



HÄLSO  
UTSKOTTET



# Program & abstracts

12-14 april 2010

State of the Science-konferens  
Trender i barns och  
ungdomars psykiska hälsa



## HÄLSO UTSKOTTET

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State of the Science Konferens

# Trender i barns och ungdomars psykiska hälsa

12-14 april 2010

Beijersalen  
Kungl. Vetenskapsakademien

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## Bakgrund

År 2006 tillsatte Kungl. Vetenskapsakademien (KVA) ett Hälsoutskott med uppgift att arbeta med "Den upplevda ohälsan under skoltiden - utveckling, mätning och förslag till åtgärder". Utgångspunkten var de rapporter om ökad psykisk ohälsa bland unga som återkommande presenterats sedan den ekonomiska krisen i Sverige vid mitten av 1990-talet. En offentlig bild har vuxit fram av att allt fler unga i Sverige mår allt sämre psykiskt. Den bilden präglar såväl den politiska debatten som mediernas rapportering. Bland forskare har det diskuterats och ifrågasatts i vilken utsträckning sådana beskrivningar har stöd i undersökningar.

Syftet med Hälsoutskottets arbete är att systematiskt kartlägga och granska kunskapsläge och att därmed ge underlag, evidens och incitament till åtgärder som kan förebygga psykisk ohälsa och främja psykisk hälsa bland barn och ungdomar. Huvuduppgiften är att anordna två state of the science konferenser 2010. Konferenserna liknar i upplägget de konferenser som i USA anordnas av National Institutes of Health. Förutom konferensen den 12-14 april om Trender i barns och ungdomars psykiska hälsa anordnas den 26-28 april en konferens om Skola, lärande och psykisk hälsa. Statens beredning för medicinsk utvärdering (SBU) har också i samverkan med KVA genomfört en systematisk litteraturgenomgång avseende metoder för prevention av psykisk ohälsa hos barn i skolåldern. Därutöver anordnar KVA och SBU den 26 maj en policyinriktad hearing om vad som bör göras för att främja psykisk hälsa och förebygga psykisk ohälsa bland unga.

## Förberedelser och genomförande

Konferensen om Trender i barns och ungdomars psykiska hälsa har förberetts av en planeringskommitté och av en arbetsgrupp, båda tillsatta av Hälsoutskottet. Arbetsgruppen har sedan hösten 2008 systematiskt "dammsugit" och granskat den existerande litteraturen om trender i barns och ungdomars psykiska hälsa i Sverige. Det gäller såväl artiklar publicerade i vetenskapliga tidskrifter som avhandlingar och rapporter.

Arbetsgruppen kommer under konferensens första dag att presentera en systematisk litteraturoversikt. Under konferensen ger också experter sin syn på frågan om förändringar över tid av ungas psykiska hälsa. Tillsammans med synpunkter från åhörarna ger detta ett underlag för en oberoende konferenspanel att uttala sig om vilka förändringar som ägt rum över tid i barns och ungdomars psykiska hälsa. Under konferensen kommer panelen att förbereda och presentera ett state of the science uttalande med svar på konferensens huvudfrågor:

1. Hur har barns och ungdomars psykiska hälsa förändrats över tid i Sverige?
2. Föreligger det regionala och/eller sociodemografiska olikheter med avseende på förändringar i barns och ungdomars psykiska hälsa i Sverige?
3. Hur skiljer sig förändringar i barns och ungdomars psykiska hälsa i Sverige utifrån olika definitioner av psykisk hälsa och olika informationskällor?
4. Vilka frågor och områden bör den framtida forskningen fokuseras på?

Konferensen kommer att hållas i Beijersalen vid Kungl. Vetenskapsakademien.

Gunnar Öquist  
Ständig sekreterare  
Kungl. Vetenskapsakademien

Arne Wittlöv  
Ordf. i Kungl. Vetenskapsakademiens  
Hälsoutskott

**MÅNDAG 12 APRIL****13.00 Konferensens öppnande**

*Prof. Gunnar Öquist, ständig sekreterare, Kungl. Vetenskapsakademien*  
*Dr. Arne Wittlöv, ordförande i Kungl. Vetenskapsakademiens*  
*Hälsoutskott*  
*Prof. Stig Wall, ordförande i konferenspanelen*

**13.30 Trender i barns och ungdomars psykiska hälsa i Sverige**

Presentation av systematisk kunskapsöversikt  
*Prof. Bruno Hägglöf, ordförande i arbetsgruppen för systematisk*  
*kunskapsöversikt*

Frågor och kommentarer

**15.00 Paus****15.30 Resultat från några svenska studier**

Nationell mätning av psykisk hälsa i årskurs 6 och 9  
*Docent Sven Bremberg, Statens folkhälsoinstitut och docent Curt*  
*Hagquist, föreståndare för Centrum för forskning om barns och*  
*ungdomars psykiska hälsa, Karlstads universitet*

Frågor och kommentarer

Trender över 20 år i självskattad psykisk hälsa  
*Docent Curt Hagquist, föreståndare för Centrum för forskning om barns*  
*och ungdomars psykiska hälsa, Karlstads universitet*

Frågor och kommentarer

Brott och problembeteenden bland ungdomar i årskurs nio enligt  
självdeklarationsundersökningar 1995-2008  
*Fil dr Jonas Ring, Brottsförebyggande rådet*

Frågor och kommentarer

**Avslutande diskussion****17.30 Ajournering – panelen sammanträder**

## TISDAG 13 APRIL

### 09.00 Barns och ungdomars psykiska hälsa belyst från olika perspektiv

How listening to the voices of children and young people should inform policy, practice and public attitudes to improving their mental and emotional health - perspectives from England  
*Prof. Sir Al Aynsley-Green, Children's commissioner in England*

The experiences and perceptions of mental health and well-being of Swedish children and youth: results from a review of qualitative studies  
*Docent Mara Westling Allodi, Specialpedagogiska institutionen, Stockholms universitet*

A methodological perspective on trends in child and adolescent mental health  
*Prof. Måns Rosén, chef för Statens beredning för medicinsk utvärdering*

Questions and comments

### 11.00 Paus

### 11.30 Internationella trender i barns och ungdomars psykiska hälsa

Time trends in child and adolescent mental health  
*Prof. Sir Michael Rutter, Institute of Psychiatry, London*

Changes over time in young people's mental health – a social perspective  
*Research Scientist Helen Sweeting, Medical Research Council, Social and Public Health Sciences Unit, Glasgow*

Questions and comments

### 13.00 Lunch

### 14.00 Förändringar över tid i självmord bland barn och ungdomar i Sverige

*Prof. Bengt Haglund, Socialstyrelsen*

Frågor och kommentarer

**14:45** Den vetenskapliga evidensen om att förebygga  
suicidala handlingar hos barn och ungdomar

*Prof. Danuta Wasserman, chef för Nationell prevention av  
suicid och psykisk ohälsa, Karolinska Institutet*

Frågor och kommentarer

**15.30** Ajournering - panelen sammanträder

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## **ONSDAG 14 APRIL**

**09.30** Presentation av State of the Science uttalande

**10.00** Diskussion i plenum

**11.30** Panelen sammanträder för slutligt ställningstagande / lunch

**14.00** Uttalande presenteras vid presskonferens

**15.00** Konferensen avslutas

## Bidragsgivare

Hälsoutskottets projekt är finansierat med bidrag från följande stiftelser och organisationer:

- Bristol Myer Squibb
  - Familjen Erling-Perssons Stiftelse
  - FAS - Forskningsrådet för arbetsliv och socialvetenskap
  - Kungl. Vetenskapsakademien
  - Riksbankens Jubileumsfond
  - Stiftelsen Clas Groschinskys minnesfond
  - Stiftelsen Kempe-Carlgrenska Fonden
  - Stiftelsen Marcus och Amalia Wallenbergs minnesfond
  - Stiftelsen Sven Jerrings Fond
  - Svenska Läkaresällskapet
  - Vetenskapsrådet
- 

## Panelledamöter

Stig Wall, ordförande i panelen, prof i epidemiologi och folkhälsovetenskap, Umeå universitet

Kristina Alexanderson, prof i Socialförsäkring vid institutionen för klinisk neurovetenskap, Karolinska Institutet

Fredrik Almqvist, prof i barn- och ungdomspsykiatri, Helsingfors universitet

Margareta Blennow, Barnhälsovårdsöverläkare, Sachsska Barnsjukhuset, Södersjukhuset, Stockholm

Gisela Dahlquist, prof i pediatrik, Umeå universitet

Anders Ekbohm, prof epidemiologi, Karolinska Institutet

Anne Fisher, prof arbetsterapi, Umeå universitet

Urban Janlert, prof folkhälsovetenskap, Umeå universitet

Michael Tåhlin, prof i sociologi, Stockholms universitet

## Föredragshållare

Prof Gunnar Öquist, ständig sekreterare, Kungl. Vetenskapsakademien

Dr Arne Wittlöv, ordförande i Kungl. Vetenskapsakademiens Hälsoutsnitt

Prof Stig Wall, ordförande i konferenspanelen

Prof Bruno Hägglöf, ordförande i arbetsgruppen för systematisk kunskapsöversikt

Docent Sven Bremberg, Statens folkhälsoinstitut

Docent Curt Hagquist, föreståndare för Centrum för forskning om barns och ungdomars psykiska hälsa, Karlstads universitet

Fil dr Jonas Ring, Brottsförebyggande rådet

Prof. Sir Al Aynsley-Green, Children´s commissioner in England

Docent Mara Westling Allodi, Specialpedagogiska institutionen, Stockholms universitet

Prof Måns Rosén, chef för Statens beredning för medicinsk utvärdering

Prof Sir Michael Rutter, Institute of Psychiatry, London

Research Scientist Helen Sweeting, Medical Research Council, Social and Public Health Sciences Unit, Glasgow

Prof Bengt Haglund, Socialstyrelsen

Prof Danuta Wasserman, chef för Nationell prevention av suicid och psykisk ohälsa, Karolinska Institutet

## Planeringskommittén

Curt Hagquist, ordf, docent i folkhälsovetenskap, Karlstads universitet

Håkan Stattin, professor i psykologi, Örebro universitet

Anders Hjern, professor i pediatrik epidemiologi, Socialstyrelsen

Viveca Östberg, docent i sociologi, CHESS, Stockholm universitet/KI

Ann-Charlotte Smedler, docent i psykologi, Stockholms universitet (repr FAS)

Marianne Cederblad, professor emerita i barn- och ungdomspsykiatri, Lunds universitet

Olle Söder, professor i pediatrik, KI

Anne-Liis von Knorring, professor i barn- och ungdomspsykiatri, Uppsala universitet

Peter Friberg, professor i klinisk fysiologi, Göteborgs universitet

Stig Wall, professor i epidemiologi och folkhälsovetenskap, Umeå universitet (ordförande i panelen för rubr konferens)

Per-Anders Rydelius, ordförande i planeringskommittén för konferensen Skola, lärande och psykisk hälsa 26-28 april

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## Kungl. Vetenskapsakademiens Hälsoutskott

Dr. Hc. Arne Wittlöv, ordförande

Professor Leif Andersson, Institutionen för medicinsk biokemi och mikrobiologi, Uppsala universitet

Görel Bråkenhielm, f.d. överläkare vid Skolhälsovården Stockholms stad

Professor Per-Anders Rydelius, Institutionen för Kvinnors och Barns Hälsa, Karolinska Institutet

Professor Olle Söder, Institutionen för Kvinnors och Barns Hälsa, Karolinska Institutet

Professor Lars Terenius, Institutionen för Klinisk Neurovetenskap, Karolinska Institutet

Professor Denny Vågerö, CHESS, Centre for Health Equity Studies, Stockholms Universitet/ Karolinska Institutet

Projektledare: Docent Curt Hagquist, Centrum för forskning om barns och ungdomars psykiska hälsa, Karlstads universitet.

## **Arbetsgruppen för systematisk kunskapsöversikt om barns och ungdomars psykiska hälsa i Sverige**

Bruno Hägglöf, (ordförande) professor i barn- och ungdomspsykiatri, Umeå universitet

Solveig Petersen, (projektledare) med dr i pediatrik, Umeå universitet

Erik Bergström, adjungerad professor i pediatrik epidemiologi, Umeå universitet

Marianne Cederblad, professor emerita i barn- och ungdomspsykiatri, Lunds universitet

Anneli Ivarsson, docent, lektor i epidemiologi med pediatrik inriktning, Umeå universitet

Lennart Köhler, professor emeritus i socialpediatrik, Nordiska högskolan för folkhälsovetenskap

Ann-Margret Rydell, professor i psykologi, Uppsala universitet

Magnus Stenbeck, docent i sociologi, Karolinska institutet

Claes Sundelin, professor emeritus i socialpediatrik, Uppsala universitet

Eero Lahelma, professor i medicinsk sociologi, University of Helsinki (augusti 2008 - februari 2009)

Svend Kreiner, docent, lektor i biostatistik, Köpenhamns universitet (augusti - december 2008)

### **Andra medarbetare i arbetsgruppen:**

Birgitta Bäcklund, administratör (projektassistent)

Jeanette Hörnqvist, psykolog (assisterande granskare vid första litteraturgallringen)

Margaretha Karlsson, administratör (projektassistent)

Hans Löfgren, socionom (assisterande granskare vid första litteraturgallringen)

Medicinska biblioteket på Umeå universitet (assistans med litteratursökning)



### **Trends in Mental Health among Adolescents in Sweden – non uniform patterns across age and genders**

*Docent Curt Hagquist, föreståndare för Centrum för forskning om barns och ungdomars psykiska hälsa, Karlstads universitet*

Two recently published studies on adolescent mental health in Sweden demonstrate non uniform trend patterns across age and genders.

O A study based on nationwide WHO-data shows discrepant trend patterns among younger and older adolescents.

O A study based on regional data collected among older adolescents shows different time trends among boys and girls.

The WHO-study is based on nationwide data collected at five points in time between 1985 and 2005 among students in grades 5, 7 and 9, i.e. adolescents about 11, 13 and 15 years old respectively. The data were collected with a questionnaire which the students completed in the school. The number of participants at each year of investigation varied between 2933 and 4421, and the participation rate varied between 85 and 90 percent in the participating schools, with a tendency towards lower participation over time..

A composite outcome measure was used, consisting of four items intended to tap information about psychological complaints. The justification for summation of these items was analysed using the Rasch model, including examinations of invariance in item functioning across years of investigations.

The results show that

- The proportions of boys and girls with mental health complaints increased between 1985 and 2005 in grades 7 and 9.
- In grade 5 the figures for mental health problems are about the same 2005 as the first year of investigation 1985, which applies to both boys and girls.
- When the proportions in 2005 are compared with those in 1998, only girls in grade 9 show higher figures.
- Only among girls in grade 9 there is a linear trend between 1985 and 2005 implying increasing rates of mental health problem at each year of investigation.
- In general there are fluctuations between individual years of investigations.
- Except for girls in grade 9 the highest proportions of mental health problems occur in 2001.

Another recent study partly confirms the results from the previous study on WHO-data by showing gender-related time trends in psychosomatic problems

among 15 000 adolescents in grade 9 (15-16 years old). This study is based on data collected in the county of Värmland at six points in time 1988-2005. The participation rate varied between 85 and 90 percent, with a tendency towards lower participation over time.

The data were collected with questionnaires in the school. The outcome measure was the PsychoSomatic problems (PSP) scale, which is based on eight items and psychometrically examined by Rasch analysis.

The results show that

- The proportions of students reporting psychosomatic problems were higher in 2005 than 1988 among both genders.
- Among boys the variance of psychosomatic problems increased across years of investigations, implying no changes in problems over time on average.
- The trend pattern for boys was different than for girls. While the increases among boys primarily coincided with the economic crisis during the 1990s the increases among girls primarily took place during the late 1990s and the beginning of the 2000s.

These studies modify the stereotype views of adolescent mental health trends frequently reported in media. The study based on WHO-data challenges the unambiguous notions of increasing mental health problems among children and adolescents in Sweden not just conveyed by media but also reflected in the public health debate during the past decade. The study on regional data confirms and further nuance the gender-related patterns indicated by the study on WHO-data.

### *References*

Hagquist C. Discrepant trends in mental health complaints among younger and older adolescents in Sweden – an analysis of WHO-data 1985-2005. *Journal of Adolescent Health* 2010; 46: 258–264

Hagquist C. Psychosomatic health problems among adolescents in Sweden – are the time trends gender-related? *European Journal of Public Health* 2009; 19: 331–336

Hagquist C. Psychometric properties of the PsychoSomatic Problems scale – a Rasch analysis on adolescent data. *Social Indicators Research* 2008; 86: 511-523

The presentation at the state of the science conference on April 12th 2010 will also include new analyses regarding the two studies reported previously, based on data collected in 2009 and 2008 respectively.

### Self-reported delinquency among Swedish youth in grade nine 1995–2008

*Jonas Ring, Ph.D., researcher at Brottsförebyggande rådet*

It is difficult to know exactly how much crime is actually committed by young people. Many offences are committed without being detected or recorded by the police, and self-report studies thus constitute an important alternative source of knowledge to the official crime statistics.

In 1995 and 1997, the Department of Criminology at Stockholm University conducted two nationally representative questionnaire surveys of crime and other problem behaviours among youths in their final year of compulsory education in Sweden (year nine). Between 1999 and 2008, a further five waves of the same survey have been conducted under the administration of the Swedish National Council for Crime Prevention (see Ring, 1999; Brå 2010). Between 5,265 and 8,200 students have participated on each occasion, with a response rate of between 81 and 95 percent. The same questionnaire has been employed each year, with a few minor adjustments. The questionnaire collects data on the pupils' social situation, family, peer relations, leisure time activities and attitudes towards crime. It also includes a large number of questions about whether the youths have engaged in any of a broad range of criminal acts or other problem behaviours, and if so which ones. The survey provides a basis for examining the associations between involvement in crime and a range of different risk factors, and also for describing crime trends over time.

On the basis of the questions posed in these surveys, the presentation will describe trends in the proportion of different groups of year-nine youth who report that they have participated in crime or other problem behaviours. It will also describe levels of self-reported victimisation among the students in relation to theft, violence and threats.

As regards the question of victimisation, the survey data show that over the period covered by the survey series, the proportions of youths reporting experience of victimisation in the form of theft or violence have fluctuated only slightly around otherwise stable levels.

As regards involvement in crime, the results show that it is relatively common for young people to have committed some type of theft offence, such as shoplifting, at some point. Approximately fifty percent of the youths in the most recent survey report having committed at least one theft-related act during the preceding twelve months. Similarly, problem behaviours such as the

consumption of alcohol, fare-dodging and truancy are also relatively common. More serious theft offences and acts involving serious violence against the person are more rare, as is having tried drugs. The levels of participation in violence against the person and drug offences lie at approximately ten per cent. Males engage in more serious theft offences and acts of violence more often than females. Involvement in shoplifting and the prevalence of drug use are more or less equally distributed across the sexes.

Over the period between 1995 and the first years of the new Millennium, the results indicate a decrease in the proportion of youths who have committed certain types of theft offences, including shoplifting and thefts from school. The prevalence of certain types of vandalism offences decreased during this period. In the most recent surveys, these declining trends have levelled off. The proportions who report having engaged in acts of violence or having used drugs have remained relatively stable throughout the period covered by the surveys.

One central finding is that the proportion of youths who have not committed any of the offences covered by the survey has increased over time. It is interesting to note that this finding is in line with trends that have also been identified in both Finland and Denmark (Salmi 2009; Kivivuori 2007, p. 89f; Balvig 2006). This trend is more marked among the males than among the females. In this regard too, however, the changes noted in the most recent surveys have been small.

### *References*

Balvig F. (2006). *Den ungdom! Om den stadig mere omsiggribende lovlydighed blandt unge i Danmark*. Glostrup: Det Kriminalpræventive Råd.

Brottsförebyggande rådet (2010). *Brott bland ungdomar i årskurs nio. Resultat från Skolundersökningen om brott 1995–2008. Rapport 2010:6*. Stockholm: Brottsförebyggande rådet.

Kivivuori, J. (2007). *Delinquent Behaviour in Nordic Capital Cities*. Publication no. 227. Helsinki: Scandinavian Research Council for Criminology and National Research Institute of Legal Policy.

Ring, J. (1999). *Hem och skola. Kamrater och brott*. Kriminologiska institutionen.

Stockholms universitet.

Salmi, V. (2009). *Self-reported juvenile delinquency in Finland 1995–2008. English Summary*. Research Report No. 246. Helsinki: National Research Institute of Legal Policy.

### **How listening to the voices of children and young people should inform policies and public attitudes to improving their mental and emotional health – perspectives from England**

*Prof. Sir Al Aynsley-Green, Professor Emeritus of Child Health, University College London; Founder and Director, ALA-G Consulting International*

Children are the most precious resource of any nation. Making sure that every child is able to develop her or his full potential should be everybody's business, and this philosophy is especially needed in supporting children and young people with mental health difficulties and in promoting emotional resilience.

In his presentation Sir Al argues that:

- Understanding the context of childhood today, public attitudes to children and young people, and the pressures children and young people face in society should underpin any debate on the genesis and management of mental ill health and the promotion of emotional resilience in childhood.
- The importance and power of the United Nations Convention on the Rights of the Child should be the bedrock upon which policy for child and adolescent mental health services should be built
- Article 12 of the UNCRC means that research from listening to children's voices, particularly those most vulnerable and marginalized, is key not only for effective advocacy to influence politicians and policy development and for improving practices in services supporting their needs, but also for improving the public understanding of childhood today.
- Empowering children and young people to be involved in decisions that affect their lives gives them confidence that they are respected as citizens of today.
- There is an urgent need for professional staff working with children and young people to be much more effective as political advocates for the needs of children and young people, and that developing the science of affective advocacy should be just as important as the discipline of effective research

In elaborating on these themes, Sir Al draws on his experience as the first children's physician in England appointed to government with responsibility for defining national standards for their health care, and then as the first independent Children's Commissioner for England with a duty to promote their views and best interests.

In the limited time available, he draws some threads from the more extensive content of his Killam Trusts Lecture delivered in Halifax, Nova Scotia in

November 2009, and asks if the challenges he presented there are just as relevant to Sweden as to the UK and to Canada. Thus:

- Do public and institutional attitudes to children and young people in Sweden need to be confronted?
- Do decision makers really know what it is like to be young today?
- Are children and young people valued sufficiently?
- Is all well with services to support their needs?
- Are children's rights taken seriously?
- Who speaks for children and young people?
- Are children and young people asked and listened to?

Without having personal knowledge of the political arena for children's health services in Sweden, nonetheless, and being provocative, he asks if it might be helpful to consider at the national level concerted and effective political advocacy for

- Cabinet level Minister for Children and Young People to be responsible for coordinating all aspects of policy affecting the lives and health of children and young people
- Explicit cross-government policy programme identifying the outcomes for children and young people that are needed, coupled with processes at the local level to coordinate the integrated delivery of health, education and social care services
- A Clinical Director in Government responsible for all aspects of children's health
- Defined standards of health care
- Appropriate financial underpinning
- Effective commissioning of services
- Rigorous inspection machinery for statutory services
- Listening to the voice of the child
- A Commissioner with power and authority to effect change based on the views of children and young people

His presentation is designed deliberately to be provocative, but set against the backdrop of the immense esteem with which Sweden is held internationally for its care and concern for children.

### The experiences of mental health and well-being of Swedish children and youth with a focus on educational situations: some results and reflections from a review of qualitative studies

*Docent Mara Westling Allodi, Specialpedagogiska institutionen, Stockholms universitet*

The practice of including in reviews people's experiences and perceptions, which are collected with non-experimental and qualitative studies, has been developed recently in the field of mental health studies. These approaches and methodologies have inspired the review of research on Swedish children and adolescents experiences of mental health and well being, with a focus on their educational situation, that was conducted as a part of a systematic review of research on School Learning and Mental health, performed by appointment of the Royal Academy of Sciences. A motive for doing a review of studies reporting children's and adolescents views on these matters was the ethical consideration to consider children and adolescents as subjects, having a right to express their views in matters that affect them. Other motives were the need to take account of the specific Swedish social and educational context through the experiences of the students that actively take part of it, and also to gain enrichment and depth from the juxtaposition of results from studies employing various methods, and taking advantage of a mixed method approach.

The aim of the review was to gather testimonies that can give indications of the experiences of mental health and well being in this specific context. Literature searches in several research databases with international and national publications were performed during spring 2009. A systematic screening of titles and abstracts was done on 527 references; 107 references were then screened in full text and 38 reports were judged to meet the inclusion criteria, requiring the presence of reports of children or adolescents' views, and that both aspects of mental health and of educational factors were treated in the study. The studies included were doctoral dissertations, academic papers, peer-reviewed articles and reports from agencies and organisation, representing the disciplines of science of education, disability studies, psychology, public health, youth studies, social work and interdisciplinary.

The results from the studies that were relevant for the aims of the review are structured in four themes: general views, protective factors, risk factors, individual factors. They are presented in a narrative synthesis, giving a particular weight to the direct and indirect report of children's and adolescents' own views.

In this presentation, the results from one of the theme identified will be reported: the theme concerning the general experiences of mental health and well being, which was represented by six reports.

The adolescents defined mental health as emotional experiences, seen both as internal feelings and as relational feelings. Family, friends and educational environments as social and physical environments were perceived as determinants of mental health. A great number of feelings were related to school, both related to satisfaction and pain, in particular when the school attendance is presented as an obligation. Harassment and rejection at school, performance stress, worries about grades and future prospects could be threats against self-worth and self-esteem, while teachers that do not care could generate negative experiences. Various kind of stress could be described and various strategies to resist stressful situations: for instance emotional support, safety and involvement. The educational environments can be an arena for social, cognitive and emotional experiences, relationships and accomplishments that are enriching the individuals and increase their well being. General structural characteristics of the educational environments may also affect well being in different directions: performance, evaluation and feedback, freedom of choice and responsibility for the future may be perceived as a burden.

The following reflections can be made: the experiences of children and adolescents change when they grow older, go through developmental processes and encounter different educational situations; the studies reporting views of younger children on the matters of this review were less well represented; the negative experiences may be expressed in rather cautious and non dramatic terms by younger children; there are unique contribution of the review of qualitative studies, but also several interesting correspondences with the results of the review of quantitative studies.

## ABSTRACT

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### **A methodological perspective on trends in child and adolescents health**

*Prof. Måns Rosén, chef för Statens beredning för medicinsk utvärdering*

There are several methodological problems to consider in analysing trends in child and adolescent health. Health and disease are associated and caused by many factors in society. The economic situation of the country, the distribution of wealth and social support, the closest environment, family situation, lifestyles of the adolescent and his or her family are all factors that might contribute to the health situation. It is extremely difficult to control for all these factors when interpreting the reasons for changes in trends. Especially, since data on individuals are not always available. Neither are randomised controlled trials a realistic option. The problems of using cross-sectional data and the risk of ecological fallacy will be discussed. Changes in available resources, administrative routines, attitudes of the population, diagnostic criteria are all factors influencing the interpretation of the results. Examples of some of these problems will be presented and discussed.

## ABSTRACT

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### **Studying time trends in psychopathology**

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The study of time trends is potentially very important because changes over time may point to the operation of environmental influences and because of the implications for service needs. Any understanding of the meaning of time changes will be crucially dependant on the time period covered and on the possibility of relating the time trend to parallel trends and this lecture will mainly focus on the range of measures of time trends, together with an assessment of their strengths and limitations.

Thus, a prime contemporaneous set of measures can be provided by administrative data – such as those concerning crime statistics, rates of suicide/ parasuicide, and hospital registers for the diagnosis of autism spectrum disorders. Illustrations of each of these will be given. Inevitably, there may be uncertainties over the consistency over time in the administrative procedures and definitions used and over the specification of the relevant age groups of interest. Secondly, reliance may be placed on the retrospective recall of disorders by people born in different time periods. For example, such data constituted the initial basis for claims on age trends in depressive disorders (this will be illustrated).

The conclusions, of course, are entirely reliant on comparability across age groups, in the quality of recall and in the people's concepts of the disorder being studied. These issues, plus the likelihood of telescoping of dates, mean that retrospective recall provides a weak basis for measuring time trends.

A third approach is provided by comparison across different birth cohorts – such as the British birth cohorts born in 1946, 1958 and 1970. Measures have mainly involved questionnaire score cut-offs but sometimes diagnoses based on standardised interviews have been available. The method has many strengths but almost all measures are comparative (e.g. 'more depressed' or 'more overactive') and hence if the population as a whole changes, the ratings may not alter because they involve comparisons with other children in the same time period. Also, many surveys have a problem with non-participation. In addition, population make-up will change over time as a result of in- and out-migration.

Fourthly, there have been attempts to use meta-analyses of surveys spanning a substantial time period in order to infer time trends – the approach employed by Costello et al. (2006) and by Trzesniewski & Donnellan (2010). The main problem is that the approach requires the bringing together of rather disparate studies, which are likely to be heterogeneous in important ways. It is clear that no approach is free of problems; accordingly conclusions need to be based on a combination of different research methods. Moreover, the finding of a time trend is of little use until one or more explanatory factors are identified. Also, it is essential to identify the population involved in the time trend.

The identification of causal influences will require a change over time in the trajectory of the postulated causal factor. It is obvious that there are major methodological problems to be dealt with.

Firm conclusions on causes remain hard to obtain; nevertheless the search is important. There is good evidence for substantial time trends over the last 60 years (at least up until the last decade or so) in the rates of adolescent suicide/ parasuicide, of substance/misuse, and crime; there is some evidence on a possible increase in conduct problems, but only weak, inconsistent evidence on a time trend for depressive disorders.

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## ABSTRACT

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### Changes over time in young people's mental health – a social perspective

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Using data from three samples identical in respect of age (15 years), school year and geographical location (West of Scotland), we have shown marked increases in self-reported 'psychological distress' (GHQ-12 'caseness'), among females between 1987 and 1999 and both males and females between 1999 and 2006 [1]. The focus of our current work is on trying to explain these increases. They might be explained by changes in exposure (changes in levels of risk or/protective factors) and/or by changes in vulnerability (changes in the relationship between risk/protective factors and psychological distress). Key areas of social change over the time period of interest allow us to identify potential explanatory factors, including:

**Economic factors:** Overall economic conditions within the UK improved between 1987 and 2006, which, if there is a relationship between socio-economic disadvantage and young people's mental health, should have led to improved mental health. However, contrasting with more severe 'mental disorder', there is actually little evidence of socio-economic inequalities in minor psychological morbidity in young people [2].

**Family factors:** Since the 1960s, the modal nuclear family of breadwinner father, stay-at-home mother and biologically related children has diversified. Maternal employment does not appear to have an adverse impact on adolescent well-being [3]. Although parental separation or father absence may impact on mental health, differences by parental structure tend to be accounted for, and/or dwarfed by differences in socio-economic factors or family dynamics [4]. However, data on time trends in family dynamics are sparse.

**Educational factors:** It has been argued that over the past 30-40 years, the UK has seen greater use of assessment to try to raise educational standards than anywhere else in the world [5]. There is evidence that academic

pressures generate worry, particularly for females [6]. A strong emphasis on achievement in some schools may also marginalise and demotivate pupils identified as unlikely to succeed [7].

Values and lifestyle factors: It has been suggested that the materialism and individualism associated with modern Western cultures are hazardous for mental health [8]. Levels of religious commitment and participation, which are both positively associated with well-being [9], have dropped. At the same time young people's spending power and commercial involvement have exploded. The commercialisation of childhood has been associated with poorer well-being and increased parent-child conflict [10]. Another aspect of consumerism refers to the construction of desirable identities, particularly related to attractiveness.

The second half of the Twentieth century also saw the rise of youth subcultures, which have been associated with both poorer and improved well-being [11]. At the same time, young people's 'lifestyles' have changed, becoming more oriented towards leisure/entertainment and involved with electronic media which have, again, been associated with both negative and positive effects.

Our study is set against this broad background of social change. It examines whether the increases in psychological distress which we observed among Scottish 15 year olds between 1987 and 2006 can be explained by a range of factors represented by variables common to each study.

### *Methods*

Our samples are drawn from two cohorts aged 15 in 1987 and 2006. All respondents were in their final year of statutory education and lived in and around Glasgow. Analyses were conducted on those with complete data on all variables ( $N = 3,276$ ), and separately for males and females since, as demonstrated previously, increases in psychological distress were significantly greater for females. Psychological distress was measured via the 12-item General Health Questionnaire (GHQ-12) [12], each item being scored as a likert scale (0123). Variables representing our potential explanatory factors included: no working parent, shared bedroom and worry about own unemployment (representing economic factors); not with both birth parents, arguments with parental figures, family outings and worry about family relationships (family factors), school disengagement and worry about school (educational factors), religious attendance, youth subculture, disco/club attendance, computer game play, spending power, obesity, worry about weight and about appearance (values and lifestyle factors).

## *Results*

The first question is how much the lives of the young people in our samples changed between 1987 and 2006. We found levels of every potential explanatory factor had changed over this 19 year period in line with what would be expected from the literature and general societal trends, suggesting changes in exposure to potential risk/protective factors. There was evidence of reduced economic hardship, mixed findings in respect of family life (fewer with both birth parents, coupled with increases in family outings but also in arguments with parents and worry about family relationships), increased school disengagement (and, among females worry about school), reduced religious attendance but increases in youth subcultural identification, spending power, disco/club attendance, computer game play and also levels of obesity and worries about appearance (weight and looks). Many changes were very large indeed. For example, while the proportion with no parent in work halved from around 16% to 8%, worries about family relationships increased from around 12% to 20%, identification with alternative youth subcultures rose from almost none in 1987 to around one-in-four by 2006, and the proportion expressing a lot of worry about looks almost doubled from around 17% to 30%.

The second question is whether these factors were actually associated with our measure of psychological distress. Only then could they qualify as potential explanations for increasing levels. Several factors were not associated, including, for both males and females, no working parent, religious attendance, spending power, going out to discos or clubs and obesity. Associations with GHQ tended to be stronger among females, and at the later date. In addition to associations with worries (about unemployment, family relationships, school weight and looks), GHQ score was also clearly related to arguments with parents, and, at the later date, disengagement from school.

The third question is whether these factors can help us explain time trends in psychological distress. This was addressed by determining how much, if any, of the increase in mean GHQ between 1987 and 2006 they could account for. The factors which best accounted for the increase were arguments with parents, school disengagement, worry about school and, for females, worry about family relationships. This was because these risk factors had increased in frequency between the two dates (suggesting increased exposure) and because the relationships between these factors and psychological distress had increased over time, particularly for females (suggesting increased vulnerability).

## *Discussion*

A number of limitations to our analysis can be identified. Importantly, in any such analysis, measures are almost bound to be less than ideal, and even if studies include identical items, the meaning of those items may change over time. It is possible that this methodological issue contributed to our results. However, and although based on very different methods, our results parallel the conclusions of others [13] in highlighting the role of family and educational factors in respect of increases in young people's psychological distress.

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## ABSTRACT

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### Trends in suicide among teenagers

*Prof. Bengt Haglund and Charlotte Björkenstam, National Board of Health and Welfare, Sweden*

Changes in the incidence of suicide over short time periods have been reported. The purpose with this study was to examine long time trends. Data are available from 1952 to 2007. As the incidence in the ages 10-14 years is very low, we restricted our study to 15-19 years old adolescents.

The lowest incidence was in the 1950-ies, 2.2 per 100 000 person years among females and 4.1 among males. During the following two decades it was an increase, resulting in the highest incidence in the 1970-ies (5.2 and 7.1, for females and males respectively). In the following decades the incidence for males was fairly stable, while for females it was a minor drop during the 1980-ies which was followed by a small increase in the suicide incidence.

## ABSTRACT

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### Evidence based actions for preventing suicidal actions in children and adolescents

*Professor Danuta Wasserman, National Prevention of Suicide and Mental Ill-Health (NASP), Karolinska Institutet*

Suicide is one of the leading causes of mortality worldwide among adolescents. Available suicide figures, especially for young people are unreliable due to under reporting, different recording processes, and variations in practices when issuing death certificates. Social stigma, religiosity, and legal issues associated with suicide also influence the reliability of data worldwide (Bertolote & Fleischmann 2009). In Sweden in 2007, suicide rates within the age group 15-24 were 10 per 100,000 for males and 7, 7 per 100,000 for females (Jiang et al 2009). In this age group the number of suicide attempters is up to 20-30 times higher than that of completed suicides. Rates for completed suicide indicate that more males in this age group complete suicide and more females attempt suicide. Sweden is the only EU country where an increasing rate of suicide was observed for both male and females teenagers during 1997-2006 (Floderus 2009) and the rate for female teenagers was the highest among the 27 EU countries. Data from the WHO European Multicentre study on attempted suicide, in which NASP is participating, indicates that rates of attempted suicide and suicide in the young significantly co-vary for males. Furthermore, several recent studies have reported a shift in suicide methods to those with higher lethality for both genders.

### *Risk factors*

Mood disorders, substance-related disorders, psychosis and disruptive behavior disorders have been identified as being most frequently associated with completed suicides (Brent 2009). However, according to the stress-vulnerability model (Wasserman 2001), there are several other important factors involved in the development of the suicidal process including; family history of mental disorder and suicidality, personality, environmental factors, psychosocial and cultural reactions and support from family and other networks.

### *Suicide can be prevented*

An effective model for suicide prevention comprises two approaches: health-care and public health. The health care approach includes adequate detection and treatment of young people with psychiatric illnesses and psychosocial stress. Follow up programmes, for up to 12 months after discharge from health care following suicide attempts, are key actions needed as suicide risk is high among psychiatric patients and suicide attempters, particularly after their discharge from hospital. The public health approach utilizes knowledge and evidence-based actions to implement on a larger scale, actions promoting mental health as well as early detection of suicidal behaviours in the general population, for e.g. early recognition of young people at risk in schools. In this approach, high risk groups are detected who normally would not seek care on their own. The Health care and public health approaches are fundamental in preventing suicidal behaviors, and should go hand in hand in suicide prevention. Evidence has also shown that policy towards suicide prevention ratified by national parliaments is very helpful in reducing stigma and increasing visibility of suicide preventive measures.

### *Depression*

Depression is the single most important psychiatric risk factor for child and adolescent suicidality, with increased risk of suicidal behaviour of around 10-50 times, therefore detection and adequate treatment of depression is a key factor in reducing suicidal risk. Children and adolescents who have early onset of depression, with severe and/or chronic symptoms have an increased risk of suicidal behavior. Young people may require both pharmacological treatment of depression, as well as psychological interventions targeting the psychosocial contextual factors for suicide risk (Brent 2009).

### *Treatment of suicidality in young people*

Antidepressants and psychotherapy, especially interpersonal and cognitive behaviour therapy, are effective in the treatment of adolescent depres-

sion (Brent 2009). The multisite ‘Treatment of Adolescent Depression Study (TADS) study’ showed that the antidepressant fluoxetine alone and the combination of fluoxetine and CBT produced substantial improvements in depression, in comparison with the placebo or to CBT alone. However, a reduction in suicide ideation was only obtained when the combination of fluoxetine and CBT was used. This underscores the experiences from good clinical praxis, that antidepressants and psychotherapy should be delivered together in treatment of young people. There are however, some risks when treating young people with antidepressants. In the TADS trial, fluoxetine was affiliated with increased numbers of suicidal events when compared to the placebo, with adolescents in the combined treatment group (fluoxetine and CBT), having a reduced number of suicidal events in the study and follow up than the group with fluoxetine treatment alone (Emslie et al. 2006; The TADS Team 2007).

Key predictors of poor response to treatment of depression in young people include chronicity and severity of depression, hopelessness, childhood abuse and family conflicts, parental depression and co morbidity (Brent et al. 2009, Emslie et al. 1998). In addition, some studies (Apter et al. 2006, March et al. 2006) suggest that self-reported ideation on entry is a key predictor of active suicidal behavior during clinical psychotherapy and pharmacotherapy trials. Bridge et al (2007) performed a meta-analysis of child and adolescents treated with antidepressants and results showed that an average of 4 percent of those on medication showed new or increasing suicidality compared to the placebo, with only 2 per cent. Increasing concern about the link between suicidality and antidepressants has led to calls for a reliable and valid standard classification for suicidal events. The Food Development Agency (FDA) in the US is recommending that US clinical trials use the Columbia Classification Algorithm of Suicide Assessment (C-CASA). More research is needed into which groups of young people are responding negatively to the use of SSRI antidepressants.

In patients with bipolar disorders, Lithium has shown protective effects against suicidal behaviors (Baldessarini and Tondo 2003; Goodwin et al. 2003). A meta-analysis of clinical trials with lithium in mood disorder patients showed a reduction of aggression and reduction of impulsive behavior in adolescents (Brent 2009).

### *Psychological interventions that target risk and strengthen protective factors in suicidal young people*

Although more studies are needed to provide an overall systematic overview

of the effects of psychotherapies for young people, according to specific studies, positive results have been achieved from several trials. These include psycho-education, cognitive behavioural therapy (CBT) and cognitive behavioural family therapy (CBFT), home based family therapy (HBFT), developmental group therapy, skills based therapy (SBT), multisystemic therapy, and youth-nominated supported teams (YST-1), development plans and dialectic behavior therapy (DBT). Variation exists in efficacy to reduce suicidal ideation and behaviors in depressed adolescents; however studies show promising results for YST-1, CBFT, HBFT, and SBT.

### *Conclusion*

The emphasis of suicide preventive work needs to shift to an earlier stage of the suicidal process. This is addressed by the WHO global suicide prevention initiative SUPRE (SUicide PREvention), the WPA/ WHO initiative “Global Child Mental Health” which aims to increase mental health awareness amongst pupils, parents, teachers and other school staff, and by the EU research funded studies: Saving and Empowering Young Lives in Europe (SEYLE); Working in Europe to Stop Truancy Among Youth (WE-STAY); and Suicide Prevention by Internet and Media Based Mental Health Promotion (SUPREME) led by NASP.

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