this report presents a snapshot of selected youth populations that may be particularly vulnerable to certain health risks. As this section illustrates, some youth face special challenges in the transition to adulthood. According to the survey results, young people with a health condition that limits activity are more likely than their healthier peers to attempt suicide. Youth who think they look older than others their age are more likely to engage in a variety of risky behaviours. A review of survey responses from Aboriginal youth in school shows that, in many respects, these students closely resemble their non-Aboriginal classmates. This section also adds to a body of evidence that a family's economic

status has an impact on health. The McCreary Centre Society plans more detailed studies of the survey data related to special population groups.

## Family background

BC youth and their families represent a rich variety of ethnic and cultural backgrounds. In response to a question about family roots, 20% of students say their personal back-ground is primarily British. Other large groups are Chinese (2%). Aboriginal (6%) and South Asian (4%). while another 21% of students do not see themselves as belonging to any particular ethnic group.

Over four in ten students speak a language other than English at home; for 14% another language is used at home more than half of the time. Nearly a quarter of students in the Greater Vancouver region speak a language other than English at home more than half of the time, compared with only 3-7% in other regions.

About three-quarters of students live with two parents (including step or adoptive parents) while 20% live with only one parent. A small number about one percent live with a non-related adult (such as a foster parent), and the remaining 3% live with other relatives, alone, or with other youth.

Many students are unsure about their family source of income. Only six percent of students report that their family receives some type of income assistance, but about a third (30%) say they don't know if their family receives income support. in response to a group of questions about family financial status, nearly one in five youth (18%) indicate that they come from lower income families.

## Physical Health Status

Most BC youth (87%) consider their physical health to be good or excellent. Only 13% see their health as fair or poor. Boys tend to give their health a higher rating than girls, with 44% of male students compared with 28% of female students reporting their health as excellent. These results are almost the same as those reported on the 1992 survey.

Despite their generally good health, many students report being troubled by health problems. One third of male students and 46% of females report having a physical complaint-including stomach aches, headaches or backache- more than once a week. An even higher percentage of both males (42%) and females (48%) report experiencing emotional health problem -such as feeling irritable or depressed-more than once a week. In addition, 13% of students report that they have a health condition, chronic illness or disability that limits their activities .

Appearance and weight

Weight, body shape, and clear skin are not trivial issues for this age group. For most teens, looking good is a matter of top priority.

Weight plays an important role in how young people feel about themselves, and many BC students are not satisfied with their current weight. Over half of all female students are trying to lose weight; 12- and 13-year-old girls are less likely than older females to want to lose weight. Only 19% of boys report trying to lose weight, while 27% say they would like to gain.

Despite this apparent concern about weight, the survey results do not suggest any increase in eating disorders among adolescents. About 7% of students say they ever vomit on purpose after eating, the same as in 1992. More girls (9%) than boys (5%) report vomiting on purpose; 3% of girls say they do this more than once a month.

Exercise and nutrition

Most students practise habits that promote good health, including exercise and proper nutrition. About seven out of ten students exercise three or more times a week. Girls are somewhat less likely to exercise than are boys. Students appear to exercise less often as they get older. About three-quarters of students exercise three or more days a week at age 13, while only 67% of males and 49% of females aged 17 report exercising that often.

Half of students always eat breakfast on school days, while 14% of males and 20% of females always skip breakfast before school. Older

students are less likely to eat breakfast than are younger students. About half (47%) of the youth surveyed consume the recommended two or more milk products each day, while only a quarter eat the recommended number of servings of protein or of fruits and vegetables.

## Injuries

Injuries continue to pose a significant risk to the health of young people despite [he fact that most injuries are preventable. Protective practices in adolescence can he influenced by legislation, education, and good role modelling by adults. However, many adolescents continue to take chances with safety.

Forty-five percent of male students and 34% of female students responding to the survey say they experienced an injury in the past year that was serious enough to require medical attention.

Over half of all injuries involve sports activities. An additional 10% of injuries occur while using roller blades, skateboards or bicycles. Another 8% involve a car or other motor vehicle. About one injury in live happens at school.

Injuries of all kinds appear to he more frequent in the Kootenay region of the province with the fewest injuries reported among students in the Vancouver region. However, Vancouver area students who reported an injury, are more likely to be injured during sports activities than students in other parts of BC.

The survey results show definite room for improvement in injury prevention behaviour among teens. About 41% of males and 31% of females who have a driver's license say they have driven a car after using drugs or alcohol. Sixteen percent of licensed teen drivers reported drinking and driving in the past month, the same rate as 1992. The rates of reported drinking and driving are lowest in the Greater Vancouver region and highest in the Kootenay and Interior regions.

In addition, only 55% of all students always use a seatbelt. In fact, seatbelt use has declined slightly since the 1992 survey.

Bike helmets, which offer effective prevention from head injuries, do appear to be gaining favour with young riders. The percentage of young people who report always wearing helmets when riding bicycles rose to 30% from only 6% in 1992. Those who report never wearing helmets declined to 32% from 76%. (Provincial government legislation requiring use of bike helmets came into effect in 1996.)

## Emotional Health

It is a common perception that the teenage years are marked by emotional turmoil. while some adolescents do experience mood swings and anxiety, only a small percentage report severe distress. According to the survey results, most youth cope well with the stresses in their lives. Teens report a lower level of suicidal thoughts, compared with the 1992 survey. Experience of physical and sexual abuse also has declined among female students.

AHS II does suggest that, for some young people, worry and depression can be overwhelming. Emotional distress appears higher among females and generally increases with age. Emotional distress also appears higher among youth with a chronic health condition and those with experiences of physical or sexual abuse. Families, schools and youth services face the challenge of finding ways to promote positive coping skills and strengthen resiliency, especially for students who are more vulnerable to emotional distress.

Emotional distress

Five questions on the survey measure emotional health status. These questions include; "During the past 30 days, have you felt you were under any strain, stress or pressure?" and "…have you felt so sad, discouraged, hopeless or had so many problems that you wondered if anything was worthwhile?" An extreme response - such as a response of "all the time" on two or more question - is seen as an indicator of emotional distress.

Overall, 9% of females and 5% of males report feeling emotionally distressed in the previous month. Older students are more likely to report distress, rising from 3% of boys and 4% of girls at age 12 to 6% of males and 11% of females at age 17. These results are similar to those reported in the 1992 survey.

Abuse

Twenty percent of female students report ever being physically abused, a decline of 4% since 1992. The percentage of males who have experienced physical abuse remained about the same at 13%.

Girls reporting a history of sexual abuse also declined to 15% from 21%, while about 3% of boys say they have been sexually abused, the same percentage as in the previous survey. Sexual abuse of females is lowest in the Vancouver region (12%) and highest in the Northwest (22%).

Suicide

A tragically high number of young people choose suicide as a response to difficult circumstances or personal despair. Since the 1992 survey, the percentage of males and females who report thinking about (14%) or planning (11%) a suicide in the previous year declined slightly. According to the 1998 survey, the number of young people who actually attempted suicide (7%) or were injured in an attempt (2%) during the past year remained about the same. Overall, female students (9%) report attempting suicide more often than male students (4%).

Suicide attempts are highest in the Northwest region at 9%, compared with 6% in the Vancouver and Capital regions.

Discrimination

Many young people report experiences of discrimination related to one or more actual or perceived differences. Overall, 46% of students say they have experienced some kind of discrimination. Discrimination due to race and gender tends to increase with age.

Experience of discrimination related to race or skin colour is highest in the Greater Vancouver and Northwest regions of the province; these two regions have higher proportions of students from Aboriginal or other visible minority groups.

## Violence

Despite well-publicized incidents of youth violence in recent months, there is no evidence that the lives of BC youth are becoming more violent. Involvement in fights remained stable for males (42%) and declined slightly among females (18%) since the 1992 survey. Fighting is least common among young people in grades 11 and 12.

However, about 9% of students carried some kind of weapon to school in the past month, most often a knife or razor. About one percent said they had a gun at school in the month preceding the survey.

Other types of aggressive behaviour are more common. Nearly two-thirds of female students (63%) and nearly half of male students say they have been verbally harassed at school in the past year. Nearly four in ten boys and a quarter of girls were threatened with physical harm, while 17% of boys and 6% of girls say they were physically assaulted.

Feeling safe at school

Only about half of all students surveyed say they always feel safe at school, ranging from a low of 39% in Grade 8 (often the first year of secondary school) to a high point of 58% in Grade 12. Only 6% of students who always feel safe at school reported carrying a weapon to school, compared with 39% of those who never feel safe at school.

*While any potential for adolescent violence is disturbing, The McCreary Centre Society cautions that it is important to maintain a sense of perspective about the minority of youth who report carrying weapons at school. The survey results cannot provide sufficient insight about the motivation for those youth who do have weapons. Further studies could provide valuable information on why some students carry weapons and on the extent to which discrimination and harassment contribute to violence in school.*

## Substance Use

Smoking

Smoking, a proven risk factor for cancer, heart disease and other health problems continues to be popular among young people. Smoking among 12- to 18-year-olds has not declined since the 1992 survey. In the 1998 survey, the same percentage of students reported smoking cigarettes as in 1992.

In total, 45% of students say they have tried smoking. One in four has experimented or is currently experimenting with cigarettes (smoked fewer than 100 cigarettes in life-time) and about one in ten smokes every day. Girls are somewhat more likely to smoke than are boys. Regionally, Greater Vancouver has the lowest rate of smokers in this age group (13%), while the Northwest has the highest (23%).

Exposure to second-hand smoke also has been implicated in a variety of health problems, including asthma. Nearly a third of students say they are exposed to tobacco smoke (including their own) inside their homes at least once a week.

The survey data reveals that experimentation with tobacco is common among teens hut daily use is much less so. Adolescents who are regular smokers are easy to identify and are most at risk for long-term health problems related to smoking. Smoking in this age group can be influenced somewhat by price, enforcement of controls over sales to minors and creation of smoke free environments. However, smoking cessation strategies for adolescents are less well developed and less accessible. Efforts to keep teens from trying cigarettes don't appear to be working; programs to help teens quit smoking once they've started may be a better idea. The McCreary Centre Society suggests a need for evaluation of primary prevention programs and a greater emphasis on successful strategies for quitting.

Alcohol

Overall, patterns of alcohol use in this age group have not changed significantly since 1992. About 37% of students say they have never had an alcoholic drink, about the same as in the last survey. The percentage of youth who have tried alcohol increases with age, rising from 47% of boys and 41% of girls at age 13 to about 80% for both males and females at age 17. Of students who do use alcohol, about three-quarters had a drink in the past month.

Students in the Greater Vancouver area are less likely to drink than are their counterparts in other parts of the province. Regional variations in alcohol use range from 44% of students in the Vancouver area who have never had a drink of alcohol, to 23% in the Kootenays.

Of those students who use alcohol, 44% say they engaged in episodes of heavy (binge) drinking in the past month. (Binge drinking is defined as consuming 5 or more drinks of alcohol within a couple of hours.) This is an increase from 1992, when 36% of students who used alcohol reported binge drinking in the previous month.

Drug

Drug use among teens has increased in recent years. The survey results show that the percentage of students who have used marijuana at least once rose sharply to 40% in 1998, up from 25% in 1992. Thirteen percent have used marijuana forty or more times. About half of those who use marijuana say they have done so in the past month. Increases in marijuana use have also been reported in other provinces.

Students report a slight increase in cocaine use, with 7% using the drug at least once, up from 5% in 1992. About 2% of students have used heroin, and another 2% report using steroids at some time in their lives.

Other illegal drug use includes mushrooms (16% of students), hallucinogens including LSD and "ecstasy" (11%), and inhalants such as glue and aerosols (6%).

Over three-quarters of students (76%) have never used any of these "harder" drugs: Cocaine, hallucinogens, mushrooms, inhalants, amphetamines or heroin. However, 6% of students report using one or more of these harder drugs 10 or more times in their lifetime.

The dramatic rise in marijuana use reported by BC adolescents raises as many questions as it answers. Of particular concern is evidence that first marijuana use is occurring at a younger age and that use is more frequent The reasons behind these changes may include greater accessibility, lower prices, or more permissive attitudes towards drug use. The McCrearv Centre Society urges caution in leaping to conclusions about the impact of increased marijuana use on adolescent health. Additional research could shed light on the circumstances, which encourage or inhibit experimentation with drugs, the health consequences of drug use and its association with other risk behaviours.

## Sexual Behaviour

The survey results portray some encouraging trends related to sexual activity among adolescents. Teens are waiting longer to have sex, and the percentage of students who have ever had sexual intercourse declined for all ages of youth since the last survey.

However, too many teens still report having sex for the first time at a very early age. Adolescents who look older than others their age seem more at risk in this regard (Many previous studies link early sexual activity with a variety of health problems.)

Delaying sexual activity

The 1998 AHS data shows that 77% of BC youth in Grades 7-12 have never had sexual intercourse, compared with 70% in 1992. Both males and females appear to be waiting longer to have sex for the first time. Not surprisingly, the level of sexual experience increases with age. At age 13, only 9% of youth have had intercourse, compared with 42% of students at age 17. However, nearly half of all youth who are sexually active said they first had sex at age 14 or younger.

Some regional differences were reported, with the Vancouver region having the lowest percentage (19%) of sexually-active students. The percentage of students who have ever had intercourse ranges from 26% to 31% in other parts of the province.

About a third of sexually-active youth answered “Yes” to a question asking "Did you drink alcohol or use drugs before you had sexual intercourse the last time?"

STD risk

Although fewer youth are having sex, many of those who are sexually active are not protecting themselves against sexually-transmitted diseases (5Th). Slightly more than half of females (52%) and 64% of males say they (or their partner) used a condom the last time they had intercourse. These results on condom use are exactly the same as in 1992. Sex with multiple partners is another recognized risk factor for sexually-transmitted diseases; 27% of sexually-active males and 20% of sexually-active females have had sex with four or more partners. About 6% of sexually-active youth say they have had a sexually-transmitted disease.

Birth control

Many young people are not taking steps to prevent unwanted pregnancy. A quarter of sexually-active youth report using either no method of birth control, or withdrawal - notoriously unreliable as a form of contraception- the last time they had intercourse. In 1992, 20% of sexually-active youth reported using withdrawal only or no method of birth control.
Ten percent of sexually-active students say they have ever been pregnant or caused a pregnancy, unchanged since 1992.

## Connectedness and social supports

The 1998 Adolescent Health Survey provides valuable insight on a topic which was not explored in the 1992 survey. AHS II asked students to respond to a series of questions about "connectedness," a term used to describe how youth feel about their social environment, including their relationships with friends, family and school. Questions on connectedness were derived from a major United States project, the National Longitudinal Study of Adolescent Health.

AHS II employed questions about connectedness to explore how the social environment

might impact on emotional health, risky behaviour and other factors affecting the overall well-being of adolescents. In this section of the survey, students answered questions such as:

· How close do you feel to your father?
· How much do you think your mother cares about you?
· How much do you feel that people in your family understand you?
· How much do you feel your teachers care about you?
· How do you feel about going to school?

The questions asked students to reflect on their satisfaction with relationships, including whether they share in fun activities with their families, and whether they feel involved in and fairly treated at school. Responses to these individual questions were combined to give the student a relative "score" of high, medium or low connectedness.

This pan of the Adolescent Health Survey covers important new ground. The findings show clearly that families continue to be key in determining choices and actions that impact on youth health. Throughout adolescence, students who are strongly connected to one or both parents are less likely to engage in risky behaviours such as early and unprotected intercourse, smoking, and use of alcohol or illegal drugs. These young people are less likely to experience emotional distress or to attempt suicide. Students with a sense of belonging and involvement with school also appear less likely to make choices that are dangerous to their health.

Connecting with family and school

Overall, 13% of students were categorized as having a high level of family connectedness, while 15% have low connectedness. The percentage of students with the strongest family connections declines with age from 25% of 12-year-olds to only 9% of those aged 17.

Connections with school follow similar patterns, with 13% of students scoring high on connectedness and the same percent scoring low. A sense of connection with school is highest (23%) among Grade 7 students, dropping to a low of 7% in Grade 10 and rising slightly to 12% in the last year of high school. Girls report stronger school connections than boys; 15% of females have high levels of school connectedness as compared to 10% of males.

Connectedness and emotional health

Students with the strongest family connections report better emotional health than students with weaker family connectedness. Only 3% of students who report high levels of family connectedness tried to commit suicide during the past year, compared with 17% of students with the lowest levels of family connection. Emotional distress and a history of physical abuse is much less common among students with high family connectedness. And only 5% of students who report strong family connection have experienced sexual abuse, compared with 18% of those with low connectedness.

Connectedness and education

As might be expected, students who feel more connected to school are better students. Among those with the strongest school connections, 24% consider themselves to be among the top students in their class, compared with 7% of students with the weakest school connections.

Three-quarters of strongly-connected students say they like school, compared with only 7% of those with lower levels of school connectedness. Students who feel strongly connected to school are more likely to have plans for post-secondary education and much less likely to skip school often.

Connectedness and risky behaviour

Students with high levels of family connectedness are less likely to engage in risky behaviour. Nearly 80% of students with high family connectedness have never smoked marijuana, double the number reporting low levels of family connections. Only 3% of students with the strongest family connections report having sex under age 14, corn-pared with 12% of those with low family connectedness.

Weaker school connections also appear to be related to risky behaviour. Among students with a stronger sense of school connectedness, fewer than 4% are regular smokers, compared

with 22% of those with a low connectedness score. (Overall, 10% of BC students are regular smokers.) Similarly, marijuana use was 21% among highly-connected students versus 60% among those with low school connectedness. The percentage of students who report using drugs or alcohol before driving in the past month was lower among students with the strongest school connections (10% vs. 29%).

Students with the strongest connections to school are much less likely to be involved in fights. Only 14% of those with high levels of school connectedness were involved in a physical fight in the previous year, compared with 53% of students with low levels of connection.

Only 14% of students reporting high levels of connections with school have had sexual intercourse, compared with 39% of those reporting lower connectedness.

Community involvement

Over 80% of all students say they were involved in some type of volunteer activity in the past year, including helping neighbours, supporting a cause or raising funds for a charity. Females (87%) were somewhat more likely than males (74%) to help others without pay. Volunteer involvement was fairly consistent across regions and age groups.

How do youth keep busy outside of school? Students report a high level of participation in extracurricular activities such as sports, music lessons or clubs. About 45% of male students and 35% of females are involved in one such activity at least once a week, while 24% of males and 39% of females participate weekly in two or more activities.

Help-seeking

Most teens say they have someone in their lives who can help with personal problems. The survey asked students who they would go to first for help with problems such as feeling depressed, needing birth control, problems with drugs or alcohol, or problems with friends or family. For most problems, female students rely on friends and/or parents, while males are more likely to turn to parents. Students were less likely to ask professionals for help with most problems. (On the questionnaire, professionals were defined as health professionals or teachers' school staff.)

## A special focus

The 25,838 responses to the Adolescent Health Survey II provide a wealth of information about BC youth. while these results convey a primary message of youthful optimism and good health, they also point out distinctions within the youth population. Some youth are not doing as well as their peers. For a variety of reasons, some youth are more vulnerable to health problems and risky behaviours.

Promoting resilience

The special focus groups were identified in part because of their perceived vulnerability, but also to help identify protective factors and opportunities for promoting resilience. Groups were selected for special focus only if the survey sample included sufficient numbers for meaningful analysis.

The McCreary Centre Society does not present these special focus results with the intention of singling out certain youth as "problems." Rather, the rationale for spotlighting these groups is to stimulate thinking about strategies that address their specific issues. With appropriate recognition and effective intervention, the youth portrayed in this section can overcome obstacles to their healthy development.

Findings for these special focus groups reinforce evidence that inter-related factors[1] including income, culture and genetic inheritance, are important determinants of health in this age group. The findings suggest that:

· Youth from lower-income families are less likely to report excellent health status.
· Youth with a chronic illness or disability attempt suicide more often than other students.
· Aboriginal students have more emotional health concerns than non-Aboriginal students.
- Youth who think they look older than their age are more likely to engage in risky behaviours.

Youth from lower income families

About one in five youth who completed the survey indicate, by their response to a group of

five questions, that they live in lower income families. These questions included: "In terms of money or income, how well off is your family?" and "Does your family have a car, truck or van?" This estimate by youth themselves is very close to the percentage of low income families reported by Statistics Canada based on actual income figures from the 1996 census.

In most respects, youth from lower income families are no different than youth from medium or higher income families. They report high levels of emotional health and are no more likely to engage in most risk behaviours.

However, lower income youth are somewhat less likely than youth from higher income families to plan to continue their education after high school. Lower income youth are somewhat more likely to consider or attempt suicide. Only 27% of lower income students report excellent health status, compared with 37% of higher income students. Lower income students also are more likely to experience two or more health problems weekly. Compared with other youth, youth from families with a lower income are somewhat less likely to participate in extracurricular activities.

Youth with a chronic illness or disability

Thirteen percent of youth who participated in the survey report having a chronic illness, health condition or disability that limits their activities. Survey results from this group of students show striking differences in both physical and emotional health status, compared with students who do not have a limiting health condition. These youth are much less likely than other young people to feel strongly connected to their families or schools. They are also less likely to plan to attend post-secondary school.

Youth with a health condition that limits activity are much more likely to attempt suicide; 17% of these youth attempted suicide in the previous year. Not surprisingly, only 15% report excellent health status, and 60% say they experience two or more health troubles at least weekly. Less than a third of youth with a chronic illness or disability are satisfied with their weight. This group of young people also is more likely to engage in some types of risky behaviour, such as smoking, than their healthier peers. Almost half of these youth report experiencing discrimination because of their appearance.

Recent changes in education practices and policy have enabled many children and youth with ongoing health problems to attend mainstream schools. The survey results indicate a clear need for better supports to protect this population of young people from emotional health problems and other risks.

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# Youth and Mental Health: Quantitative and Qualitative Analyses of Youth Net/Réseau Ado Focus Groups

Executive Summary
Background

Youth Net/Réseau Ado (YN/RA) is a regional bilingual youth mental health promotion and mental illness prevention program developed as a result of the 1993 *Canadian Youth Mental Health and Illness Survey* (CYMHIS), sponsored by the Canadian Psychiatric Association. This survey indicated that mainstream Canadian youth are at a disturbingly high risk for mental health problems. It also indicated that youth are largely dissatisfied with existing mental health services and that they are most willing and comfortable interacting amongst themselves. Furthermore, previous research has revealed that death by suicide remains the second most common killer of youth in Canada, and that adolescence is the only age group where suicide is on the rise.

Youth Net/Réseau Ado strives to increase awareness and communication and decrease the negative stigma regarding mental health and illness issues, promote good mental health, facilitate early intervention for mental illness, develop plans for making the present mental health services more youth appropriate, and help youth develop connections with a safety net of professionals. A primary way in which YN/RA is achieving this is by listening to youth via focus groups, which provide an open forum for them to communicate their issues and opinions. We listen to the experts, the youth themselves. To date, YN/RA has organized 446 focus groups in Western Quebec and Eastern Ontario.

Focus groups are 1.5 hour sessions with generally 8 - 12 participants and are facilitated by two young people (aged 20 - 29). Facilitators receive training in group facilitation and in crisis intervention. These facilitators bring different educational backgrounds and life experience to the program (students from psychology, social work, former street-involved youth, youth group leaders, etc). All have a definite commitment to the well-being of youth. The team of facilitators is also made up of young women and men from diverse ethnic, cultural and linguistic backgrounds to reflect the heterogeneity of the youth population with whom they are working. Each focus group is structured around 5 main questions: (1) What is mental health? (2) What is mental illness? (3) What issues are important to you? (4) How do you deal with these issues (with prompts to discriminate between help involving and not involving others)? Who do you talk to when you have a problem? (5) How would you change the mental health system so that it better meets your needs?

From September 1995 to June 1998, 4624 youth (aged 12-20 years) participated in YN/RA focus groups. Fifty-one percent of the groups were held in English and 49% in French. Fifty-six percent of the participants were female and 44% were male. Eighty-four percent of the groups were held with youth in mainstream school programs and 16% were held with youth in non-mainstream programs (including street youth, youth in alternative education programs, youth in care, young offenders in detention centers, gay, lesbian and bisexual youth, aboriginal youth, adolescent mothers). The present is a summary of the quantitative and qualitative information provided by youth in the focus groups.

## Synopsis of Quantitative Findings

Youth who participated in YN/RA focus groups were asked to complete a brief questionnaire on their attitudes and behaviors as they related to mental health and illness. Many of these questions were similar to those used in the CYMHIS (1993). The following summary compares and contrasts the responses from both mainstream and non-mainstream YN/RA groups, with particular attention to gender differences.

Non-mainstream youth reported both more physical health (50.3% vs. 45.1%) and mental health (39.2% vs. 35.1 %) concerns relative to

mainstream youth. Females reported significantly more physical health (53.0% vs. 37.3%) and mental health (41.7% vs. 28.2%) concerns than did males.

Overall, a great number of youth reported significant levels of stress (68.6% of non-mainstream youth and 62.5% of mainstream youth) and depressive feelings (48.6% of non-mainstream and 39.8% of mainstream youth). Looking at stress and depression data by gender, more females reported significant feelings of stress (71.9% vs. 52.7%) and depression (47.8% vs. 32.8%) than did males.

The high proportion of youth reporting having thought of suicide or having purposely attempted to kill themselves was particularly disturbing. Of mainstream youth, 25.4% reported having had suicidal thoughts at some time in their lives, with 9.8% having had such thoughts within the last three months. Nine percent of mainstream youth reported having made a past suicide attempt. In contrast, 38.9% of non-mainstream youth reported past suicidal thoughts, with 19.1 % of youth having had such thoughts recently. Twenty-three point eight percent of non-mainstream youth indicated that they had made a past suicide attempt. Females reported significantly more lifetime suicidal ideation (32.4% vs. 21.4%), recent ideation (13.6% vs. 8.4%), and suicidal behavior (14.4% vs. 7.6%) than did males. In spite of these elevated rates of suicidal ideation and attempts, 41.8% of mainstream youth and 37.2% of non-mainstream youth never disclosed these thoughts or feelings to anyone. Young men (49.7%) were much less likely than young women (36%) to have ever disclosed such thoughts or feelings to anyone.

There are many youth who, when faced with a mental health concern, will cope by keeping problems to themselves. Non-mainstream youth were more likely to report trying to cope on their own than were mainstream youth (43.7% vs. 33.4%). If youth approach anyone for help about their mental health concerns, they were most likely to talk to friends (32.3% non-mainstream and 47.5% mainstream). A minimal number of both non-mainstream (3.2%) and mainstream (1.1%) youth indicated that they would talk to a professional about such concerns.

Overall, the quantitative YN/RA findings suggest an even higher rate of distress than has been reported previously (e.g., CYMHIS, 1993). Gender differences remain striking across all aspects of mental health. Females reported more concerns for their mental health and more feelings of stress and depression than did males. They also had more suicidal ideation and behavior than males, and they sought out others to discuss their mental health concerns more often than males. There were also many differences between mainstream and non-mainstream youth in both their attitudes and behaviors relative to mental health and illness. This underscores the importance of considering the heterogeneity among youth and the need to consider a variety of solutions to better meet the mental health needs of youth.

## Synopsis of Qualitative Findings

The following summary highlights the thoughts, opinions, and ideas of youth participants, as they communicated these to us through the focus groups.

*"Mental health is like you're on a teeter-totter and someone can get off."*

In their discussions on mental health, only a minority of youth (20%) defined this term in a positive manner. Such comments included an emphasis on effective coping strategies, positive mental states, and high self~steem. The majority of youth defined mental health in either very negative (32%) or neutral (48%) terms. There appeared to be a limited framework for youth in their understanding of mental health.

*"Mental illness means the inability to deal with school, work, parents."*

Overall, youth's comments and discussions on mental illness could be grouped into four main areas:
negative emotional states, ineffective coping strategies, sicknesses, and/or specific mental disorders. The following mental disorders were most frequently discussed in focus groups: depression (45.0%) and eating disorders (25.0%). Not surprisingly, there were no (0%) positive definitions given for mental illness. Ninety percent of the comments relating to

mental illness were negative, with the other 10% being more neutral.

Youth identified the following issues (stressors) as being important to them: parents (80.0%), drugs and alcohol (65.8%), money (64.2%), and peer issues (61.7%). When asked who they would turn to for help in coping with such stressors, the number one source of support identified by youth was friends (86%), with family (50%) coming in a distant second. Youth reported that they would not turn to the following sources for support: (1) psychologists and/or psychiatrists (43%), and (2) guidance counselors (26%). Clearly, the youth considered their friends as the most important resource for them when they need help coping. Friends were described as trustworthy and able to relate and youth reported feeling comfortable in approaching their friends when they have problems. In contrast, youth did not have a positive view of many professionals and did not want to use their services. Given the predominantly negative view of mental health professionals and services, youth were asked to suggest ways to change the system to better meet their needs.

*"Professionals need to learn to shut up and listen and get to know a person, work through options, pros and cons, instead of telling you what to do."*

Youth suggested that 24-hour accessibility to support is important. As well, trust and confidentiality when using such services was stressed. Youth mentioned a need for more community-based services and supports. However, youth suggested that the most important change needed in the mental health system is the encouragement of professionals to be more "youth friendly". When asked to explain what "youth friendly" meant to them, the following themes were identified: active listener (35.8% of respondents), understanding (32.3%), positive personality traits (i.e., sociable, dynamic, sense of humor, approachable, positive attitude, approachable) (28.8%), not judgmental (17.0%), helpful (14.6%), cool/like youth (i.e., closer in age to youth or at least youthful in their attitude) (12.4%), respect for confidentiality (11.0%). Youth suggested that professionals need to respect youth, refrain from judging youth, and learn to appreciate all that youth can offer society. Participants also emphasized the need to create a link between friends, who are valued coping resources but who do not always know how to help, and professionals, who are trained but not sought out by youth.

*"Send professionals on 'field trips', 'youth immersion', see firsthand what is happening in the youth world, help them identify with the youth they've forgotten."*

## Updates and Future Directions:

YN/RA is continuing to offer focus groups throughout Eastern Ontario and Western Quebec. In addition to its focus groups, YN/RA also provides longer-term therapeutic support groups to youth having difficulties. These groups were initiated as a result of hearing from youth that they needed more practical supports delivered through a continuing group format where they could explore and discuss their life issues and stresses and problem solve together to find solutions. The goals for our youth support model are to: be flexible, youth-directed and empowering in our approach; build youth's capacity to cope with their life stressors; respect and promote youth-identified adaptive coping strategies; and provide a safety net community and professional resources.

Support groups are co-led by experienced facilitators, psychology graduate students, psychology interns, or psychiatry residents, under the supervision of a psychologist and psychiatrist. Two distinct models have been developed and are being implemented throughout the region. The "depression group model" targets those youth with significant depressive symptomatology. Both prior to the group and following the group, participants are assessed on an individual basis. During the group, participants meet weekly for a period of 12 weeks to discuss their lives and any problems they may be having, and to offer suggestions and support to one another. The "support group model" is more general in focus and does not include pre or post assessments. The length of the support group varies depending on the needs of the youth and the schedules involved in their setting.

In partnership with a variety of agencies serving youth, these community-based support groups have been provided to diverse groups

of youth. This includes, youth suffering from depression, street youth, youth in alternative education programs, rural youth, and chronically ill youth. The variety of youth reached by this service is ever widening with our model currently being adapted for young offenders in detention centers, and youth in care.

A participatory evaluation of Youth Net/ Réseau Ado's therapeutic support groups was undertaken in 1998. The evaluation was designed to be participatory both through the involvement of the youth in the research design and in participating with their peers in the data collection. Facilitators, staff and community partners were all involved in each step. Results of the evaluation were very positive. Youth and community contacts indicated that YN/RA facilitators were effective at creating a safe, open environment that promoted trust, sharing and mutual support. Youth participants were able to discuss life issues and group problem solve with the support of facilitators. Our facilitators, who formed strong connections with youth participants, were able to serve as a bridge to the safety net of community and professional resources in the community.

From a traditional analytical perspective, the data collected may be viewed as "soft". However, it should be noted that a commitment was made at the onset to ensure equal participation of youth in the conceptualisation and implementation of the evaluation. In addition to the measurable outcomes of the pre-post assessments reflecting increases in self-esteem, reduction in depressive symptomatology and increases in self-perceived global functioning, the less quantifiable outcomes, as expressed by the youth, were central to our participatory evaluation. Both approaches suggested that our therapeutic support groups were an innovative, respectful, and effective way of meeting the mental health needs of many youth.

In addition to the focus and therapeutic groups offered, YN/RA also encourages youth to empower themselves by creating their own mental health promotion and mental illness prevention initiatives. Such initiatives have included a "Healthy Mind in Healthy Body Snow Boarding Project" and the creation of "Youth Fax" "Fax Ado". The later two are newsletters written by youth on a variety of mental health topics identified by youth. Each edition contains poetry, art-work and information written in “speak” on the topic at hand with identification of youth friendly resources that are available for those facing that challenge. YN/RA is available to facilitate the implementation of such youth-generated programs and offers facilitator training to youth so that youth can organize their own focus groups.

Through YN/RA, links are being established between youth and mental health professionals, using a youth friendly and community-based program. YN/RA is trying to educate youth about mental health and illness, and at the same time educate professionals on the flexibility and sensitivity required to better serve youth. YN/RA is now facilitating the development of satellite programs in communities across the country. The goal is for communities to benefit from the lessons learned at YN/RA while adapting our approach and tools to meet the needs of youth in their community.

## For information:

Youth Net
401, Smyth
Ottawa, ON K1H 8L1
Tel: (613) 738-3915 or 738-3914
Fax: (613) 738-3917

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# Surviving Adolescence

by Lisbeth Krawiecki, LMSW, ACSW

If you are the parent of a teenager with special needs and do not know what to expect, do not worry, you are not alone. Parents ask for guidance during the "terrible twos" and during teen years more than at any other developmental stage. During both of these stages, kids are seeking out autonomy and independence and finding measures of control over their environment. At the same time, they need support and nurturing. Their job is to test their limits-and they will! Adolescents are going through physiological changes as well as emotional and developmental changes. Their bodies are changing and developing-perhaps not in the ways they thought. It is during this stage that teens begin to form identification with peers, start to question beliefs and values, and sort out their own identities and future goals. When we look at how we can foster a sense of competence in our children, we need to look at issues of self-acceptance, social inclusion, and autonomy.

## What are we really dealing with?

All of this may not happen easily, even for a "typical" teen. Parents will need to keep a few things in mind in order to survive adolescence. Your kids may have differences, but they are probably more like their peers than not. So, first make sure you are dealing with the real issue. It is human nature for a parent to blame the disability. Kids with shunts get headaches, and it is not always a shunt malfunction. Deciphering the real issue may not always be easy!
Do not assume that your child has the same feelings you do. You bring with you the history of your own teen years and what your dreams are for your child. He has grown up with his differences, and may not have the thoughts or feelings you perceive. Part of being a teenager is learning who you are-physically and emotionally. Living with his disability since birth does not mean he understands the true nature of it or what the future holds for him. Teens who have physical disabilities may have feelings about the "intactness" of their bodies. This is a good time to explain, or re-explain if told before, the nature of his disability. Tell him as much as he can understand, and invite him to ask questions.

## Allow your teen to make choices

Many teens have questions and fears about their future. It is important to their self-esteem to understand and learn coping mechanisms to keep a disability from becoming a handicap. Part of your teen's coping abilities will depend on how "normalized" her life can be. Be aware of the obstacles your child may face and help her to make choices. Despite lack of language or independent movement, any child can make some sort of choice. Teens need to be allowed to make choices so they may feel somewhat in control of their lives. We forget how many choices we make for our kids with special needs. There are many choices we cannot let our kids make. They have to go to therapy, take certain medications, allow a caregiver to bathe them, etc. So, seek out situations in which they can make choices. If your child chooses to dye her hair green, this may be the only realistic choice of expression she can make for herself.

## How can we help our kids fit in?

Part of the nature of adolescence is the need to "fit in" and not be different. Your kids do have differences, and they live with them every day. They need to be given as many opportunities as possible to feel "the same," and to engage in typical teen activities like going to the prom or getting a driver's license. There are many programs available to assist young people who have special needs with social and recreational activities. Get your teenager involved and talk to him about what he wants to do. Remember, some kids are social butterflies and some are loners, whether or not they have special needs. So be careful not to push them into relationships and social situations they are not interested in.

There are some creative ways to attract peers. Canine Companions for Independence (an organization which provides service dogs for

people who have disabilities) is a wonderful way of supporting your child's independence. Dogs are a natural magnet, and often attract people and invite questions and conversation. We cannot make friends for our kids, but we can invite situations which will promote these possibilities.

## Pick your battles!!

It is easy to stay in continual conflict with a teenager. Let him win the unimportant battles, but set firm limits. Parents of children with special needs often take on too many roles-that of therapist, nurse, and friend. Some of you may not have choices, but whenever possible, be a parent first. Set limits for your child, and have expectations of him. Ensure that there are consequences when rules have been broken or limits pushed. One of the most difficult things for parents to do is to have their teen learn from natural consequences, at times allowing them to fail. We have to remember that we all learn from our mistakes, and our kids should be given that opportunity as well.

## Teach your kids to be proud

Give your kids responsibilities for themselves and for the household. We all know it is easier and faster to do certain things ourselves, but a major part of helping our kids become self-competent and helping ourselves stay sane later on will be to teach them to be as independent as possible. Let them feel proud of their accomplishments, no matter how small and insignificant they may seem to you. Help your teen practice how to feel proud about who she is. Help her practice how to explain her disability to others if she chooses to do so. Help her with a repertoire of "come backs" for those unwanted questions or unkind comments. Focusing on strengths can help us cope.

## More than the birds and bees!

As parents of teens who have special needs, you too will need to learn coping strategies to meet the challenges that you face. One of the hardest challenges to deal with is that your teen is a sexual being, and part of your ability to survive will depend on acknowledging this. Your child may be a 6-year-old developmentally, but her body will most likely mature at an age-appropriate level. "Typical" kids can learn about maturation, sexually appropriate behaviors and sexual activities incidentally, through everyday activities and social situations, as well as from their parents. As the parents of a child who has special needs, your job as "sex educator" has more responsibility.

Talk to your teen regularly and repetitively about the changes that are going on in her body. Teens need to be taught socially appropriate ways of handling some of their sexual feelings, and they need education about personal safety. If your belief system allows for it, they need the opportunity to have privacy for masturbation, and need to be taught when and where this is appropriate. If you are the parent of a child who has a physical disability, and who requires personal assistance for self-care, you and your child may begin to feel uncomfortable with this situation as maturation begins. If possible, look into using a same-sex care provider. Your teen may have questions about sexual performance and reproduction. If you feel uncomfortable, it is perfectly okay to seek outside help in discussing these issues. You may want to schedule an appointment for your teen to talk with her physician or a counselor who has experience in explaining these physiological issues.

## Give yourself permission

Your kids may require adult assistance at all times. Seek out other parents, pair your kids up, and share caretaking responsibilities. Give yourself permission to take a few hours for yourself. Use respite. Your kids need time away from you as much as you may need time away from them!! Kids with disabilities do not often have the luxury of privacy, so they may need their privacy re-defined as time away from their primary caretaker.

Around the time of adolescence, parents often have a recurrence of grief and the need to once again learn acceptance. [It is often a time when they realize that their child's disability will always be with them.] Their child who has a disability will become an adult who has a disability. Prepare yourselves, gather supports, and you and your teen will survive adolescence! EP

## Resources

American Association of Adapted Sport Programs
Bev Vaugh, President and Founder
PO Box 538
Pine Lake, GA 30072
(404) 294-0070
Web site: http://www.aaasp.org

Canine Companions for Independence
National Headquarters
PO Box 446
Santa Rosa, CA 95402-0446
(800) 572-2275 V/TDD

Lisbeth Krawiecki, LMSW, ACSW, is a Social Worker at Egleston Scottish Rite Rehabilitation in Atlanta, GA, and works in private practice mainly with children who have special needs and their families. She serves on the board of FOCUS, Families of Children Under Stress, an organization in Atlanta offering support and resources to families of children with special needs. Ms. Krawiecki has survived adolescence three times, from the parent's perspective, and now enjoys the company of her grown children.

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# Adolescent Fatigue: A crossroad symptom

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When discussing teenagers, two clichés usually come to mind: The thankless image of the continually tired adolescent and the appealing one of the adolescent bursting with energy like all those sport idols commercials. Both those clichés are obviously just snapshots in a kaleidoscope of very different situations, ranging from one period to another for the same adolescent, from one teen's lifestyle to another.

Having said this, certain figures speak for themselves: more than 40% of teenage students often feel tired (1).

Fatigue is the result of integrated perceptions of which interpretation varies depending on the individual and the circumstances. It's an impression that is relative and subject to multiple influences. A bout of fatigue can suddenly disappear after a motivation, a new interest or a strong emotion. Boredom, dullness or annoyances can either trigger or enhance fatigue.

Whatever the origin, fatigue is the result of a more or less vague perception of a shift of balance and the need for rest to reestablish normal equilibrium. Fatigue ends up limiting physical, intellectual and psychic activity. But first, we must distinguish two very different situations:

a) "Normal" fatigue, that appears after and proportionally to an effort. It is a healthy and necessary signal. This handicap is momentary and it disappears with rest. This fatigue is reversible and, therefore, almost enjoyable.

b) Morbid or "pathological" fatigue, an iterative suffering that is not related or is disproportional to any effort. This fatigue only slightly disappears and can even be accentuated with rest. It is a fatigue that takes its toll on moral, makes us complain, a fatigue that we try to fight in vain. Symptoms include diurnal sleepiness, insomnia and irritability, aches, headaches, decreased appetite, etc. Attention span and perception capacities are diminished. Physical and intellectual performances are altered and errors, even accidents can more easily occur. This state is best described by the terms "general fatigue" or asthenia, especially if it is chronic. This type of fatigue, when observed in teenagers, deserves our full attention. Whether it is detected objectively or only expressed subjectively, it always has a significance.

Fatigue or tiredness is commonly used to describe very different states. On the other hand, any perception of fatigue can be expressed by other terms. Both these uses are particularly frequent with adolescents. This can be more easily understood when we know that most adolescents' concept of health is both vague and global, and that, generally, teenagers have difficulties targeting their complaints (2,3). Therefore, "I'm tired" can be a substitute for "I've had enough", "I'm bored", "I don't feel good enough", "I'm stressed out" or "I'm sad", etc. On the other hand, an actual fatigue is sometimes expressed by statements like "I'm fed up", "It's not going very well", "I have a headache", "I can't fall asleep", etc.

## The frequency of adolescent fatigue

Literature on adolescent fatigue has grown considerably over the past 10 years. But the ideal longitudinal study that would allow us to evaluate the fatigue parameters for a same individual according to different biological, psychosocial and environmental circumstances does not yet exist. This would be a precious study given a teen's dynamic and changing character and the varied profile of external circumstances that he or she goes through along his or her development.

The first few surveys with teenaged students show that a large proportion of them, especially girls, feel tired. This phenomenon seems often related to sleeping problems (4.5).

Fatigue is not the primary motive for consulting our adolescent medicine service in Bicêtre,

Paris; however, more than 45% of adolescents consulting us state on a self administered questionnaire that "they are often tired during the day" and almost one third of them admitted having trouble falling asleep and frequent nocturnal awakenings.

## Does social context play a role?

Lifestyle and socio-cultural contexts are often mentioned when discussing fatigue. Thus, making some preliminary remarks around this question seems worthy.

Is it still relevant to evoke the idea of an "abused generation" (6)? It is difficult to deny the impact that socio-cultural contexts have on adolescents (7,8): adolescence has stretched in time, whereas, the right to adolescence as a privileged, creative and independent period, is hardly being recognized. Teenagers must handle difficult external demands, this on top of numerous developmental internal conflicts that he or she must confront alone (2). Most demands come from family, school (often elitist), peers relationships, certain contemporary threats (aids, violence, etc) and, finally, socio-economical worries about the future (9).

Many adults, themselves unstable, question their commitments and values without giving any credible alternatives for teens. Adolescents may have to make the difficult choice of approving, mimicking or deserting "mandatory" social steps. In an increasing movement of cultural independence, the new generation may want to enter the "adult world" without limiting themselves to it or by developing their own identity taking a different road. But the adolescent tends to rely on his or her peer group and to conform to it; thus, he or she may only find a short-lived or debatable solidarity.

Some, disappointed by the perspectives and roles assigned to them by society, will only see inertia and closure. Already in 1980 in France, close to half of 16-21 year olds not in school were unemployed or occupied precarious jobs. In 1987, 50% of 23 year-old men and 50% of 22 year-old women were still living with their parents (9).

The adolescent feels often the intense desire of wanting it all and wanting it now. Once confronted by reality, he or she may find himself or herself unable to accomplish his or her projects. Oscillating between promises and fears, between repeated states of excitement and disappointment, the adolescent could become the victim of feelings of incompletion and incomprehension. This may render the teen vulnerable to moroseness, anguish and solitude, while the right to sadness, or simply the right to "be tired" is paradoxically denied by adults.

## Adolescent fatigue

Causes of fatigue are either isolated or simultaneous and able to produce the same effect. In clinical cases, this symptom brings us at a crossroad where it is important to distinguish:

1) The physiology of fatigue: its connection with sleep, growth and energetic balance.

2) The pathology of fatigue: its value as a sign in certain somatic pathologies and mostly its links with the psyche of a teen in crisis.

We will address each item separately.

## Sleep and its troubles during adolescence

Sleep, for its repairing qualities, is the first physiological parameter to consider as regards to fatigue. All studies with adolescents whether they are American (5), French (11, 12, 13) or Swiss (14), show that more than half of the teens surveyed were unsatisfied with sleep, feeling tired when they wake up. As for sleep troubles, they clearly affect girls more often than boys, as they will later on affect women more often than men. As is, one out of two girls have trouble falling asleep and one out of three clearly wake up before its time (11). The most recent French epidemiological data on sleep and its troubles during adolescence can be found in Table 1 (1). It would be tempting to interpret all those manifestations as a direct consequence of a new lifestyle at that age. However, during adolescence, we know that sleeping problems (trouble falling asleep, nocturnal awakenings, nightmares) are less often linked to lifestyle (staying up late, noisy environment, etc.) than they are to anxiety and relationship problems. Adolescents themselves agree on the influence of the latter in the quality of their sleep (13).

Sleep rhythm and organization: the influence of puberty

Even if teenagers' "nights" last on average 8,7 hours (1), time spent sleeping is very different depending on circumstances, with a "catching up" rest period on the weekends and vacations as opposed to school days (14, 15) (see Figure 1).

It is true that a "phase delay preference" (going to sleep at a later hour in relation to waking up), unknown to children, starts during adolescence (16). This shift in sleep-non-sleep rhythm is more important on weekends and vacations when one third to half of teens go to bed after midnight (17). Remarkably, this phenomenon, which seems to be independent of psychosocial factors, corresponds to puberty's developmental stages.

In fact, studies done in laboratories on sleep during adolescence have shown that sleep organization evolves more with pubertal maturation as opposed to chronological age (18). During puberty, physiological nocturnal sleep time regularly declines. Moreover, certain important qualitative changes occur during that same period: from puberty stage 1 (child) to puberty stage V (adult). There is a progressive shortening of the "falling asleep" phase before the first paradoxical sleep. But mostly, a progressive drop in stages III and IV of sleep pattern is observed. At the same time the proportion of paradoxical sleep stays constant. This data is interesting since we know that *deep sleep* stages III and IV are the recuperation and restoration stages of sleep, indispensable after sleep deprivation.

These studies also show that diurnal sleepiness that rarely exists among pre-adolescents, progressively increases with pubertal maturation stages (nocturnal sleep time being constant). This tendency, observed in girls as well as boys, is at a peak in the afternoon. Finally, teenagers have a more difficult time spontaneously waking up than pre-teens.

Shift in sleep-non-sleep rhythm and the influence of new habits.

Thus, adolescence is a special period where diurnal sleepiness tendencies occur and increase with physical and neuroendocrine maturation processes and this, regardless of the number of hours slept. Of course, the voluntary or involuntary reduction of sleep during adolescence increases this phenomenon. Obligatory morning awakenings are often set, although social demands and a normal longing for later evenings are more insistent. If they could do what they wanted, many teens would go to sleep late and get up quite late. For some older adolescents, the chronic incapacity of falling asleep at night with difficulties getting up in the morning can lead to a chronic source of fatigue not to be overlooked. This is a real and well-documented syndrome (18).

Sleep length, sleep problems and morning fatigue syndrome.

The average sleeping time continually decreases from the beginning of adolescence. It goes from 8,6 to 7,6 hours from 9 to 14 year-olds, i.e. minus 12% for girls as well as for boys (11). But generally, 86% of teens think their sleep is good (1) and their dissatisfaction with sleep is independent of the amount of time they sleep (11). Furthermore, adolescents' tolerance to sleeping difficulties is quite remarkable: half of those who complain about a chronic sleep problem (mostly difficulties falling asleep) are, however, satisfied with the general quality of their sleep (12). This tolerance will decrease with age.

No matter the sex, sleep dissatisfaction is first and essentially linked to the presence of frequent fatigue when waking up. It appears less dependent upon general sleeping problems (nocturnal awakenings, nightmares) for girls or fatigue felt throughout the day for boys.

One of the rare longitudinal studies available can enlighten us on this phenomenon (14). In a sample of one hundred teens evaluated every 2 years and 5 times between the ages of 10 and 14, 54% to 75% (depending on the evaluation year) expressed a "desire for more sleep" (A higher percentage than adults, generally at 40%). This desire is always paired with what the authors have described as morning fatigue syndrome combining: fatigue when waking up, wanting to stay in bed longer, a need for more than 15 minutes to completely wake-up. This phenomenon does not seem to be the result of general sleep disorders but rather of multiple

factors. Only 3.3% of teens said they had enough sleep throughout the whole study. For the rest, the most striking finding is the extreme individual variability in time, with almost 15% of teens constantly wishing for more sleep.

Sleeping pills

According to a recent national adolescent survey in France, one out of every six teenager has used, during the year, medication for nervousness, anguish or insomnia. For girls, this tendency increases with age (1). Another study with students in Lyon indicates that among the students with chronic problems falling asleep, one out of ten (5% of boys, 12% of girls) have used sleeping pills more than once a week (12). This use is clearly influenced by family habits. Among these teenagers, 7% of boys and 16% of girls have diurnal sleeping urges on a regular basis.

*Hypnotics*, if they induce or maintain sleep bring a poorer quality of sleep (with differences depending on the molecule) (19). They alter the deep sleep which can eliminate stages III and IV and decrease the first stages. Thus, they oppose the organism's restoration and recuperation process. Some *hypnotics* decrease the paradoxical sleep (with dreams), and could affect long-term harmonization of lived experience and psychological history. Teens who regularly use sleeping pills may encounter the following: other than an artificial sleep resulting in a qualitative aggravation of the deficit, a rebound insomnia after medication is stopped, and maybe a *hypnotics* dependency, a vicious circle of chronic fatigue covering up anxiety. Finally, these medications can lead to accidents, especially road accidents that lead to high mortality in this age group.

## Growth, Diet and Energetic Balance

Puberty and growth

Is the explosive biological and physical maturation process during adolescence itself tiring?

This question, often evoked by teens' parents and surroundings, seems to have created some false ideas. It is true that growth is the most obvious characteristic at the beginning of adolescence. Nutritional and energy needs are superior to any other life stage. Starting at 10 years old for girls and 12 for boys (individual variations are great), growth acceleration reaches its maximum about 2 years later, and can reach more than 10 centimeters per year. Close to 15% of height and as much as 50% of adults "musculo-skeletic" mass is acquired during and following this acceleration phase (20).

A widely discussed and debated notion is that the teen is "growing faster than his or her strength", thus becoming weaker or more easily tired. This hypothesis has never been seriously proved. In fact, muscular mass increases proportionally until the ages of 12-13 for both sexes. After this age, for boys, muscular mass increases very rapidly. Muscular strength, already greater than girls, also increases. So it seems that puberty is a period of rapid gain of strength, physical ability and endurance without any "weakening" stage. However, growth acceleration and muscle development's peak comes one year before the development of muscular strength. During this period, we cannot expect from a teen, especially boys, the same strength as an adult of the same built.

Another frequent error comes from comparing teens by their age. That is how they are grouped in classes and sporting activities. This last point can be criticized when looked at by a strictly maturational point of view. It is illogical to expect the same performance of a 14 years old just starting puberty than you would from his cousin or classmate of the same age finishing his. The prejudice for the first boy is easy to imagine.

Diet, nutrition and energetic balance

A malnourished body is quickly tired: this is true for everybody no matter the age. For teenagers, in developed countries and when looking at global statistics, problems with energetic balance seems to be mistaken.

American nutritional guidelines are usually attained with an average diet (22). For boys, at onset and end of adolescence, they recommend respectively 2700 to 2800 calories and 45 to 56 grams of protein per day; for girls, 2,200 to 2,100 calories per day and 46 grams of protein. These numbers are an average. A teen that does a lot of sports will need more. We may

ask ourselves what about fast foods since it is quite popular with teens compared to home-cooked meals. At a dietary standpoint, it is far from being a catastrophe (23). Relatively inexpensive, their protein ration seems quite balanced and they provide enough calories (sometimes too much). Thus, sometimes a hamburger is better than a cake or a skipped meal.

We must admit teens generally go for foods that are simple and fun. They look at eating in its symbolic dimension, and like a way of experimenting and straying from family traditions. At a dietary standpoint, their choice of products only slightly differs from that of the general population (24).

Practically speaking, it is mostly nutritional errors that, during adolescence, can create real gaps in nutrition or fatigue. The most recent French epidemiological data, for teens, on eating habits and perceptions related to weight, speak for themselves (1). A typical example is breakfast. They sleep in, notice they are late so they leave without eating. But 20% of calories used by the body are consumed during the morning. This explains several discomforts that appear at the end of the morning. The importance of breakfast should be publicized, especially among teens. This meal should not only consist of sugar and butter but also protein and must contain at least 400 to 500 calories. Two studies have shown that skipping breakfast at that age has a negative effect on vigilance and concentration whereas it has a positive effect on memory skills (25, 26). Skipping lunch is not rare among certain teens and can contribute to the same consequences. For some, this may be the result of rejecting home-cooked meals, source of parental control (27). Another phenomenon is that of girls trying desperately to lose weight in an unbalanced and unsupervised way. This desired weight loss is sometimes achieved but it is always associated with a nutritional unbalance. Not including the beginning stages of anorexia nervosa (28), rapid weight loss always gives a sensation of general fatigue. Finally, a survey with 200 older teenagers shows that the more a girl's eating habits are unhealthy, the more she is likely to have other bad habits (tobacco, alcohol, absence of sports, etc…). This combination of risks concerns 1 out of 5 girls in this study which is quite alarming (29).

The role of iron

Out of all nutritional elements that are a direct source of fatigue, iron deserves a closer look.

We will not be looking at extreme lacks of iron. But the teen's muscular anabolism, to which we must add girls' menses, requires an additional amount of iron. These increased needs, about 1.6 mg /day for girls and 1.4 mg/ day for boys, are rarely covered by the adolescents normal diet so 70% to 95% of teens do not have the required amount of iron. That is why 12% of boys and 25% of girls show different degrees of deficiency (30, 31). Iron plays an important role in "musculo-skeletic" growth. Iron deficiency results in a decreased physical strength, endurance and an increase in fatigue, which is well documented among athletes.

## Fatigue in somatic pathologies

Fatigue can be associated with several somatic pathological conditions. Having said this, if infectious illnesses, severe organ illnesses or malignant afflictions are logically linked to fatigue, not all illnesses are.

During adolescence, a recent and general state of fatigue, especially if it's unusual or all the more so if accompanied by fever or other signs, first evokes a flu-like illness, an infectious mononucleosis or a viral hepatitis. We must also remember that a diabetic can be revealed by a general fatigue without the polyuria-polydipsy being apparent as well as pulmonary tuberculosis without the classic symptoms being apparent. More rarely, asthenia can reveal an anemia, hypothyroidism, etc. Post–hepatitis or post-mononucleosis asthenia are not myths. This is also true for authentic chronic fatigue syndromes, which, even if they are multifactorial, are often associated with post-viral infections (32, 33).

This said, certain *rest prescriptions* could perpetuate or create a fatigue. A prolonged immobilization due to a broken leg is also susceptible to induce this type of situation. This is also relevant for medical exemption from physical education classes, especially when they aren't justified.

Among chronic illnesses that occur during adolescence, which affects less than 10% of teens (34), fatigue poses a particular problem. Other than various physical handicaps that they can bring, varying from one illness and one stage to another, these illnesses can have noticeable subjective impact: anxiety, self-esteem, social competence, autonomy. However, we know that some adolescents tend to develop very efficient defenses (such as denial) against their real state. A complaint of fatigue in this type of context must make us systematically look at, other than a symptom linked to the illness' own evolution, the chronic illnesses psychological impact, or an asthenia of another origin.

## Fatigue and psyche during adolescence

Psychic fatigue

An adolescent *psychically tired* can present with evident fatigue. But with some adolescents, this fatigue can only be a vague complaint without any congruence between their statement and their non-asthenic appearance. This complaint should not be brushed off with general advice only. It may be hiding a more profound trouble of the psyche, which is even not accessible to the teen's conscience (35). This must especially be looked at when the complaint of fatigue comes from a third party (usually the mother) that initiated the consult.

No matter the situation, we must distinguish two different contexts:

Inhibition or over-excitement

A repeated complaint of fatigue, in its different forms, appears sometimes as inhibitions or "a functional limitations of the Ego" (36). A perfect example would be that of an intense and transient fatigue that appears at a precise moment of the day, reminding the teen of an unpleasant activity imposed by a parent, or a fatigue at school corresponding to a particular activity or class.

In other cases, this fatigue can appear in certain situations as a "super symptom" that replaces a multitude of symptoms, which their psychic conflict "absorption functions" are missing. Fatigue is therefore a type of shyness which the adolescent expresses easily during moments or activities that does not protect him or her against psychic conflicts.

With hysterical manifestations, a "fatigue" associated with a particular atmosphere or circumstance, can be expressed as the cause of the following symptoms: passing out, aches, hyperventilation, etc. It is then possible to imagine that this sensation, named fatigue afterwards, could have been caused by a controlled excitement, unmastered by the mind and expressed by the body.

Moroseness, fragility and "acting-out"

Here, the "fatigue" complaint is expressed in a less insistent though paradoxical way and is related to difficult emotional situations. When questioning the adolescent, a decrease or loss of emotional investment and an attitude of moroseness are noticed. This attitude isn't necessarily a depressive state but shows the adolescent's vulnerability confronted by circumstances, including familial, which cause depressive feelings, and shows the teen's struggle to overcome his or her fragility by acting-out. Separation anxiety can also exist and can be the cause of sleeping phobias. In reality, instead of secreting asthenia, the adolescent is searching for "tiring" behavior. In most severe cases, this vulnerability could result in a dangerous act such as a suicide attempt. For this adolescent, talking about his or her suffering is an intensely sensitive subject that he or she fears, being afraid by the feeling of not being able to resist depression. This is why this type of "fatigue" complaint – even discreet- deserves our full attention and a thorough analysis. The useless appearance of our intervention, as frustrating as it may seem, does not eliminate the opportunity for a preventive attitude. In certain cases, a professional placed in the path of this type of adolescent can be an unexpected lifesaver.

Adolescent's depressive state is often hidden, which only means that the classic symptoms are not apparent. A depressed teen can complain about sleeping problems: falling asleep, insomnia, nocturnal awakenings or premature awakenings. A self-depreciation could be hidden by irony. The loss of self-esteem can only surface through external signals or by a poor body image.

"Mental Fatigue" among adolescents should always be taken seriously and be considered as a rupture of balance and, sometimes, as a signal of a possible dangerous impulse.

Contextual elements

In a clinical context, sleep problems rarely appear isolated and are usually a consequence of other problems, either personality disorders or environmental problems or both.

But studies on this type of correlation are rare. A recent French study with 713 students ranging from 15 to 23 years of age clearly confirms the frequency of this type of association (Vignau Jet coll, 1997). The adolescents were separated in 2 groups, depending on how they answered 5 questions pertaining to difficulties falling asleep, precarious awakenings, the feeling of needing more sleep, the poor quality of sleep and the use of medication for sleeping. Compared to good sleepers (see Table 2) poor sleepers reported suicidal thoughts more often, prior suicide attempts, disrupted family relationship and mothers experiencing problems. Certain deviant behaviors were also more frequent.

This study also shows that sleep problems among teenagers living alone or in a foster home are constant; whereas, they are absent in 60% of those living at home with their parents. All of these contextual elements are important, even through they don't draw a formal conclusion on their causal links. However, they offer interesting leads for detection and prevention.

## Conclusion

When teenagers are consulting, fatigue is a frequent complaint if we systematically ask them about it. Looking into the possibility of this symptom often represents for the adolescent an interesting way to send a message during the consultation, no matter the initial motive. Sometimes a witness to a physiological unbalance, this fatigue can be inflicted on or produced by the adolescent.

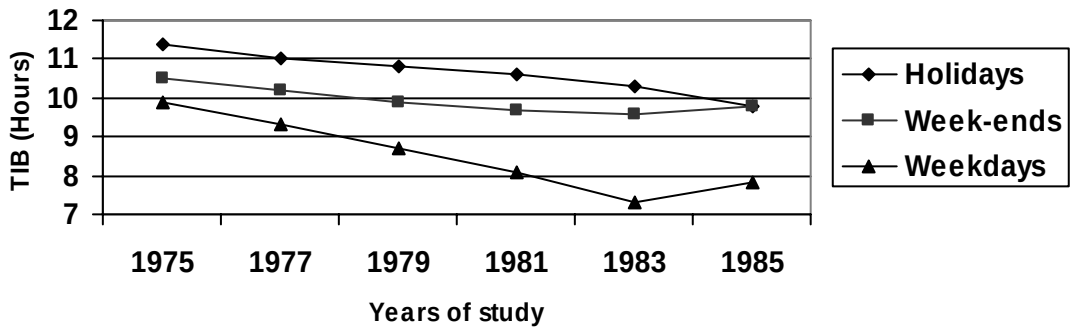
This overview on fatigue does not claim to bring pertinent answers to this crossroad symptom (37). Rather, its goal is to synthesize principal factors that are linked to fatigue and can help explain it. A fatigue complaint, whether vague, discreet or only subjective should not be quickly dismissed. Also, it shouldn't be dreaded nor treated like an isolated manifestation. The teen's environment can bring important elements to the analysis of this symptom. Its significance and relationships can only be correctly evaluated with a complete health assessment over a sufficient period of time during the consultation.

| Table 1: Sleep and tiredness among adolescents | | | |
|---|---|---|---|
| **Frequent or very frequent troubles** | **% adolescents** | **♀ > ♂** | **With age** |
| Trouble to get asleep | 41 | + | |
| Awaken during night | 19 | + | + ♀ |
| Nightmares | 9 | + | |
| | | | |
| Waking up tired | 50 | | + |
| Sleepy during the day | 7 | | |
| Sensation of tiredness | 43 | | + |

**Table 2:** Frequency of significant contextual variables correlated with the quality of sleep among adolescents (both sexes).

| Associated Variables | Good Sleepers (N = 439) | Poor Sleepers ( N = 302) |
|---|---|---|
| Suicidal thoughts | 15% | 38% |
| Suicide attempts | 1% | 9% |
| Been drunk | 31% | 39% |
| Theft | 21% | 29% |
| School absenteism | 31% | 40% |
| Disrupted family relationships | 4% | 17% |
| Problems among mothers:<br>- Depression | 18% | 30% |
| - Psychotropic treatment | 22% | 31% |
| - Somatic illness | 8% | 20% |

## Figure 1: Time spent in bed during weekdays, Weekends and Holidays



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