The Society for Adolescent Health and Medicine (SAHM) Annual Meeting

New Orleans, USA, 14th – 17th March 2012

"Impact of Trauma on Teens: Building the Safety Net"

In 2012, 684 adolescent health professionals – including a significant number of UK and international members – met in New Orleans. This meeting provides clinical, policy and research activities for delegates through plenary panels, workshops/institutes, 'hot topics' and research in the form of platform and poster sessions. This report will cover a cross-section of these activities that were directly helpful to me in my service to adolescents, primarily as a researcher and policymaker.

The Gallagher Lecture - "Preventing violence and bullying through social-emotional and character development: Theory and results from randomised trials" (Dr Brian Flay, Oregon State University)

Dr Flay drew on a complex psychological model – the 'Theory of Triadic Influence' – to help us to understand the factors that influence violent behaviour. These factors relate to three important aspects of a young person's life: intraPersonal, social Situation, and Environment (PSE). The relative importance of each aspect, as an influence on the development of behaviour patterns, changes over time. Dr Flay described interventions that have been designed around this 'Theory of Triadic Influence'.

The focus of these interventions was primarily to maximise intrinsic, rather than extrinsic, motivation for young people to adopt good behaviours – essentially to 'feel good when you do positive actions' and vice versa. The Positive Action Programme (http://www.positiveaction.net/) has six unit concepts as below:

- Unit 1: Self-Concept. What It Is, How It's Formed, and Why It's Important (Philosophy and Circle)
- Unit 2: Positive Actions for your Body and Mind
- Unit 3: Managing Yourself Responsibly
- Unit 4: Treating Others the Way You Like to be Treated (Social Skills and Character)
- Unit 5: Being Honest with Yourself and Others (Mental Health)
- Unit 6: Improving Yourself Continually (Setting and Achieving Goals)

The intervention is school-based, for primary and middle school students, incorporating 140 x 15-minute lessons provided over 6 years of school. There are options to extend the scheme to include parents (shared homework!) and wider communities. The trials were done in two contrasting areas: Hawaii and Chicago.

In Hawaii, there were substantial positive effects on absenteeism, suspensions and SAT reading scores. In Chicago, different significant positive effects were seen on substance use, food and exercise, and hygiene behaviours. Moreover, the effects increased over time as the young person went through adolescence and got the steady 'drip' of lessons throughout their schooling.

Dr Flay concluded that school-wide social character development education can be effective: it increases multiple positive behaviours, decreases multiple negative behaviours, and increases academic outcomes.

He made the point that violence and other antisocial behaviours have common early causes. Education like this needs to start in primary school. Family and community involvement can improve outcomes, and the intervention has the strongest effects for those who really need it.

Plenary Session - Violence and Injuries in Adolescents: From Global Perspectives to Practical Responses (Prof Russell Viner (UK); Dr Shanthi Ameratunga (New Zealand); Dr Richard Catalano (USA))

Russell Viner opened this plenary session with an overview of global data concerning adolescent injuries for young men aged 15-19. It was enlightening to see the different patterns in types of injury between different regions:

- In OECD countries (excluding USA), there is relatively low mortality but injuries are split between violence, transport, suicide and other self-reported causes;
- In the USA we see relatively more injury from transport and violence;
- In Russia we see more injury from violence and suicide
- In New Zealand, suicide and transport injury is notable
- In Venezuela, the injuries skew sharply towards violent causes, with very little suicide

Another analysis showed that, in 50 countries over a significant recent period of time, the mortality rate of 15-19 year-old men has started to exceed that of male children aged 1-4 years.

When looking at the causes of mortality for young men aged 15-19 in OECD countries, over the period from 1955 to 2005, communicable diseases have been wiped out BUT suicide and violence have increased.

The recent WHO report on social determinants of health (http://www.who.int/social_determinants/en/), led by Sir Michael Marmot, comments on the distribution of wealth. Analyses by Prof Viner of international data had led to the following statements:

- National wealth benefits young children, but does less for adolescents
- Rapid economic development blunts falls seen in injury mortality
- Secondary education protects against injury mortality
- Inequalities are linked to violence mortality
- Suicide is not related to social determinants
- Health spending by a country is not related to injury mortality

Dr Ameratunga focused on road traffic accidents, the leading killer of young people globally. She quoted Dr C. Everett Koop, former US Surgeon General, who had said about injury that if *"some infectious disease came along that affected one out of every four children in the United States, there would be a huge public outcry and we would be told to spare no expense to find the cure – and to be quick about it."*

She cited milestones in the battle against road traffic injury and deaths, highlighting Ralph Nader's book "Unsafe at any speed", and William Haddon's matrix that detailed interventions for helping people pre-crash, during a crash and post-crash related to the host, the agent/vehicle, and the environment.

Worldwide, 1.2 million people die each year in road traffic accidents, and one-third to one-half of these are adolescents. The Red Cross and Red Crescent Societies have called this situation "a worsening global disaster" and a "poverty trap" (http://www.redcross.int/EN/mag/magazine2005_2/4-9.html).

When looking at fatalities in road accidents, in low to middle income countries (LMIC) more pedestrians and motorcyclists die than car occupants. In the absence of road infrastructure improvement in these

countries, this also reflects a statement from the WHO report – "Why treat people, then send them back to the conditions that made them sick?"

There is also a trend in LMIC that young people see cars as the new 'must-have'. A syndrome among youth in Africa has been called "I must drive" (http://www.youthforroadsafety.org/activities/news/news_item/t/brian_s_column_the_i_must_drive_syndrome_hitting_africa_youth)

YOURS (Youth for Road Safety http://www.youthforroadsafety.org) gives young people a voice on these issues. YOURS says that, generally, young people do not have a strong voice in discussions about road safety, nor is there significant youth participation in decision-making on this issue. YOURS has developed some highly effective "surreal poster" communication materials for young people http://www.youthforroadsafety.org/media/downloads

The key message echoed William Haddon's conviction that road traffic incidents were largely predictable, and therefore preventable. More investment was needed in research. Ruefully, Dr Ameratunga reflected that if there were a possibility of a drug or vaccine that could treat the cause, more investment may be forthcoming!

Dr Catalano spoke on violence perpetration and prevention, with a focus on the USA. Globally, violence is the second cause of death for young men aged 10-24 (it is not within the top ten causes for women of the same age, but comes out as the third cause of death overall across both genders).

In the US, a 'bulge' of violence takes place in the mid-teens for both males and females, with black youth greater than white as well. An early onset of violent behaviour is more likely to predict persistent offenders. Risk factors for violent behaviour are widespread:

- Community – drugs, firearms, social norms, media, low attachment, extreme deprivation;
- Family – History of violence, management, conflict, parental attitudes
- School – Academic failure, lack of commitment
- Individual/Peer – Early antisocial behaviour, friends' attitudes

Patterns of exposure to risk, leading to violence, can follow two patterns:

- 'Snowball' – Accumulation of risk over time
- 'Snowstorm' – Extreme exposure without protection

Effective interventions to reduce violent behaviour include: early childhood education; parent education; after school recreation; classroom curricula; classroom management strategies; positive youth development; media education and even better housing initiatives. Indeed, some preschool programmes have shown beneficial effects out to age 40! It is never too early, and never too late to intervene, but later intervention is likely to be more costly.

Hot Topic Session – Developing and implementing comprehensive teen dating violence prevention in high-risk urban communities – "Dating Matters" (Dr Andra Teten Tharp, US CDC)

Teen dating violence (TDV) can take many forms including emotional/psychological harm, physical harm, sexual harm and stalking. It can be perpetrated electronically or in person. In the US Youth Risk Behavior

Survey (YRBS), 10% of youth reported being a victim of TDV in the past year. There was no gender difference in overall TDV experience, but girls experience more physical and sexual harm than boys.

One in 5 women, and 1 in 7 men, report ever having experienced dating violence, and their first experience of dating violence tends to be between the ages of 11 and 17, so adolescence is a crucial period for intervention.

The CDC "Dating Matters" programme http://www.cdc.gov/violenceprevention/DatingMatters/index.html engages young people, parents, teachers, neighbourhoods and public health professionals in high-risk urban communities. The goals of the programme are to promote respectful relationships, and to reduce TDV of all kinds. The programme is targeted at middle-school students aged 11-14. It takes a whole school approach. There are other risk behaviours associated with TDV, such as substance misuse and unsafe sex, so the programme is comprehensive to cover these issues. It works on a "high dose of prevention", and draws upon developmental psychology.

Young people experiencing TDV have usually also experienced other forms of victimisation e.g. bullying, and they need coping skills to avoid future harm: a recent study indicated that 100% of TDV victims had experienced other forms. The programme provides both primary and secondary prevention of TDV.

"Parents Matter for Dating Matters" is an adjunct programme. There are parenting factors that increase the risk of TDV, such as harsh parenting.

Young people were heavily engaged in the communications side of "Dating Matters", creating the brand, shaping social media and text campaigns, and doing State policy work.

Another good resource for violence prevention is www.vetoviolence.org

Workshop – "Navigating the Pipeline from Research to Policy: Building an Advocacy Base for Research-informed Adolescent Health Policy" (Drs Charlotte Gaydos and Lana Lee)

In this workshop, we were provided with a case study that would stimulate discussion about advocacy efforts informed by research. This case was that impending legislation would mean that students attending a nurse-led school-based clinic would have to seek consent from parents to have tests and treatment. The nurse believed that this would deter students who wished to visit for confidential advice about sexual health and other sensitive issues. The task for the group was to identify how this nurse might start an advocacy effort to stop this piece of legislation.

We discussed a number of issues that could be applied to a range of advocacy efforts:

- Who are the people with the power to influence the passing of the legislation?
- Understanding the levers that can influence those with power e.g. gaining re-election, not wanting to look stupid;
- Recognising that the staff members supporting the legislators tend to be young people, who are likely to identify with the issue and might be open to discussion;
- The power of starting with a story about someone with whom the audience would identify, to complement statistical data and to keep the human focus;
- Knowing the evidence base (and the counter-evidence base to prepare for challenge!);

- Realising that – in cases like this where sensitive and complex issues are involved – ideology may render the evidence almost useless;
- Being able to negotiate a deal where one part of legislation is dropped in order to pass a larger bill that could have the full support of the people who negotiated the deal (in this case, it was the 'Family Unification Bill' that would prevent confidential visits – youth health professionals support the role of the family, and could support most of it wholeheartedly, but not the bit that would prevent young people visiting the clinic!).

In the case given, we realised that it was very important to engage parents as spokespeople supporting a need for confidential access, as the legislators may think that they are protecting parents by forcing this legislation through. Recognising that this is not an ideal world, some young people will never be able to talk to their families about unplanned pregnancy or STIs.

I found this session invaluable for developing future strategies to influence evidence-based policy about young people's health.

There were 2 sessions where I had a leadership role. We ran a meeting of the ***Qualitative Research Special Interest Group. The topic was about the role of theory to underpin qualitative research studies***. We recognised 4 roles of theory in this endeavour:

- As a hypothesis generating, inquiring driving force
- As a way of explaining/complementing findings that have already been generated from data
- As a product of qualitative research
    - The case of grounded theory
- As something modified by qualitative work
    - To change it and refine it and/or to adapt it to new circumstances

I particularly like a quote by Kristin Montgomery (2002, please see Appendix) in a nursing research article: "A guiding theoretical framework in research serves not only to guide a single research study, but also to link previous and future research that is guided by the same framework." That feeling of being part of something bigger with your modest research study has always appealed to me.

We talked about structure and agency, and how your theoretical perspective was likely to be influenced by your relative emphasis on structure or agency in the problem under investigation. For example, studies of smoking prevention among adolescents might emphasise structure if looking at tobacco legislation or advertising, but agency if looking at individual protective factors.

We also noted that many naturalistic qualitative methods implicitly privilege the individual's point of view, and that the 'classic toolkit' of interviewing, ethnography etc were a product of symbolic Interactionist sociologists.

We provided examples of studies where theory has influenced analysis of data. I had asked Dr Ann Hagell, Editor of the Journal of Adolescence, for some thoughts for the session, and she reflected - from the manuscripts that she receives - that:

- Qualitative work *does not, by definition, test theory*, so it is quite hard sometimes to unpick the underlying perspectives informing the work as they may not be terribly explicit.

- The interpretation of the qualitative data are often set within a theoretical framework *towards the end* of the piece, rather than necessarily being part of the investigation from the outset.
- It is about *informing the questions and the conclusions*, rather than being something that is confirmed or otherwise by the research, given the exploratory & inductive nature of qualitative work.

This might encourage us to strengthen our enquiry with prospective use of theory. One attendee said that she had gone around different disciplinary departments in her University to 'pitch' her young people's health study, and that this had resulted in the suggestion of several approaches incorporating theory, including those from business and communications schools. Talking to colleagues is invaluable: one can never know all the theories, or how to apply them!

A list of resources that we circulated to the SIG members is attached as an appendix to this report.

I also moderated the last ***Platform Research Session entitled "Pregnancy and Substance Use"***. The presentations were eclectic and interesting.

Dr Brian Primack (Pittsburgh) presented two fascinating papers about tobacco use. The first explored adolescent exposure to smoking in the movies. Their study found that early exposure to smoking in the movies was strongly associated with the likelihood of being a young smoker. He was asked whether smoking was seen mostly in 'R' movies, but their study had found that all types of movies from 'PG' could have images of smoking. Brian's second paper looked at clean air legislation and hookah smoking. It showed that legislative loopholes allow hookah smoking in bars and cafes in most major cities in the USA, despite the toxicity of hookah smoke. He also showed qualitative quotes from young people saying how much easier it was to smoke using a hookah than cigarettes, and how pleasant it was. The group concluded that this was a major cause for concern, needing extensive advocacy and public outcry as the tobacco lobbies were incredibly strong.

Dr Jennifer Louis-Jacques (Boston) presented a paper about the effect of friends on an alcohol intervention. Her study concluded that a primary care intervention was actually more effective for young people who had 'risky friends', possibly because of salience effects and as a counterbalance measure.

Dr Patti Cavazos (Washington) presented on students' perceptions of school-based prevention efforts related to their substance use. Her analysis indicated that, in schools where there was perceived to be a strong effort to prevent/punish substance use, students were less likely to use. Although causality could not be confirmed, this suggested that the impact of such efforts should be emphasised and encouraged.

Dr Susan Rubin (NYC) explored doctors' experiences of providing long-acting reversible contraception to adolescents. Her qualitative study suggested that doctors from different training backgrounds felt different levels of comfort about offering these methods to young women. There were also issues with having the necessary products in the practice, not least as these items were expensive. Another main theme from her data was a competing concern – that if they used LARC to prevent pregnancy, then young people would not protect themselves against STIs (this was disputed strongly by the audience!). Providers also wanted clear guidelines for use in young women. Dr Rubin, and many others in the audience, felt strongly that these 'non-forgettable' forms of contraception should be offered routinely to young women.

Dr May Lau (Texas) presented an interesting paper about the characteristics of young men who have fathered a child. The audience felt strongly that we did not know enough about teenage fathers and that there should be more studies to help us to understand the context for young men who impregnate their partners.

As this report shows, the conference offers a smorgasbord of stimuli and contacts for inspiring and developing work around young people's health. I attended my first SAHM meeting in 2002, as a Commonwealth Fund Harkness Fellow based in Rochester, NY, and I have derived great benefit from this international group. This meeting, yet again, gave me insights and ideas that are as relevant to UK youth as those from the US and beyond. I look forward to making good use of these ideas over the next 12 months.

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Appendix – Qualitative Research SIG Resource – Ideas for theories and models that have been applied to health and social science research about adolescence.

Many thanks to Dr Ann Hagell, Editor – Journal of Adolescence, for her input.*

***Adolescent attachment**. It is something that is becoming of more interest currently, and is a big deal amongst practitioners. Based on models of attachment, studies do things like explore how attachment to parents can be related to attachment to others outside the family & how this might influence behaviour, etc.
Hogan NS et al. Things that help and hinder adolescent sibling bereavement. Western Journal of Nursing Research 1994; 16: 132-53.

Feminism. This is a collection of movements aimed at defining, establishing, and defending equal political, economic, and social rights for women (http://en.wikipedia.org/wiki/Feminism). In addition, feminism seeks to establish equal opportunities for women in education and employment.
Tolman DL et al. Looking Good, Sounding Good: Femininity ideology and adolescent girls' mental health. Psychology of Women Quarterly 2006; 30: 85-95.

***Identity development**. These theories were what really started to kick off studies of adolescence in some quarters - Erikson, Marcia, Waterman. They began to propose stages that people go through, much refined in the 1980s and 1990s, and still the basis of lots of qualitative investigations.
e.g. Hutnik N & Coran Street R. Profiles of British Muslim identity: Adolescent girls in Birmingham. Journal of Adolescence 2010; 33: 33-42.
Meek R. The possible selves of young fathers in prison. Journal of Adolescence 2011; 34: 941-9.

Nutbeam's model of Health Literacy. A robust view of health literacy includes the ability to understand scientific concepts, content, and health research; skills in spoken, written, and online communication; critical interpretation of mass media messages; navigating complex systems of health care and governance; and knowledge and use of community capital and resources, as well as using cultural and indigenous knowledge in health decision making. (http://en.wikipedia.org/wiki/Health_literacy)
Gray NJ et al. The Internet: A window on adolescent health literacy. Journal of Adolescent Health 2005; 37: 243.e1-e7.

Postmodernism (e.g. writings of Michel Foucault). Postmodernity (also spelled post-modernity or termed the postmodern condition) is generally used to describe the economic or cultural state or condition of society which is said to exist *after* modernity. Some schools of thought hold that modernity ended in the late 20th century, in the 1980s or early 1990s replaced by postmodernity, while others would extend modernity to cover the developments denoted by postmodernity.
(http://en.wikipedia.org/wiki/Postmodernity)
Biering P. Caring for the involuntarily hospitalized adolescent: the issue of power in the nurse-patient relationship. Journal of Child and Adolescent Psychiatric Nursing 2002; 15: 65-74.

Risk Society. This is a term that emerged during the 1990s to describe the manner in which modern society organises in response to risk. The term is closely associated with several key writers on modernity, in particular Anthony Giddens and Ulrich Beck. (http://en.wikipedia.org/wiki/Risk_society)
Skidmore D & Hayter E. Risk and sex: Ego-centricity and sexual behaviour in young adults. Health, Risk and Society 2000; 2: 23-32.

Schema / Everyday Memory Theory. A schema, in psychology and cognitive science, describes any of several concepts including: An organized pattern of thought or behavior; A structured cluster of pre-conceived ideas; A mental structure that represents some aspect of the world; A specific knowledge structure or cognitive representation of the self; A mental framework centering on a specific theme that helps us to organize social information; Structures that organize our knowledge and assumptions about

something and are used for interpreting and processing information.
(http://en.wikipedia.org/wiki/Schema_(psychology))

Gray NJ et al. 'Health repertories': an understanding of lay management of minor ailments (young adults aged 16-24). Patient Education & Counseling 2002; 47: 237-44.

***Social capital**, and social bonds. Studies of what young people get from different kinds of relationships, or rules governing their behaviour in certain situations, interpreted in terms of how they are maximizing their social capital or strengthening social bonds.
e.g. Gwadz MV et al. The initiation of homeless youth into the street economy. Journal of Adolescence 2009; 32; 357-77.
Perez BF & Romo HD. "Couch surfing" of Latino foster care alumni: Reliance on peers as social capital. Journal of Adolescence 2011; 34: 239-48.
Godenzi A et al. Toward a gendered social bond/male peer support theory of university woman abuse. Critical Criminology 2001; 10: 1-16.

Social Cognitive Theory. Social cognitive theory, used in psychology, education, and communication, posits that portions of an individual's knowledge acquisition can be directly related to observing others within the context of social interactions, experiences, and outside media influences.
(http://en.wikipedia.org/wiki/Social_cognitive_theory)
Bandura. Health promotion from the perspective of social cognitive theory. Psychology in Health 1998; 13: 623-49.
Contento IR et al. Adolescents demonstrate improvement in obesity risk behaviors following completion of Choice, Control, and Change, a curriculum addressing personal agency and autonomous motivation. Journal of the American Dietary Association 2010; 110: 1830-9.

***Social ecology**. This is something growing in the literature; interpreting individual's meanings & behaviours, or those of dyads, in terms of the broader social context; quite a lot on the school environment.
Stevens JW. The social ecology of the co-occurrence of substance use and early coitus among poor, urban black female adolescents. Substance Use & Misuse 2001; 36: 421-46.

Symbolic Interactionism. This is a sociological theory that places emphasis on micro-scale social interaction to provide subjective meaning in human behaviour. The approach focuses on creating a framework for building a theory that sees society as the product of the everyday interactions of individuals.
(http://en.wikipedia.org/wiki/Symbolic_interactionism)
Peterson GW. Role Transitions and role identities during adolescence: A symbolic interactionist view. Journal of Adolescent Research 1987; 2: 237-54.

Theory of Planned Behavior. This states that attitude toward behavior, subjective norms, and perceived behavioral control, together shape an individual's behavioral intentions and behaviors.
(http://en.wikipedia.org/wiki/Theory_of_planned_behavior)
Harakeh Z et al. Parental factors and adolescents' smoking behavior: an extension of the theory of planned behavior. Preventive Medicine 2004; 39: 951-61.

Mixed theory.
Wagenaar AC & Perry CL. Community strategies for the reduction of youth drinking: Theory and application. Journal of Research on Adolescence 1994; 4: 319-45.
Montgomery KS. Health promotion with adolescents: Examining theoretical perspectives to guide research. Research and Theory for Nursing Practice 2002; 16: 119-34.