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Adolescents in specialty mental health services (BUP): time trends, referral problems, and co-occurring conditions

Thesis for the degree philosophiae doctor

Trondheim, April 2007

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NTNU
Innovation and Creativity

NTNU
Norwegian University of Science and Technology

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ISBN 978-82-471-1657-9 (printed version)
ISBN 978-82-471-1660-9 (electronic version)
ISSN 1503-8181

Doctoral theses at NTNU, 2007:75

Printed by NTNU-trykk

Acknowledgements

In my professional career I have had the privilege to participate in the development of the specialty mental health services for children and adolescents (BUP) in Nordland County from the start in 1974. Through the years I have observed the shifting panoramas of problems among children and adolescents in the BUP services, and have often wondered what these time trends were about. My first attempts to investigate these issues were made in the late 1980s.

Referrals of “new” kinds of problems to the BUP services such as sadness/depression and hyperactivity/attention problems seemed to increase strongly from the beginning 1990s.
Reflections over these changes and what they might be related to led my colleague Kirsti Jørgensen and I to contact Lars Wichstrøm at the Department of Psychology, Norwegian University of Science and Technology (NTNU) in Trondheim. We wanted to research these issues, and we asked him for advice and supervision. Lars kindly accepted, and introduced us to Anne Mari Sund, then at R- BUP in Trondheim and she generously offered us the opportunity to use instruments from the questionnaire used in her “The Youth and Mental Health Study” in Trøndelag. Thanks to her generosity we had the opportunity to compare adolescents from the BUP services with adolescents from the community.

Doing research in clinical settings, however, is a challenging and complicated venture. Clinical considerations and practice always have priority and the study would have been difficult to accomplish without the help and support from our colleagues, above all, from the secretaries at the nine BUP clinics in Nordland. None mentioned and none forgotten.

I am first and foremost grateful to my good friend and colleague Kirsti Jørgensen for our co-operation during the study period. It has been a long journey since our preliminary research ideas. I have appreciated and enjoyed our monthly journeys to Lars in Trondheim which provided us with the time and opportunity for conversations and reflections away from stress and daily duties.

Most of all I am grateful to Lars Wichstrøm for his continuous support, his critical questions, his good advices, his assistance with the statistical analyses, his patience, and never failing feed back during the writing process. As a result of our discussions the scope of this study enlarged. Without his wisdom, experience, and guidance this study never would have been accomplished. It has been a great effort, including many lessons in humbleness, but I have had great fun.

Special thanks to Steven Balmbra for his advice with the English language.

However, without the interest and encouragement from my family, the patience and support from my wife Turid, and my daughters Marit, Kristin and Torunn and their families, I would not have had the spirit to enter such an ambitious project at the very end of my professional career.

Thanks to The Norwegian Association of Child and Adolescent Institutions (NFBUI) which kindly gave accept to use the national BUP-data files for analyses, and to Helle Wessel Andersson at SINTEF who nicely provided us with the files converted into the statistical program SPSS.

I appreciate the support from my colleagues at BUPA, Nordlandssykehuset, and many thanks to director Eivind Solheim who provided me the opportunity to accomplish this study.

And lastly, thanks to all the adolescents who participated in the study and made it possible.

This study has received funding from the Norwegian Research Council and from Nordlandssykehuset.

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List of papers

I. Reigstad, B., Jørgensen, K. & Wichstrøm, L. (2004) Changes in referrals to child and adolescent psychiatric services in Norway 1992 – 2001. Social Psychiatry and Psychiatric Epidemiology, 39, 818-827.

II. Reigstad, B., Jørgensen, K., Sund A.M. & Wichstrøm, L. (2006) Adolescents referred to specialty mental health care from local services and adolescents who remain in local treatment: what differs? Social Psychiatry and Psychiatric Epidemiology, 41, 323-331.

III. Reigstad, B., Jørgensen, K. & Wichstrøm, L. (2006**).** Diagnosed and self-reported childhood abuse in national and regional samples of child and adolescent psychiatric patients: prevalences and correlates. Nordic Journal of Psychiatry, 60, 58-66.

IV. Reigstad, B., Jørgensen, K. & Wichstrøm, L. (2006). Pain in adolescent psychiatric patients. Child and Adolescent Mental Health, 11, 185-191.

V. Reigstad, B., Jørgensen, K., Sund A.M. & Wichstrøm, L. Prevalences and correlates of sleep problems among adolescent patients in specialty mental health services and in the community: what differs? (Submitted).

Abbreviations

BUP = Child and Adolescent Mental Health Service
ASEBA = Achenbach System of Empirically Based Assessment
CBCL = Child and Adolescent Behavior Check List
YSR = Youth Self-Report
TRF = Teacher Report Form
MFQ = Mood and Feelings Qestionnaire
IPPA = Inventory of Parent and Peer Attachment
FAD = Family Assessment Device
EASQ = Early Adolescence Stress Questionnaire
CISS = The Coping Inventory for Stressful Situations
DAS = Dysfunctional Attitude Scale
ICD 9 = International Statistical Classification of Diseases and Related Problems: The Classification of Mental and Behavioural Disorders. Ninth Edition
ICD 10 = International Statistical Classification of Diseases and Related Problems: The Classification of Mental and Behavioural Disorders. Tenth Edition.
DSM-III-R = Diagnostic and Statistical Manual for Mental Disorders. Third Edition – revised.
DSM-IV = Diagnostic and Statistical Manual for Mental Disorders. Fourth Edition
OR = Odds Ratio
CI = 95% Confidence interval
LEON = Lowest effective level of care
WHO = World Health Organization
n.s. = non-significant

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1 INTRODUCTION

1.1 Background of study

Referrals.

Traditionally, research on mental health problems among children and adolescents has focused mainly on prevalences and predictors of stability and changes in these disorders. Less is known about associated conditions as referral problems, and co-occurring conditions as pain and sleep disturbances, and psychosocial adversities like abuse and neglect. The purpose of this study is to focus on these less investigated problems and conditions which might be highly significant in day-to-day clinical practice.

The proportion of the child and adolescent population treated in child and adolescent mental health service(BUP) has been rising sharply during the last few decades, and over time, the types or categories of behavioural and emotional problems referred to the BUP services in Norway have changed as well (Reigstad, 1994). The occurrence of referrals of psychosomatic problems has decreased. The share of referrals of enuresis and encopresis were five times as high in the 1970s as in the beginning of the 1990s (Reigstad, 1988; Ytterhus, 1991). During the latter two decades, sadness/depression and hyperactivity/attention problems have emerged on the agenda of the BUP services, and proportions of referrals of these problems appear to have strongly increased. On the other hand, the proportion of referrals of psychotic, anxiety, and behaviour problems do not appear to have increased significantly, and this also seem to be the case for eating disturbances (Lossius, 1994; Sitter, 2005). One has to keep in mind, however, that the referral problem categories are not equivalent with ICD-10 diagnoses, and this raises the interesting question of the degree of convergence that exists between them.

We do not know whether or not these changes in referral patterns reflect changing time trends in actual prevalence of child and adolescent psychiatric symptoms or mental disorders. The rate of referral of a specific problem or disorder to child and adolescent psychiatry may also change over time due to a range of changes in the wider society. Among such societal changes are new understandings, more knowledge based on research, changes in media attention, and more public openness about mental health issues. Moreover, increasing professional competence

in the local services may influence the selection of problems that are referred to the specialty mental health services. The occurrence of grassroots advocacy groups organised around specific child disorders may also play a role. Likewise, increasing access to information from the internet seems to be more and more important. To summarise, we are left with profound changes in the type of problems that are referred to the specialty mental health services for children and adolescents without having any empirically based knowledge to explain these changes. The assignment of which patients should receive treatment in specialty mental health service is by and large beyond the control of the BUP services themselves. More knowledge is thus needed about which factors that influence changes in referral of mental health problems to the BUP services in Norway, and such information may have implications for prevention of psychiatric disorders among children and adolescents. Further information about these issues may present opportunities for political as well as for professional interventions related to factors that may be found to associate with changes in referrals. The BUP services are constantly expected to contain the necessary expertise to assist local services in their efforts to help children and adolescents with mental problems. More knowledge about time trends give the specialty mental health services better prospects to synchronise professional competences to the shifting spectrum/panoramas of child and adolescent mental health problems which are referred.

The Norwegian health system is based on the LEON principle that presupposes patients to be treated at the lowest effective level of care (Stortingsmelding nr. 9 (1974-75)). Assumedly, the degree of pathology or severity of symptoms is the basis for the referral of patients from the local to the specialty mental health service (BUP). However, we do not know if this is the case, or if other crucial factors are involved in the help-seeking process. We need to know more about differences between children and adolescents treated in the BUP services and those who are treated locally.

Co-occurring conditions.

The referral problem categories in the BUP-data patient register have been unchanged since 1992. This has made it possible to collect information about changing and/or stable time trends for the register categories of referral problems. However, the list of categories of referral problems is not comprehensive. Co-

occurring conditions which are not registered as main problems are at risk of being unnoticed or to receive little attention in clinical practice as well as in research. Accordingly, traumas such as childhood abuse and neglect are among problems in jeopardy of being overlooked as targets for therapeutic interventions and/or research by professionals. These problems are prevalent among children and adolescents, and numerous community studies have documented associations with psychiatric disorders (Brown et al., 1999; Krantz & Östergren, 2000; MacMillan et al., 2001; McHolm et al., 2003; Putnam, 2003; Ystgaard et al., 2004). However, we have no knowledge about prevalences of abuse and neglect among BUP patients in Norway today, and research is strongly needed. Lack of awareness in clinical practice of possible childhood abuse and neglect may have negative implications for evaluation and treatment of psychiatric disorders where such underlying traumas may need to be targeted in therapy. Data from the BUP services from the beginning of the 1990s indicate that abuse may be associated with severe psychiatric problems such as self-harm and suicide risk. A study of emergency referrals to the BUP services in Nordland County in the period 1990 to 1995 indicate the need for a more alert attitude among clinicians toward childhood abuse. Questions of sexual abuse were registered in 21.8% of the 495 emergency referrals in this period (Reigstad et al., 1996).

Frequently co-occurring conditions as pain and sleep problems are also not among the main problem categories encompassed in the BUP-data register, and are likewise in danger of being unnoticed by clinicians. If asked, ordinary children and adolescents frequently report such problems, and relationships between pain conditions and emotional and behavioural problems have been documented in many community surveys (Larsson, 1991; Kristjansdottir, 1997; Egger et al., 1998; Hakala et al., 2002; Harma et al., 2002).This is also the case for sleep problems (Ford & Kamerow, 1989; Paavonen et al., 2000; Walsh, 2004). Associations have as well been found between pain, sleep problems and mental distress in Norwegian school children (Bruusgaard et al., 2000).

In a longitudinal study Gregory and O'Connor (2002) found that sleep problems at age 4 were a robust predictor of behavioural and emotional problems in mid-adolescence, and that there was no evidence that early depression, anxiety or aggression predicted sleep problems in mid-adolescence. Early sleep problems

were therefore consistently associated with an increase in later behavioural/ emotional problems, but an opposite relationship was not found. They also found a steady and significant increase in the overlap between sleep problems and depression/ anxiety from early childhood to mid-adolescence. Sleep problems may thus be a marker for developing psychopathology.

Clinical studies on pain complaints (Campo & Fritsch, 1994) and sleep problems (Ivanenko et al., 2004; Bullock & Schall, 2005) in children, and their comorbidity with psychiatric disorders are often based on selected groups from different medical settings. Less is known about pain conditions and sleep problems among child and adolescent psychiatric patients, and we do not know if these problems are qualitatively different, or are correlated differently with symptoms, biological and psychosocial factors in this group than among children and adolescents in the community. We have little or no information about prevalences of these problems among patients in the BUP services in Norway. Neither do we know much about relationships with behavioural and emotional problems. However, sleep problems and pain are among the diagnostic criteria of depressive and/or anxiety disorders. These concerns should be addressed, and research on these often “unnoticed” problems among BUP patients is needed.

1.2 Main research aims

Most knowledge of emotional and behavioural problems in children and adolescents comes from community surveys, from school surveys, from paediatric patients, or from patients in primary health care. However, knowledge from such samples is not necessarily applicable to, and may not apply to, child and adolescent psychiatric patients. In Norway, as in most countries, studies on representative clinical samples from the child and adolescent psychiatric services (BUP) are scarce. More information is needed about prevalences and correlates of the above mentioned problems among children and adolescents in the BUP services. The present research aims to contribute to the expansion of such knowledge. Firstly, the aim is to examine time trends in patterns of referral of behavioural and emotional problems to the BUP services in Norway, and to study differences between adolescents receiving local help and those referred to BUP services. Secondly, the aim is to focus on “unseen” and often co-occurring conditions among BUP patients that may have

negative impact on mental health and quality of life, and where more clinical attention and research are strongly needed.

1.3 Changes in epidemiology

Epidemiological studies have reported prevalence rates ranging from 9% to 20% for psychiatric disorders among children and adolescents in different parts of the western world (Almqvist et al., 1999; Costello et al., 1996; Fergusson et al., 1993; Kazdin, 1992; Anderson et al., 1987, Ford et al., 2003). A mean prevalence rate of 15.8% of child and adolescent disorders was reported from an international meta-analysis of 52 studies (Roberts et al., 1998). Costello et al. (2005) estimated in a 10-year research update review a median prevalence of 12% of functionally impairing child and adolescent psychiatric disorders.

In Norway, Lavik (1976) found differences in prevalences of mental problems between adolescents living in Oslo and in rural areas, based on semi-structural interviews and self-report questionnaires to pupils, and partly on interviews with teachers. While prevalences in Oslo were 23.1% and 15.9% for boys and girls, respectively, the prevalences in rural areas were correspondingly 7.7% and 8.2%. Kolstad (1983) used the same mental health categories as Lavik in another study of mental health among children and adolescents in the county of Sogn og Fjordane in the period 1976-77. He found prevalences of mental health problems among children and adolescents to be considerable lower than those found in Oslo, and even lower than those found in the rural areas in eastern part of Norway. He attributed his results to more social stability in the communities in the western part of Norway. In a different study from the county of Nord Trøndelag, Vikan (1985) also found a low prevalence rate (5%) of mental health disorders among 10-year-old children living in rural communities based on responses to symptom checklists for parents and teachers.

Time trends. In a major literature review of time trends in psychosocial disorders of youth across the second half of the last century Rutter and Smith (1995) found evidence for substantial changes. Rates of youth crime, alcohol and drug abuse, depression and suicide had increased in most industrialised countries over the years after World War II, slowing in some instances in the eighties. However, there are major methodological challenges to providing conclusive answers about secular

changes in disorders. Changes in diagnostic criteria, differences in assessment methods, and changes in official reporting practices often affect comparisons of rates of disorders at different points of time. Such changes may create unsystematic noise in the data, but changes in practices may also be correlated with time, creating systematic errors. Few studies have remedied these errors by examined this issue using the same instruments at each time point (Collishaw et al. 2004).

Comorbidity. Research on clinical and population samples demonstrate that mental health disorders co-occur with each other. Comorbidity may occur as a result of overlapping symptomatology, one disorder manifesting itself as an earlier form of the other, or from shared risk factors. It is also well established that internalising and externalising syndromes are correlated with one another (Garnefski & Diekstra, 1997; McConaughy & Achenbach, 1994; Volk et al., 2005). Ford et al. (2003) reported from The British child and adolescent mental health survey that almost one third (29.4%) of the children with any DSM-IV diagnosis had more than one disorder. The authors found that children with depression were most likely to have a comorbid diagnosis (66%), while children with a disruptive disorder were least likely have one (21%).

1.3.1 Psychotic problems

Epidemiological data on childhood psychosis are limited. In a recent Finnish 10 – 15 years community follow-up study of boys from age 8, Sourander et al. (2005) found that, according to military statistics, 0.5% of the young men fell into the psychotic disorder group. In a UK community survey, Brugha et al. (2005) found 4.5 per 1,000 subjects prevalence for functional psychosis in the past year, whereof 5% of the males and 4% of the females were 16 to 19 years old. The shares of referral of psychotic problems to the BUP services in Norway have stayed at a stable rate from 1.4% in 1992 to 1.2% in 2004 (Lossius, 1994; Sitter, 2005).

1.3.2 Autism spectrum disorders

A considerable body of evidence indicates a significant increase in both the prevalence and incidence of autism spectrum disorders (Chakrabarti & Fombonne, 2001; Fombonne, 2001, 2002, 2003) in recent birth cohorts, documented in the UK, the US, Scandinavia and Japan. The rate for Asperger disorder is not well established, and a conservative figure is 2.5/10,000 (Fombonne, 2003). Rates of

autism spectrum disorders are reported to increase with age (Williams et al., 2005). The increases reported may be considered to reflect a broadening of the diagnostic concept and diagnostic criteria for autism as well as increased awareness and improved detection of pervasive developmental disorders at all ages and all levels of intellectual ability (Fombonne, 2003). The ratio of boys to girls is estimated to 7:1 in a Scottish study on autism spectrum disorders (Harrison et al., 2006). Chakrabarti and Fombonne (2005) found a prevalence rate of 58.7 per 10,000 for all pervasive developmental disorders in a birth cohort study in an UK area, and the rate was higher than reported 15 years ago. The rate in their study was comparable to that in previous birth cohorts from the same area and surveyed with the same methods, suggesting a stable incidence. The rates of referral of autistic problems to the BUP services in Norway have stayed at stable rate from 2.5% in 1992 to 2.2% in 2004 (Lossius, 1994; Sitter, 2005).

1.3.3 Hyperkinetic and attention disorders (ADHD)

Attention deficit hyperactivity disorder is a common diagnosis among school children that affects approximately 3% to 5% of the population (Havey et al., 2005). In the period 1987 to 1997 a three to fourfold increase in the diagnosis and treatment of ADHD was found in user surveys (Olfson et al., 2003) and in reports from physicians (Robinson et al., 2002) in primary care in the US. However, community surveys of the prevalence of hyperkinetic disorders (Taylor et al., 1991; Meltzer et al., 2000) suggest little change in the underlying rates of hyperactive and attention problems over the same period based on parent and teacher-rated dimensional measures (Achenbach et al., 2003; Collishaw et al., 2004; McArdle et al., 2003; Sourander et al., 2004). Gaub and Carlson (1997) reported from a meta-analysis of 18 studies male to female ratios in clinic-referred samples to range from 9:1 to 6:1, and 3:1 for population based studies. Biederman et al. (2005) found no gender differences in age at onset, impairment related to ADHD, duration of ADHD, or individual ADHD symptoms in a non-referred sample of siblings. However, comorbidity with disruptive behaviour disorders seems to drive referrals to specialty mental health services, and may help explain the large gender differences in referrals (Gaub & Carlson, 1997; Biederman et al., 2002; Biederman et al., 2005). The rates of referral of hyperactivity/attention problems to the BUP services in Norway have increased strongly from 1.2% in 1992 to 19.4% in 2004 (Lossius, 1994; Sitter, 2005).

1.3.4 Behavioural problems

Achenbach et al. (2002, 2003) found that adolescent externalising problems as evaluated on the ASEBA instruments completed by the adolescents themselves (YSR), parents (CBCL) and teachers (TRF) in the US, increased from 1976 to 1989, but decreased in 1999. In a Dutch study Verhulst et al. (1997) found no significant differences in CBCL problem scores from 1983 to 1993. Sourander et al. (2004) found fewer psychiatric symptoms in Finnish boys in 1999 compared with 1989, whereas no clear change had occurred in girls' symptoms, except for more hyperactive symptoms. An increase in antisocial problems, however, was found among Swedish girls between 1970 and 1996 (Wångby et al., 2005). Collishaw et al. (2004) found, in three general population samples of UK adolescents, a substantial increase in adolescent conduct problems over the 25-year study period. Conduct problems affect children of all ages. Most studies on time trends relate to adolescents, but the few findings on younger children suggest little changes in rates of behavioural problems between the 1970s and 1990s (McArdle et al., 2003; Sourander et al., 2004). The rates of referral of behaviour problems to the BUP services in Norway have increased moderately from 17.1% in 1992 to 20.4% in 2004 (Lossius, 1994; Sitter, 2005).

1.3.5 Emotional problems

Depressive symptoms vary in frequency in adolescence in different studies of community samples. In a review of epidemiological studies of childhood and adolescent depression, Birmaher et al. (1996) found that the prevalence rates of depression range between 0.4% and 2.5% in children and between 0.4% and 8.3% in adolescents. There are no gender differences in depression rates in prepubescent children, but, after the age of 15, girls and women are about twice as likely to be depressed as boys and men (Petersen et al., 1991; Nolen-Hoeksema & Girgus, 1994; Kessler et al., 1994; Wichstrøm, 1999).

Few studies have focused on time trends in emotional disorders in children and adolescents (Fombonne, 1995; 1999). Some studies indicate that there most likely has been an increase in depressive symptoms among adolescents in recent birth cohorts (Lewinsohn et al., 1993; Prosser & McArdle, 1996). Rossow et al. (2005)

reported an increase in depressive symptoms among Norwegian girls as well as among boys from 1992 to 2002.

Repeated parent and teacher questionnaires in Holland (Verhulst et al., 1997), Great Britain (McArdle et al., 2003) and Finland (Sourander et al., 2004) documented stable or declining levels of emotional problems between 1970s and 1990s among primary school children. In Finland, however, children's self reports indicated a small significant increase in depressive symptoms in the late 1990s. Wångby et al. (2005) found self-reported emotional problems among Swedish girls to remain stable between 1970 and 1996. Levels of anxious and depressed mood increased from 1976 to 1989 and decreased in 1999 but remained higher than in 1976 among children and adolescents in the US (Achenbach et al., 2003), while in the UK levels of emotional problems remained stable between 1974 and 1986, but had risen in 1999 (Collishaw et al., 2004). Costello et al. (2006) concluded from a meta-analysis of 26 studies with successive birth cohorts that no evidence existed for an "epidemic" of child or adolescent depression. The rates of referral of sadness/depression problems to the BUP services in Norway have increased strongly from 0.5% in 1992 to 18.1% in 2004, while anxiety/phobia problems stayed at a relatively stable rate from 8.8% in 1992 to 7.7% in 2004 (Lossius, 1994; Sitter, 2005).

1.3.6 Suicidality and deliberate self-harm

Suicide is rather uncommon among prepubertal children (Grøholt et al., 1998). However, rates of completed suicide increase with increasing age. The rate of suicide in the US among prepubertal children and young adolescents had increased by 120% from 1980 to 1992 but from 1992 to the present the rate has decreased by 33% (Roche et al., 2005). Over the second part of the last century, rates of suicide have been rising in the western industrialised countries, and especially among young men. Mittendorfer-Rutz and Wasserman (2004) compared trends in suicide rates from 1979 to 1996 among adolescents 15 to 19 years of age in 30 countries of the WHO European Region. In 21 of the 30 studied countries, male adolescent suicide rate increased during the study period. Female adolescent suicide rates rose less markedly than in males in 18 countries, with the exception of strong increases in Norway and Ireland. National statistics show a slight decrease in suicide rates in Norway from 28 to 21 per 100,000 for male adolescents 15 to 19 years of age, and a small increase from 7 to 9 per 100,000 for female adolescents in the 1991-95

compared with.the 2001-04 period (Statistics of Norway, 2004). The low suicide incidence in childhood may be related to fewer risk factors such as affective disorders, disruptive disorders, and not living with two biological parents, rather than to resilience to risk factors (Grøholt et al., 1997).

Parasuicidal behaviour or deliberate self-harm seem to have increased in recent years. In a WHO multicenter study on parasuicide in 13 European countries (Schmidtke et al., 1996), suicide attempt rates were higher among women than among men. In the majority of centres, the highest rates were found in the younger age groups. The rates for individuals aged 15 years or over decreased between 1989 and 1992. Following a decline in deliberate self-harm among adolescents in the UK in the late 1970s and mid 1980s, rates were beginning to increase in the late 1980s until the mid 1990s, but there were no demographic alterations to explain the changes (Hawton et al., 2000). From 1990 to 2000 a rise was found in those aged 15 to 24 years (Hawton et al., 2003). Rates for suicide attempts among young women in Sør-Trøndelag County in Norway increased during the second half of the 1990s subsequent to a decrease during the first half of the decade, while the rates for young men decreased during the first half of the decade and thereafter remained stable (Hjelmeland, 2001). Rossow et al. (2005) reported an increase in rate of self-reported suicide attempt from 1992 to 2002 among Norwegian girls but not among boys. In Norway 6.6 % of adolescents 15 and 16 years of age in a community sample reported one or more acts of deliberate self-harm over the course of the previous twelve-month period (Ystgaard et al., 2003). Cutting (74.1 %) and self-poisoning (16.9 %) were most prevalent. 14.7 % had been in contact with a hospital. 46.7 % of self-poisoning episodes but only 6.1 % of cutting episodes were treated in hospital. Deliberate self-harm was more common in females than in males (10.2 % vs 3.1 %). Wichstrøm and Rossow (2002) reported from another Norwegian study that more adolescent girls (10.4%) than boys (6.0%) reported a previous suicide attempt. Their results supported the conclusion that higher levels of risk factors for girls, especially depression, account for their higher level of self-reported non-fatal suicidal behaviour. Grøholt et al. (1998) found a strong correlation between adolescent depression and suicide, and that half of the adolescents who committed suicide had an affective disorder. The rates of referral of suicidal risk to the BUP services in Norway have stayed at a stable rate from 3.7% in 1992 to 4.1% in 2004 (Lossius, 1994; Sitter, 2005).

1.3.7 Alcohol and drug use

In the national surveys in 1995 and 1999, Norwegian adolescents' use of alcohol and drugs were rated at a relatively low level compared with youths in most European countries (Skretting & Bye, 2003). However, according to annual surveys among adolescents in Norway, the annual consumption of alcohol increased more than fifty percent from 1990 to 2000, and use of illicit drugs more than doubled during the same period (Bye, 2003). Further, from 1999 to 2003 a decrease or no change was found in use of both alcohol and cannabis (Skretting & Bye, 2003). The same trend was found for other illicit drugs. Lately, a decrease in use of alcohol as well as cannabis has been reported from 2003 to 2005 (Skretting, 2005). In spite of reported increases and decreases in adolescent use of alcohol and drugs during the last 15 years, the rates of referral to the BUP services in Norway in this period have stayed at a remarkable low rate from 1.0% in 1992 to 0.3% in 2004 (Lossius, 1994; Sitter, 2005).

1.3.8 Eating disorders

There seem to be a misconception that rates of anorexia nervosa are rising. In a review of epidemiological studies, Fombonne (1995) concluded that anorexia nervosa remains a rare disorder and there is no evidence of a lasting increase in its incidence. Similarly, Fombonne (1996) concluded, in a review, that epidemiological studies conducted since 1980 did not show an upward trend in rates of bulimia nervosa in spite of popular beliefs. However, more recently epidemiological studies from the UK found an increase in bulimia nervosa in the 1990s, but this now appears to be falling (Turnbull et al., 1996; Currin et al., 2005), and further evidence has supported the stability of anorexia nervosa incidence rates (Currin et al., 2005). In a sample of 1,960 Norwegian adolescents Kjelsås et al. (2004) found 0.7% of the girls to fulfil DSM diagnostic criteria of anorexia nervosa and 1.2% of bulimia nervosa. Corresponding numbers for boys were 0.2% for anorexia and 0.4% for bulimia. The rates of referral of eating problems to the BUP services in Norway have stayed at the same low stable rate of 2.9% in 1992 as well as in 2004 (Lossius, 1994; Sitter, 2005). This may reflect a stability of the incidence of anorexia nervosa, as well as a limited influence of possible changes in the incidence of bulimia nervosa because this disorder tends to begin in late adolescence or in early adult life (Fombonne, 1995c).

The average age of onset for anorexia nervosa has been reported to be between 16 and 18 years (Theander, 1970; Halmi, 1974; Crisp et al., 1980; Fombonne, 1995c) and according to different reports, the average age of onset for bulimia nervosa is between 18 and 21 years (Russel, 1979; Fairburn & Cooper, 1984; Mitchell et al., 1986; Fombonne, 1995c).

1.4 Co-occurring conditions

1.4.1 Abuse and neglect

Child physical and sexual abuse and neglect was not given serious attention in Norwegian society until the beginning of the eighties (Kloster, 1983; Sætre et al., 1986). Ulstein et al. (1982) found an incidence of physical child abuse in Nordland County of 33/1,000,000 inhabitants per year, and Otterstad (1987) found the same rate of incidence in Østfold County (34/1,000,000). In both studies data were collected through questionnaires to local health, social and school services about registration and work with maltreatment cases. New information about the negative effects of childhood abuse and neglect on mental health put these issues on the agenda of the child and adolescent services (Reigstad & Sørgaard, 1987). In the first half of the nineties the standardised referral form for child and adolescent psychiatric services in Norway contained special environmental categories for child abuse. The form included categories for physical and sexual abuse from 1990 to 1994, but these categories were removed when the referral form was revised in 1995. The referral problem concerning sexual abuse was registered in 9.7% (N = 6,633) of the cases in child psychiatric services in Norway during this period and physical abuse was registered in 1.4% (N = 936) of the referrals. In 1992 neglect was also included as an environmental problem, and reached a level of 1.2% of referrals in 1994 (Ytterhus, 1991; Lossius, 1994; Lossius & Sæbø, 1995). From 1995 we have no official data about prevalence of abuse and neglect as referral problems in the child and adolescent psychiatric population in Norway, and there may hence be a risk that these issues are overlooked in clinical practice.

Ystgaard et al., (2003) found in a school-based study on adolescents 15 to 16 years of age (N=4,060) in the counties of Hedmark and Oppland that 2.5% of the boys and 10.7% of the girls reported sexual abuse, and 4.3% of the boys and 7.8% of the girls reported physical abuse. Abuse strongly increased the risk for self-harm in both

genders. Among boys, physical abuse was more strongly related to deliberate self-harm than was sexual abuse.

Child abuse and neglect operate, however, in context with other childhood adversities. Risk factors may be found in four areas: (i) in the child (such as difficult temperament, handicaps, or physical or psychiatric disorders or symptoms), (ii) in family relationships and child rearing, (iii) in the parents (such as poor mental and/or physical health, alcohol and/or substance abuse, or very young age), and (iv) in poverty and related stresses in the family and the community (Belsky, 1993; Brown et al., 1998; Brown et al., 1999). Prospective studies have shown that all these risk factors are predictors of abuse and neglect (Brown et al., 1998; Fergusson et al., 1996). An important perspective is the risk for transference of the problem to the next generation. Famularo et al. (1992) found that maltreating mothers exhibited a significantly greater incidence of mood disorder, alcohol abuse, and personality disorder than did controls. Rates and correlates of abuse and neglect have been studied extensively in the general population and, to some extent, in selected types of clinical populations. Several studies of clinical as well as community samples have confirmed the relationship between retrospectively reported childhood abuse and adult psychiatric disorders. Findings from child and adolescent samples indicate the same correlates as among adults (Famularo et al., 1992; Flisher et al., 1997; Brown et al., 1998). Cross-sectional studies (McCauley et al., 1997; Cohen et al., 2002; McHolm et al., 2003) point in the same direction: childhood abuse entails increased risk for psychopathology in adolescence and adulthood. Longitudinal studies (Cohen et al., 2001) confirm the relationship between childhood maltreatment and mental health disorders. Some studies indicate different effects of being physical abused or/and being sexually abused in childhood (Goldman et al., 1992; MacMillan et al., 2001).

The only knowledge we have today about the occurrence of sexual and physical abuse in the child and adolescent psychiatric population in Norway is from the ICD-10 diagnostic system, axis 5 “Deviant psychosocial relationships”. Sexual abuse within the family is given the code 1.4, outside the family 6.4, and physical abuse 1.3. In 2002 52% (N = 5,451) of the closed cases in the national clinical population (N = 10,487) were given an ICD-10 diagnosis on axis 5. A sexual abuse diagnosis was given to 3.1% (N = 166) of these patients, and a physical abuse diagnosis was given to 0.3% (N = 14) of the patients this year (Reigstad, unpublished data).

Most studies on abuse and neglect stem from community samples where associations between childhood abuse/neglect and mental health problems in children and adolescents are well documented. More knowledge about associations between these childhood adversities and emotional and behavioural problems, and psychosocial factors among child and adolescent patients is needed. The gap between prevalence of abuse in population studies and prevalence of abuse diagnoses on ICD-10 axis 5 in the BUP services, demonstrates that attention to these problems need to be more strongly focused within the BUP services.

1.4.2. Pain

Pain suffering among children and adolescents is a common problem that may interfere with a healthy development and psychological wellbeing. Pain in children and adolescents as a referral problem has, over the years, been registered under the label of “psychosomatic problems”. Pain problems have never been a separate referral category in child and adolescent psychiatry. Because of this, we have no formal registration of how often these problems are referred or how prevalent they are among child and adolescent psychiatric patients in Norway. Many studies have, however, found associations between pain and psychiatric symptoms (Larsson 1991; Tamminen et al., 1991; Egger et al., 1998; Larsson & Sund, 2005). In population samples frequent headache and abdominal pain have been reported in 8% to 30% of school-age children and adolescents (Garber, Zeman & Walker, 1990; Borge et al., 1994; Larsson & Sund, 2005). The incidence of psychosomatic complaints and experience of pain in children seems to have been rising in the Nordic countries in the last decade, and are common among as many as one fifth of the population of children and adolescents, more often so among girls than among boys, and rates increase with age (Berntson & Köhler, 2001; Larsson, 1991; Hakala et al. 2002; Kristjansdottir, 1997).

In the ICD-10 diagnostic system, persistent, severe, and distressing pain which cannot be fully explained by a physiological process or a physical disorder can be diagnosed as a psychiatric disorder on axis 1. A diagnosis of Persistent somatoform pain disorder (F45.4) may be given if pain has existed for at least six months and is not a part of another mental health disorder. An analysis of the national database for all child and adolescent patients in Norway in 2002 concerning of rates of the F45.4 Persistent somatoform pain disorder diagnoses in closed cases, found that 8,001

patients had received an axis 1 diagnosis (76.3%), and that only 5 patients had received a F45.4 diagnosis (0.1%) (Reigstad, unpublished data). Accordingly, pain diagnoses are almost never used in the BUP services, at least in Norway. However, the criteria for a persistent somatoform pain disorder diagnosis (F45.4) are strict, and presuppose that pain is severe enough to cause emotional conflict or psychosocial problems. Pain conditions where such influences are less clear should be excluded. An explanation of the low rates of pain diagnoses in the BUP services could be that pain suffering traditionally is defined by clinicians in the BUP services as a matter for somatic health care services, the GP and paediatrics, and so receive little attention. Most studies of pain conditions among children and adolescents come from somatic medicine. Little is known about rates of pain suffering among children and adolescents in specialty mental health service, nor about associations with emotional and behavioural problems, psychiatric symptoms, and psychosocial factors. Yet, Masi et al. (2000) found in a study of a sample of patients referred to an Italian clinic that somatic complaints were reported by 69% of the patients, and that headache was the most frequent reported somatic symptom (51%). No gender differences were found. Subjects with anxiety and/or depression reported particularly high rates of somatic complaints. Chronic pain symptoms are, in several studies, reported to be associated with depressive symptoms among adolescents (Mikkelsson et al., 1997; Harma et al., 2002; Larsson & Sund, 2005). Egger et al. (1998) found that girls with depression and anxiety disorders had a significantly greater prevalence of headaches than girls without an internalis ing disorder. They did not, however, find this association for boys where conduct disorder was significantly associated with headaches. The presence of chronic pain is reported to increase the duration of depressive mood (Ohayon & Schatzberg, 2003). Chronic pain is related to emotional and behavioural problems, reduces quality of life and has negative social and educational consequences for children and adolescents (Egger et al., 1998; Larsson & Sund, 2005). More knowledge is needed to include pain suffering as a target for interventions and thus improve therapeutic measures in the BUP services.

1.4.3 Sleep problems

Sleep problems in children and adolescents are common, and their impact on emotional and cognitive functions is significant (Ohayon et al., 2000; Pilcher &

Walters, 1997). Sleep disorders may be harmful to development and well being. It is important to focus on the developmental aspects of childrens' sleep problems.
A highly differentiated diagnostic effort is required because sleep in children is extremely variable between individuals and undergoes a constant natural development. It depends on cultural influences, and the pathogenesis is predominantly due to environmental variables, especially to the child-parent interaction (Frolich & Lehmkuhl, 2004).
In referrals to the BUP services in Norway, sleep problems are also registered under the label “psychosomatic problems”. As a consequence we lack information about how prevalent these problems are among BUP patients. Traditionally, small children with sleep problems have been referred to the BUP services when the parents themselves have been exhausted. Sleep problems in older children and adolescents seem seldom to be referred to child and adolescent mental health services. Insomnia is a pervasive problem for many patients suffering from medical and psychiatric conditions. Even when the comorbid disorders are successfully treated, insomnia often remains. In addition to compromising quality of life, when untreated insomnia may also aggravate and complicate recovery from the comorbid condition (Smith et al., 2005). Sleep problems are prevalent in the child and adolescent population and, in epidemiological studies, vary from between 22% to 43% (Kahn et al., 1989; Stores & Wiggs, 1998; Paavonen et al., 2000). Sleep problems are correlated with a range of psychiatric problems in childhood and adolescence, including depression (Sadeh et al., 1995; Johnson et al., 2000; Barbe et al., 2005), posttraumatic reactions (Glod et al., 1997), behavioural disorders (Aronen et al., 2000; Smedje et al., 2001), hyperkinetic and attention disorders (Gruber et al., 2000; Lindberg et al., 2004; Golan et al., 2004), eating disturbances (Delvenne et al., 1992), autism and Asperger’s disorder (Patzold et al., 1998). Despite this, the impression remains that clinicians in child and adolescent psychiatric services relate to sleep problems to only a limited degree and not very systematicly in their everyday practice, and that information about sleep problems is seldom brought up. Treatment strategies aimed directly at these problems might have positive influences on depressive symptoms and hyperactivity/attention problems (Weissman et al., 1997; Picchietti et al., 1999).
ICD-10 F51 covers the different non-organic sleep disorders: F51.0 Non-organic insomnia, F51.1 Non-organic hypersomnia, F51.2 Non-organic disorder of the sleep – wake schedule, F51.3 Sleepwalking (somnabulism), F51.4 Sleep terrors (night

terrors), F51.5 Nightmares, F51.8 Other non-organic sleep disorders, F51.9 Non-organic sleep disorder, unspecified.

An analysis of the national database for all child and adolescent mental health patients in Norway in 2002 looked at rates of ICD-10 Different non-organic sleep disorders (F51) in closed cases and found that only 13 out of 8001 patients (0.2 %) had received this diagnosis (Reigstad, unpublished data). This indicates that sleep problems are overlooked in clinical practice in child and adolescent mental health services in Norway. Studies on sleep problems among children are almost exclusively from community samples or from paediatric settings. More knowledge is needed about rates of sleep problems among child psychiatric patients, as well as how these problems are related to, and symptomatic of, other mental health disorders.

1.5 Psycho-social factors

Psycho-social stressors are found to be associated with psychiatric symptoms as well as with mental health disorders among children and adolescents in numerous studies. In the ICD-10 revision (WHO, 1992), axis 5 is defined as the psycho-social axis where stressors are divided into 9 main categories, and most of these are divided into subcategories giving a total of 40 psychosocial stressors. From a diagnostic and therapeutic perspective the clinician needs to map and relate to intra- as well as extra-familial stressors and adversities. However, psychosocial epidemiology, which pertains to the influence of social factors on a person's behaviour and to the interrelation of behavioural and social factors, is a controversial field within epidemiology (Mutaner & Chung, 2005). The question of whether psychosocial stressors are a part of the aetiology of psychopathology, or if effects of stressors on psychosocial functioning are mediated through psychopathology and/or individual vulnerability, has yet to be settled.

Stress can be defined as the psychological, physiological and behavioural response by an individual when they perceive a lack of equilibrium between the demands placed upon them and their ability to meet those demands, which, over a period of time, leads to ill-health (Palmer, 1989).

Unhealthy adaptation to stress can take many forms: physically, such as somatic complaints where different types of pain and sleep problems are responses to severe levels of stress (Greene et al., 1985; 1997; Hall et al., 2000); cognitively, such as

reduced attention span with resulting academic problems (Fallone et al., 2005; Gibson et al., 2006); socially, such as maladaptive coping patterns, including verbal and physical aggression, defiance of authority, acting out, and juvenile delinquency (Compas et al., 1989); and emotionally, such as anxiety reactions, depression and suicidal ideation are other reactions to stress (Swearingen & Cohen, 1985; Cohen-Sandler et al, 1982).

Stressful life events are consistently related to depression in children and adolescents as well as in adults (Allgood-Merten et al., 1990; Petersen et al., 1991; Williamson et al., 1998). Accumulation of stressful life events combined with developmental tasks (Petersen, 1988; Simmons et al., 1987) in interaction with individual vulnerability (Brooks-Gunn & Warren, 1989; Petersen et al, 1993) might increase the risk for depressive symptoms, and for suicidal ideation (Beautrais et al., 1997; Chastang et al., 1998; Wilburn & Smith, 2005). Stressful life events are thought to precede depression in adolescence, and associations between stress and depressive symptoms are also found in several Norwegian studies (Sund et al., 2003; Murberg & Bru, 2005).

In an overview, Fleming & Offord (1990) found only 4 factors consistently associated with depression in children and adolescents: Age, low self-esteem, family dysfunction, and number of stressful life events.

Williamson et al. (1998) found that depressed adolescents had experienced one or more severe events during the year prior to onset, and so had been exposed to high levels of stress prior to becoming depressed.

Negative life events and stress are related to behavioural problems as well as emotional problems (Greene et al., 1985; Cuffe et al., 2005). In a Norwegian study of relationships between negative life events, perceived social support and misbehaviour among pupils, misbehaviour was found to correlate with negative life events, and support from parents, friends and teachers were found to correlate negatively with misbehaviour (Bru et al., 2001). Many studies have demonstrated direct relationships among stressful life events, social support, problem solving, and adolescent adjustment (Printz et al., 1999). Social support has been found to prevent maladaptive reactions in coping with stressful life events and developmental tasks (Kessler et al., 1985). The impact of life stresses might depend on how well the child is protected. Ge et al. (1994) found that social support from the mother protected against stressful life events for girls, but not for boys. Goodyer et al. (1997) found that

perceived lack of support from family and friends was the most important factors that predicted a new depressive episode in depressed adolescents.
However, Waaktaar et al. (2004), in a Norwegian longitudinal study on a cohort of community-based adolescents, found that depressive symptoms predicted stressful life events rather than vice versa. Psychiatrically disturbed children are also found to have an increased risk of experiencing behaviour-dependent life events and long-term adversities compared with their peers in the community (Sandberg et al., 1998; 2001). Bolton et al. (2004) found that long-term effects of psychological trauma on psychosocial functioning in young adults were mediated by psychopathology. Patton et al. (2003) reported from a population based cohort study that pre-existing depressive and anxiety symptoms among adolescents predicted later events, increasing three-fold the risks for both neutral/positive and negative events in females and seven-fold the risk of negative events in males. They also found that life events, in turn, predicted the onset of depressive disorder independently of previous symptoms. In a review study Grant et al. (2004) concluded that stressors predict changes in rates of symptoms of psychopathology in children and adolescents over time, and that results also suggested the opposite relationship over time. The relationship between stressful life events and mental disorders may therefore be seen as cause as well as consequence.
Cuffe et al. (2005) found, in a longitudinal study, that family structure and cohesion and stressful life events were associated with adolescent affective disorders. Psychiatric evaluation, diagnosing, and treatment of children and adolescents should include a family and network perspective where knowledge of possible psychosocial stressors is important. Clinicians need more knowledge about the prevalences of such psychosocial stressors and relationships with psychiatric symptoms as self-harm, suicide attempts, and mental disorders among patients in the BUP services.

1.6 **Service use**

1.6.1 Help-seeking models

Models of help-seeking in health services have been formulated and described by several researchers (Andersen, 1995; Aday & Andersen, 1974; Goldberg & Huxley, 1980; 1992; Fischer et al., 1983; Phillips et al., 1998). Few of these models specifically apply to help-seeking for child and adolescent mental problems, however (Zwaanswijk, 2005). Although the models differ, most have some key elements in

common. According to Zwaanswijk (2005), Goldberg and Huxley (1980; 1992) described 5 levels at which mental health problems could be apparent: (a) in the community, (b) among attenders of primary care, (c) as recognised by primary care providers, (d) among individuals referred to outpatient mental health services, and (e) among those admitted to hospitals. Patients are supposed to move through these subsequent filters on their way to specialty mental health treatment. The filters refer to (a) problem recognition by the individual and the decision to consult a GP, (b) problem recognition by the GP, (c) referral to mental health care by the GP, and (d) admission to mental health care (Zwaanswijk, 2005). In this model, the GP has a gatekeeper function and a central role in the help-seeking process. This model is based on the British health care system, and built on the same mould as the Norwegian LEON-principle (care at the lowest effective level). Referrals to the BUP services in Norway have, since 1989, been supposed to follow this principle with the GP in a central role. Since then, referral reimbursement to the clinics from the government presumed registration of the GP as the primary referral agency. However, referrals from the child protection agencies also receive reimbursement. Before 1989, all agencies, and parents or youths themselves were also allowed to refer to BUP services. Help-seeking for children and adolescents is different from help-seeking for adults simply because children and adolescents depend on the recognition of parents and/or other caregivers of their problems and their willingness to consult a GP or a child protective service. On this background Costello et al. (1998) have underlined the significance of including a broader social context in a help-seeking model for child and adolescent mental health problems.

1.6.2 Factors related to service use.

Many children who need help from mental health services still do not receive it (Verhulst & Ende, 1997; Wu et al., 1999). Certain factors seem to be associated with using these services. Children and adolescents are dependent upon parents and local professionals in order to get help for their problems. It is reasonable to believe that expectations of successful treatment and lessening of symptoms, suffering and burden will make it more likely that these services are sought after. Distance and travelling time to clinics seem to be important for use of these services (Rössler et al., 1991). Capacity and waiting lists in child mental health clinics, on the other hand may also be factors that influence access and use of these services. However, the

strongest correlate of specialty mental health service seems to be the effect of children's symptoms on their parents (Angold et al., 1998; 2002; Logan & King, 2002; Zwanswijk et al., 2003). Contradictory results are found concerning the effect of type of child and adolescent mental problems on problem recognition and referral. Several studies have confirmed a higher probability of referral of externalising problems than of internalising problems (Cohen et al., 1991; Cornelius et al., 2001; Pavuluri et al., 1996; Wu et al., 1999). Other studies have found variable or no higher probability (Gasquet et al., 1999; Sourander et al., 2001; Verhulst & van der Ende, 1997). Sayal (2004) found, in a UK longitudinal study, that symptom severity of behavioural as well as emotional problems best predicted future referrals to specialty mental health services for children.

In a study of pathways to care for children at risk for attention deficit hyperactivity disorders, parents were found to be the main gatekeepers for access to specialty services (Sayal et al., 2002). Children's internalising problems such as depression and anxiety appear to be associated with fewer burdens to others than is the case with other diagnoses, and children with depressive disorders have previously been found to be less likely to receive specialty mental health services (Anderson et al., 1987; Angold et al., 1998; Wu et al., 1999). However, self-reports of depression are higher than others' report, and children's own perception of the need for professional help is more related to depression than to disruptive disorders (Wu et al., 1999; Romano et al., 2001). Depressive problems in preadolescence tend to be underestimated by parents compared with teachers, and teachers' evaluation of the child's needs are among the best predictors of referral to the mental health services (Mesman & Koot, 2000; Sourander et al., 2001). Thus, professionals may be better at detecting internalising problems than parents, and hence to greater extent refer children to specialty mental health services for such problems. Internalising as well as externalising problems have been found to contribute to service use in the Netherlands (Verhulst & van der Ende, 1997) and in Finland (Sourander et al., 2001), although the effect was strongest with externalising problems. In a Dutch prospective study on adolescent mental health service use, a remarkable delay was found between the awareness of the adolescent's problem and seeking and/or receiving professional help (Laitinen-Krispijn et al., 1999). The authors found that problem behaviour perceived by parents in early adolescence predicted the incidence of

mental health service use, even 5 years later. A range of other factors than psychiatric symptoms have also been found to affect child psychiatric service utilisation: age (Cohen & Hesselbart, 1993; Zahner & Daskalakis, 1997), gender (Goodman et al., 1997; Zahner & Daskalakis, 1997), family stress (Verhulst & van der Ende, 1997; Zwanswijk et al., 2003), family socio-economic status (Garralda & Bailey, 1988; Cohen & Hesselbart, 1993; John et al., 1995), parental use of mental health services (Garralda & Bailey, 1988; John et al., 1995), and perceived parental burden (Angold et al., 1998; Angold et al., 2002; Logan & King, 2002). These factors almost exclusively pertain to known differences between child and adolescent psychiatric patients and the rest of the child and adolescent population.

1.6.3 Referrals from the local services

In 2004, 3.6% of the child and adolescent population under the age of 19 had received treatment from the specialty mental health services in Norway, but there were considerable regional differences (Sitter, 2005). Zwaanswijk et al. (2003) found that 3.1% of a Dutch general population sample of adolescents had been referred for mental health services in the preceding year, and among adolescents who scored in the borderline/clinical or deviant range of the YSR total score only 7.7% had been referred for mental health services. The borderline/clinical range includes scores ranging from the 82nd percentile equivalent to T scores from 60 in normative samples (Achenbach, 1991). Sourander et al. (2001) reported that 7% of a Finnish child and adolescent community sample had been in contact with some kind of child mental health services during an 8-year follow-up. Only 13% of the adolescents within the deviant range of the YSR total score in the Finnish study had used child mental health services. No difference was found between groups of treated and untreated children, 7 to 11 years of age, in those receiving a psychiatric diagnosis and with scores in the clinical range on the CBCL (Costello & Janiszewski, 1990). Thus only a small proportion of children who supposedly had mental health problems were referred for treatment. It may be unclear why some of these children are brought for treatment and others are not. When a psychiatric problem is recognised, local treatment will be an option if it has not already been tried. At present we know very little about which children are referred to child and adolescent psychiatry and which children are treated locally.

1.7 Main research questions

The following main research questions were addressed in this study:

- Have patterns of referral problems to the BUP services in Norway changed during the last decade (1992 – 2001)?
  Which social factors influenced referral practices? What degree of convergence exists between referral problems and diagnoses?
- Do adolescents referred to the BUP services differ from those who receive only local help?
- What are the prevalences of sexual and physical abuse and neglect among adolescents in the BUP services, and to what extent are emotional and behavioural problems, psychiatric symptoms, and psychosocial factors related to these childhood adversities?
- What is the prevalence of pain suffering among adolescents in the BUP services, and what impact has these problems on their mental health?
- How prevalent are sleep problems among adolescents in the BUP services compared to adolescents in the community, and are sleep problems differently correlated in these two groups?

2 METHODS

2.1 Design

This thesis reports on data from 3 main sources:

(i) *A clinical sample from the BUP services in Nordland:* Data from the study "Depressive symptoms in a one-year's population of adolescents referred to child and adolescent psychiatric outpatient clinics in Nordland: prevalences and correlates" was analysed (paper II, III, IV and V).

(ii) *A community sample from Trøndelag:* The clinical sample from Nordland was compared with the population sample from The Youth and Mental Health Study which is a prospective survey from Trøndelag (Sund, 2004) (paper II and V). The two samples completed almost identical measures.

(iii) *The national BUP data base:* Data from all child- and adolescent outpatient clinics in Norway including all patients was analysed for the period 1992 to 2001 (paper I and III).

A clinical sample from Nordland (Paper II, III, IV and V). A cross-sectional clinical sample (n = 129) consisting of outpatients aged 12 to 18 was recruited consecutively from June 2000 through the year 2001 from the nine specialty mental health service clinics (BUP) in Nordland County. The Regional Ethical Committee and the Norwegian Data Inspectorate approved the study. Informed written consent was obtained from all participants. Comparisons were made with those who did not participate with respect to gender, age, referral problem, and diagnosis. Information about referral problems and diagnoses were collected from the patient's medical notes. The sample was representative with respect to referral problems and diagnoses. Pairwise comparisons showed no difference in rates of ICD-10 axis 1 diagnostic categories between these two groups. However, the study sample was slightly older (15.2 years vs. 14.8 years) and contained more girls (70.5% vs. 60.4%) than those who did not participate (both $p = .04$). In a clinical population, however, age and gender will be correlated. In the total sample of 12 to 18 olds, girls were older when they were referred to child and adolescent psychiatry as compared to boys (15.1 years vs. 14.6 years). Patients referred in Nordland County were, however, 14 days older than patients residing in the rest of the country ($t = 2.54$, $p < .05$), and were somewhat more often girls (61.4% vs. 55.2%; $\chi = .002$). Patients from Nordland and patients from the rest of Norway (N = 6,692) did not differ in ICD-10 axis 1 diagnoses or in reasons for referral.

Nordland County has 236,945 inhabitants, covers an area of 38.327 km^2, and the distance from north to south is 450 km. It has a long coast line and consists of 50 communes with several small towns. The county administration is situated in the city of Bodø which has 43,775 inhabitants. The main industries are fishing, agriculture and heavy industry. Nordland is served by 9 child and adolescent psychiatric outpatient clinics located in local hospitals.

A community sample from Trøndelag (Paper II and V). The representative clinical sample of 129 adolescent psychiatric patients from Nordland County was compared with a stratified random and representative community sample in a prospective survey of 2,538 adolescents from the neighbouring counties of North Trøndelag and South Trøndelag (The Youth and Mental Health Study) (Sund, 2004). The adolescent population sample was aged 13 to 17 (mean age = 15), comprising 50.8% girls and

49.2% boys who completed questionnaires at school in 1999. Written informed consent were obtained from both pupils and parents. Schools were drawn according to proportional allocation. The participation rate was 88.3%. Data was treated confidentially. The community sample stems from a representative sample of 2,538 adolescents attending 22 private or public schools during 1999 (Total population, N = 9,292) (second wave of data collection in The Youth and Mental Health Study) (Sund, 2004). For a closer description of the catchment area see Sund (2004).

The BUP national database (Paper I and III). From 1990 national data were stored as summary statistics in annual records based on registrations in the BUP-data program. In order for local professionals to refer to child- and adolescent psychiatry, they have to fill in a standardised referral form. Referral problems for the child are divided into 19 categories. Relevant information about referral and treatment are computerised and has been annually reported to a national database for publication of national statistics. From 1992 there have been no changes in the problem categories used in the referral form. From 1996 onwards databases are available on file for each referral. It should be noted that the file consist of referrals, not individual cases. The database includes all referrals in Norway. The published statistics from 1992 on provide the opportunity to analyse changes in referral problems and diagnoses over time at a national level. The databases from 1997 to 2001 were used for more detailed analyses. There is no information concerning the reliability of this reporting, but lack of accuracy should be limited merely to typing errors. The multiaxial diagnostic system ICD-10 was introduced for use in child and adolescent psychiatry in Norway in 1997. Many patients who were admitted in the latter part of the year will not have received a definite diagnosis at the time of reporting (ie. late December). ICD-10 axis 1 diagnoses will therefore only be analysed from closed cases (N = 40,274). The records are provided individually for each year. Identification numbers are not included for reasons of anonymity. In 2001 32.2% of patients were referred during the year of reporting. The average time in treatment from referral date was 1.75 years (S.D. = 1.49 years). 39.4% of patients registered in 2001 were also registered in 2000, 15.9% also in 1999, whereas 12.5% were registered in 1998 or previously. For this reason, the same person may be referred more than once the same year, and more importantly, the same person will be

registered in more than one year if health care is provided in more than one calendar year. Cases in these records are therefore not independent. To counter this non-independence, analyses were performed on cases that were referred in the year of reporting.

ICD-10 axis 5 is commonly referred to as “The psychosocial axis”. In Norway clinicians are expected to use all axes in the diagnostic process. In this national database we have recordings of sexual and physical abuse from the ICD-10 diagnostic system, axis 5.

National data files for the years 2000 and 2001 encompassing the national population of closed cases (N = 20,652) are presently the ones available that cover this information. In all, 76.8% of these patients received an ICD-10 axis 1 diagnosis, while 50% (N = 10,326) received an axis 5 diagnosis. National data files for the years 2000 and 2001 were analysed to cover this information compared to self-report of abuse from the clinical sample from Nordland County (paper III).

2.2 **Procedures**

2.2.1 Procedures at the BUP clinics in Nordland

The project was first presented at the meeting of BUP leaders in Nordland in May 1999, and more detailed information was given in February 2000. All of the nine participating out-patient BUP clinics in Nordland County were visited during the spring of 2000, and the staff and the secretaries were informed about of the project and the procedures. All secretaries at the nine clinics met in Bodø for more information and training. Each BUP clinic received written an instruction of procedures. The secretaries gave out written information about the project to the adolescent patients and their parents, and collected written consents. The adolescents filled in the self-report questionnaire alone at the clinic they were attending, but they had the option of asking for assistance. The questionnaire was then put in an envelope and sealed by the adolescents themselves, and it was sent by the secretary at the clinic to the researchers in Bodø where it was scored. The secretaries were paid for their extra work, and were continuously in contact with the leader of the project.

2.2.2 Procedures at The Youth and Mental Health Study in Trøndelag.

The Youth and Mental Health Study was performed under the leadership and administration of Anne Mari Sund (2004) who described the procedures as follows: "At each of the participating 22 schools, a member of the staff was responsible for the administration of the questionnaires. They were trained at seminars in the spring of 1998 and again during the spring of 1999. They sent written information both to the parents and the pupils, obtained written consent and collected the data. They were paid a small amount of money for their extra work and they were in regular contact with the project leader. The two questionnaires were administered and completed by the pupils during two consecutive school lessons. The pupils sat by themselves. The completed first questionnaire was put into an envelope and sealed by the pupils themselves and during the next lesson the procedure was repeated for the second questionnaire. Teachers were instructed to help the pupils when necessary, ie. to read the questions aloud and explain difficult terminology, but this was rarely necessary. Some of the adolescents filled in the questionnaire in small groups after hearing the questions read aloud. Absent students were asked to complete questionnaires during the following months" (Sund, 2004, p. 33).

2.2.3 Procedures concerning the BUP national database in Norway.

From 1992 the published statistics from the BUP national database were used to analyse changes in referral problems. From 1997 onwards databases were available on file and were used for more detailed analyses for the period from 1997 to 2001. Access to the databases was granted by The Norwegian Association for Child and Adolescent Psychiatric Institutions.

2.3 **Assessment in the present study**

Information from the BUP national annual reports 1992 to 1996 and from the BUP national datafiles 1997 to 2001 was collected and analysed. The following were also included in the self-report scheme: referral problems, demographics, depressive symptoms, psychiatric symptoms, suicide attempts and ideation, physical and sexual abuse, neglect, use of alcohol, solvents and drugs, help for mental problems, pain, somatic health, sleep, school functioning, and functional impairment. In addition were factors from the following main conceptual domains included: (i) stressful events, (ii)

psychological variables: self-esteem and coping styles, (iii) attachment, (iv) family functioning.

DEMOGRAPHICS.

The adolescents were asked about parental education, parental divorce/separation in years, family economy, living at home or in lodgings, number of house moves.

MEDICAL NOTES (Paper II and IV).

Information about referral problems, ICD-10 axis 1, and ICD-10 axis 5 diagnoses were collected from the patients' medical notes.

THE YOUTH SELF-REPORT (Paper II, III, IV and V).

The Youth Self-Report (YRS) , the adolescent version of the Child Behavior Checklist (CBCL), was included in the questionnaire (Achenbach, 1991). Several studies have shown significant associations between DSM diagnoses and CBCL scores including YSR scores (Edelbrock & Costello, 1988; Kasius et al., 1997; Weinstein et al., 1990; Morgan & Cauce, 1999). Achenbach (1991) tested the discriminative efficiency of various cut-off points by comparing the distributions of the problem scores in demographically matched referred and non-referred youths, independently for each gender. T-scores at 60 to 63 for the YSR total were found to provide the most efficient discrimination for most age/sex groups, and therefore chosen to demarcate the borderline clinical range. The deviant range of the YSR scores is defined as a 60 t-score cut off for the YSR total, the YSR internalised, and the YSR externalised scores. The rest of the YSR dimensional scores have a 67 t-score cut-off (Achenbach, 1991).

THE MOOD AND FEELINGS QUESTIONNAIRE (Paper II, III, IV and V).

The Mood and Feelings Questionnaire (MFQ) is a self-report measure of depressive symptoms covering the previous two weeks (Angold, 1989). The MFQ contains 34 questions (e.g. "I felt very restless"," I did everything wrong") designed for children

and adolescents 8 to 18 years of age. It has been useful in discriminating depressed and not depressed clinical cases, and for predicting the persistence of major depression in clinical samples (Angold, 1989; Kent et al., 1997; Goodyer et al., 1997; Pellegrino et al. 1999). Responses were registered on a three-point scale ("Not true", "Sometimes true" and "True"). A cut-off score of 27 was suggested by Wood et al. (1995) from analysis of a clinical sample, and was used in the present study.

ABUSE AND NEGLECT (Paper II and IV).

Self-reports of physical abuse were obtained through questions of whether (1) "a closely related person had hurt you physically, one or more times, in a way that you were still injured or had bruises observable the day after", and when was the first and last time this had happened (Brown et al., 1999). Neglect was covered by the question of they (2) "had been left overnight or longer, one or more times, without an adult caretaker before age 10" (Brown et al., 1999), and sexual abuse by whether; they (3) "ever, one or more times, had been sexually abused", and when was the first and last time it happened. It should be noted that patients reporting more than one kind of abuse or neglect were included in the separate analyses of the types of abuse or neglect, in order to increase statistical power.

SLEEP PROBLEMS (Paper V).

Problem scales based on the CBCL sleep items have been used in previous research on sleep problems. Consistent with these previous studies (Stoleru et al., 1997; Gregory & O'Connor, 2002) a single sleep problem scale was chosen because the study was more concerned about assessing general disturbances in sleep problems rather than specific kind of problems. Five items from the YSR rate types and frequency of sleep problems: "I have trouble sleeping"; "I sleep less than most kids"; "I sleep more than most kids during day and/or night"; "I have nightmares"; "I feel overtired". The YSR item assessing excess sleep was excluded because of low correlation with the other items. A total "sleep problem scale" was defined by the mean scores of four items on the YSR ("I have trouble sleeping", "I sleep less than most kids", "I have nightmares", "I feel overtired"), and one item from the MFQ "I did

not sleep as well as I do usually". This scale had adequate internal consistency (α = .71).

PAIN (Paper IV).

Patients were asked whether they currently had regular and troublesome pain (excepting menstrual pain) (Larsson & Sund, 2005). If they replied "yes" they were further asked to rate frequency of pain ("1-3 times a month", "1-3 times a week", or "daily or almost daily"), in addition to duration of pain ("less than an hour", "1-4 hours" and "more than 4 hours") for headaches, stomach, back and pains in the arm or leg (thereafter called limb pain). Those who reported at least weekly pains were regarded as frequent pain sufferers.

STRESSFUL LIFE EVENTS (Paper II, III, IV, and V).

"The Early Adolescence Stress Questionnaire" (EASQ) is a 37-item questionnaire scale that was constructed for The Youth and Mental health Study (Sund et al., 2003) based on different questionnaires (Heisel et al., 1973; Swearingen & Cohen, 1985), covering areas of stressful life events and chronic stressors concerning family, school and peers (e.g. "Your mother or father has lost her or his job", "You don't get enough help with your school work", "One of your friends is in serious trouble". The respondent was asked whether a stressor or event had occurred during the last 12 months, "Yes" or "No". Higher scores on this instrument indicate higher levels of problems.

THE DAILY HASSLES SCALE (Paper II, III, IV, and V)

This scale is derived from the Unpleasant Event Scale (Lewinsohn et al., 1985), and is a 9-item scale covering unpleasant, irritating or disappointing events in every day life during the preceding month (e.g. "You have been criticized") (Sund et al., 2003). The 4-point Likert response scale ranges from "Not at all" to "Every day". Higher scores on this instrument indicate higher levels of problems.

THE INVENTORY OF PARENT AND PEER ATTACHMENT (Paper III, IV, and V) (IPPA) (Armsden & Greenberg, 1987). The revised IPPA (Armsden & Greenberg, 1989) consists of three 25-item instruments covering three domains: (1) trust (e.g. “My mother respects my feelings”), (2) communication (e.g. “My father helps me to talk about difficult things”), and (3) alienation (e.g. “My mother has problems of her own so I don’t bother her with mine”). IPPA is designed to measure attachment to mother, father, and close friends. The peer scale has fewer items than the mother and the father scale. Scores correlate with several measures of psychological well-being: self-concept, positiveness, life satisfaction, problem-solving, and locus of control. Higher scores on IPPA indicate higher levels of perceived attachment. A 5-point Likert scale of scores is used (1 = “Almost never true”, 5 = “Almost always true”).

FAMILY ASSESSMENT DEVICE (Paper II, III, IV, and V).

The McMaster Family Assessment Device (FAD) is a self-report questionnaire designed to assess various areas of family functioning (Epstein et al., 1983). In the present research, however, an overall measure of family functioning was utilised, the General Functioning subscale (12 items) (Byles et al., 1988). The McMaster Family Assessment Device includes items relating to problem solving, communication, roles, affective responsiveness, affective involvement, and behaviour control. The individuals rate each item (e.g., "We avoid discussing our fears or concerns") along a 4-point scale (1 = “Strongly agree”, 4 = “Strongly disagree”). Negatively oriented items were reversed so that higher scores represented greater family dysfunction.

THE COPING INVENTORY FOR STRESSFUL SITUATIONS (Paper II, III, and V). The Coping Inventory for Stressful Situations (CISS) (Endler & Parker, 1990) assesses three coping styles based on Folkman & Lazarus (1985): Task-Oriented (e.g. “I concentrate on the problem and try to find a solution”), Emotion-Oriented (e.g. “I get angry”), and Avoidance-Oriented Coping (e.g. “I watch TV or video”). Task-Oriented Coping is an instrumental approach of dealing with stressful situations. Emotion-Oriented Coping measures the adolescent’s fixation on the emotional consequences of stress. Avoidance-Oriented Coping pertains to the attempt to cope

by focusing on more pleasant experiences or seeking the company of others aimed at avoiding the stressful situation. CISS consists of 17 items, and the adolescents were required to rate, on a 5-point Likert scale (1 = “not at all”, 5 =”very much”).

THE RESPONSE STYLES QUESTIONNAIRE (Paper II, III, and V).

Measures of responses to depression were originally developed for adults, and may have limited utility for young adolescents. However, measures of response styles suitable for children and adolescents have since been developed (Abela et al., 2000). A new measure of responses to depression based on the Response Styles Questionnaire (Nolen-Hoeksema, 1991) was developed and used in the present study, taking into consideration the age group in question. Factor analysis was carried out with Maximum likelihood extraction, eigenvalues > 1, Scree-test, and interpretability as criteria for factor solution. This identified the following three factors:

Rumination (6 items, α = 0.73,(sample items “Thinking about why I have problems that nobody else have”, “Listening to music that fits being sad”),

Distraction (5 items α = 0.74) (sample items “Try to be together with good friends”, “Try to see the funny side of the situation”), and

Problem-Solving (4 items α = 0.61) (Sample items: “Try to find out why I am sad”, “Try to think positively”).

THE DYSFUNCTIONAL ATTITUDE SCALE (Paper III and V).

An abbreviation of the Dysfunctional Attitude Scale (DAS) (Weissmann & Beck, 1978) suggested by Andrews et al. (1993) was included. It consists of 9 items that were rated on 5-point Likert scale (1 = “Totally agree”, 5 = “Totally disagree”). DAS assesses attitudes and beliefs (e.g. “When I fail it is always my own fault” and “I should be happy all the time”) that are thought to predispose individuals to depression.

THE SELF-CONSCIOUSNESS SCALE (Paper III and V) (Fenigstein et al., 1975).

This scale was abbreviated by Lewinsohn et al. (1997) and contains items covering two subtypes of self-focus: (a) self-focus where individuals evaluate their actions taking into account the social context (e.g.” Large groups make me nervous”), and (b)

private self-focus where individuals evaluate their actions without reference to others (e.g. “I easily get embarrassed”). The scale consists of 8 items and were rated on a 5-point Likert scale (1 = “totally disagree”, 5 = “totally agree”).

THE SELF-PERCEPTION SCALE FOR ADOLESCENTS (Paper II, III, V) (Harter, 1988; Wichstrøm, 1995).

Three subscales were used in the present studies: Physical Appearance (e.g. “I wish my body was different”), Global Self-Worth (e.g. “I mostly like the person I am”), and Social Acceptance (e.g. “I have many friends”). The individual rate each of the 15 items on a 4-point Likert scale (1 = “Almost right”, 4 = “Almost wrong”).

2.3.1 Missing data

Those who had omitted more than 10 % of the items at the various measures were not included in the analysis. Missing values were otherwise replaced with the mean score of each item. However, any report of a stressful event on the EASQ scale (Y/N) was included. The different N’s for the analyses are provided in the respective tables.

2.4 **Ethics**

The Regional Ethics Committee for Medical Research, the Norwegian Data Inspectorate, and the Nordland County hospital administration approved the study. For patients less than 16 years of age written consent was obtained from the adolescent patients as well as from the parents. For patients over 16 years of age written consent was obtained only from the adolescents themselves because of their legal right to seek help from the mental health services without their parent’s knowledge or consent.

2.5 **Statistics**

The Statistical Package for the Social Sciences (SPSS) for Windows was used in the statistical analyses.

Paper I. Changes in proportion of each referral category were analysed with linear regression. The unstandardised regression coefficient * 100 show the

change (in percentages) in referrals from one year to the next. Referral categories that changed strongly in their frequency of use during this period were analysed further. An explanation for this effect of time was sought in stepwise multiple regressions by entering first potential explanatory variables, and then time. With respect to the period 1997-2001, referrals and diagnoses were analysed with logistic regression. Interactions and polynominals were investigated according to change in model fit when terms were entered in a stepwise procedure.

Paper II. Differences between the clinical sample and those receiving only local help, were analyzed with logistic regression and t-test. In search for multivariate predictors of referral to specialty mental health service, stepwise multivariate logistic regression was used. Because we had no strong argument for the primacy of particular variables, predictors were entered into the model according to their L.R. Chi-square.

Paper III. Associations between abuse and neglect, respectively, and psychosocial variables and diagnoses were analyzed with t-tests and crude odds ratios.

Paper IV. Correlations between frequent pain and various factors were analysed with logistic regression and t-test. In search for multivariate associations with frequent pain, multivariate logistic regression was used. Variables were entered into the model according to their ability to improve L.R. Chi-square.

Paper V. Differences in correlations between sleep problems and psychosocial variables in the clinical sample and the community sample were analysed with standard scores (z-values) after Fisher's transformation. Because there were slight differences in the age and gender distributions between samples, age and gender were controlled. Multivariate associations between psychosocial variables and sleep problems were tested with stepwise multiple regression, forward inclusion. In order to compare the slopes of the betas between samples, two identical models were identified. This model included variables concurrently predictive of sleep problems in both or either sample. Differences in the magnitude of the regression coefficients were tested with a t-test for independent samples designed for this situation (Paternoster et al., 1998).

3 RESULTS

3.1 Paper I

In this study changes in types of problems referred to child and adolescent psychiatry in Norway from 1992 to 2001 were analysed, and possible associations between changes in referral practices and changing media attention were investigated. Data from all the patients at all the child- and adolescent outpatient clinics in Norway were analysed for the period 1992 to 2001. From 1992 there have been no changes in the problem categories used in the referral form. Since then the published statistics provided the opportunity to analyse changes in referral problems over time on a national level. Initially, data were only stored as summary statistics. However, from 1997 onwards databases were available on file for each referral, and these were used for more detailed analyses. The archives of two major Norwegian newspapers ("Aftenposten" and "Bergens Tidende"), as well as the Norwegian Press Bureau, were electronically searched for the years covering the period of investigation (1992 to 2001). These sources were searched for number of articles on suicide, depression, eating problems and ADHD that included the words "children" or "adolescents". Articles on anti-depressive medication and stimulants for ADHD were also searched for. In order to tap professional attention, the Journal of the Norwegian Medical Association was searched for articles containing the same words as above. Changes in the proportion of each referral category were analysed with linear regression. The referral categories that changed strongly in their frequency of use during this period were analysed further. This effect of time was explained in stepwise multiple regressions by entering potential explanatory variables first and time thereafter. With respect to the 1997 to 2001 period, referrals and diagnoses were analysed with logistic regression.

Two categories of referral problems increased strongly from 1992 to 2001. The proportion of referrals for sadness/depression increased from 0.5% to 15.4%. Referrals for hyperactivity/attention problems increased from 1.2% to 13.6%. These increases could be statistically attributed to decreased use of other referral categories, and/or to media attention on these and related topics. The convergence between affective and hyperkinetic diagnosis and corresponding referral problem increased in the period.

3.2 **Paper II**

This study investigated whether adolescents referred to the BUP services from local services differed from adolescents who only have received help for psychiatric problems locally. Adolescents (N=76) from an adolescent population sample (N = 2,538) in Trøndelag (The Youth and Mental Health Study) (Sund, 2004) who had received help during the last year for mental problems from local services were compared to a clinical sample of adolescents (N = 129) referred to specialty mental health services from such local services. Comparisons were made according to scores on the Youth Self-Report (YSR); depressive symptoms; family functioning; attachment to parents; self-concept; coping styles; response styles; dysfunctional attitudes; negative life events; daily hassles; sociodemographics. In this study we found that a total of 5.3% of the Norwegian adolescents in the population sample reported to have received help for mental health problems during the last year, whereof 56.3% reported to have received help from local services only. We found that 86.1% of the adolescents within the deviant range on the YSR Total Problem scale in the population sample reported not to have received any professional help for mental health problems during the last year. Importantly, internalising problems in general, and depression in particular, were more frequent among those referred to specialty mental health services as compared to those who received local help, but this was not the case for externalising problems. YSR scores were not, however, multivariately associated with specialty mental health services use, whereas MFQ was. Psychological variables did not distinguish the two groups except for ruminative coping. Multivariate logistic regression analysis identified four factors predictive of receiving specialty mental health service: poor family functioning; moved previous year; knowing someone who had attempted suicide; own suicidality. The paper concluded that poor family functioning as reported by the adolescents, and not mental health problems, except for suicidality, were the strongest predictors of referral to specialty mental health services.

3.3 **Paper III**

This study investigated whether rates of ICD-10 axis 5 abuse diagnoses in the total child psychiatric population in Norway were different from self-reported abuse, and we investigated their respective correlates.

Study 1: The official register of the total child psychiatric population in Norway in the years 2000 and 2001 were analyzed for rates and correlates of axis 5 diagnoses of sexual and physical abuse. Prevalence of diagnosed sexual abuse inside and outside the family was low (1.6% and 1.9%, respectively) in the total Norwegian clinical population. Physical abuse diagnoses were even lower (0.4%). Rates of diagnoses of physical abuse and sexual abuse in the national clinical population in Norway indicate that these problems are generally not diagnosed, physical abuse in particular. The rates seem very low compared with reported rates of sexual and physical abuse from from several Norwegian community studies (Sætre et al., 1986; Pedersen & Aas, 1995; Ystgaard et al., 2003). Conduct and hyperkinetic problems reduced the risk of a diagnosis of sexual abuse whereas Neurotic/Stress related diagnoses increased the risk for diagnosed sexual abuse. Personality disorders strongly increased the risk for diagnosed physical abuse.

Study 2: Self-reports of abuse and neglect in a representative clinical sample of 129 adolescents referred during the same period were analysed for rates and correlates. A large proportion (60.2%) of this psychiatric sample, representative on referral problems and diagnoses, reported to have been physical or sexual abused, or neglected. One-fourth (25.5%) of the adolescents reported more than one kind of abuse/neglect. 37.6% (N=32) of the girls reported physical abuse, and 24.2% (N=8) of the boys. Sexual abuse was reported significantly more often by girls (37.2%) than by boys (6.3%). Self-reported abuse and neglect were associated with high YSR scores and other indicators of problems and symptoms such as referral for depression, symptoms of depression, and referral for suicide risk. The risks for suicide attempts, truancy, and use of alcohol, solvents, cannabis, or other illicit drugs were 3.3 to 8.5 times greater for the physical abuse group, and the sexual abuse group was 4.7 times at greater risk for daily smoking. The neglect group was from 2.5 to 5.7 times at greater risk for overdose/self-harm and headaches and stomach pains. Fifty-eight percent of the total sample reported to have frequent pains (N=65).

In conclusion, we found that there is a large discrepancy between rates of ICD 10 axis 5 diagnoses of sexual and physical abuse and self-reports of such abuse. Abuse and neglect need more attention in child and adolescent mental health services.

3.4 **Paper IV**

In this paper, the extent of pain among adolescent psychiatric patients was analysed, and the relationships with psychosocial factors and psychiatric symptoms such as depression were investigated. A representative sample of 129 adolescent patients were assessed with measures including the Youth Self-Report (YSR), the Mood and Feelings Questionnaire (MFQ), and instruments assessing self-perceptions, coping styles, stresses, sociodemographic factors, and childhood abuse. More than half of the adolescents (54%) reported suffering from concurrent frequent pain. Comorbidity between various pain locations was high: seventy percent of the patients reported more than one type of pain. Headache was the most common type of pain - reported by more than one third of the patients, closely followed by back and stomach pain, whereas a little less than one quarter suffered from limb pain. No significant gender differences were found either in pain frequency, number of pain locations, or duration of pain in this clinical sample. Pain was strongly correlated with internalising problems, but not with externalising problems. Adolescent psychiatric patients with frequent pain were two to four times at greater risk for depressive symptoms, almost three times more at risk for overdose or self-harm, and more than twice at risk for suicide attempts compared to psychiatric patients without such pain. Adolescent psychiatric patients with pain had fewer friends, were more often dissatisfied with school, and more often reported that they had to reduce or end leisure activities. Pain seems to be associated with more social dysfunction. Frequent pain also correlated with ruminative and emotion oriented coping. Adolescent patients suffering from frequent pain had more often experienced childhood abuse and/or neglect. A stepwise multiple regression analysis revealed that depression, alcohol intoxication and childhood neglect were the strongest concurrent predictors of frequent pain. The nature of these relationships is, however, not clear. Greater attention to pain is needed in clinical work, and adolescent patients should be asked about pain. The direct treatment of pain within child psychiatry is scarce.

3.5 **Paper V**

This study aims to examine whether adolescents in specialty mental health services differ in frequency and correlates of sleep problems from adolescents in a community sample. Youths from a community sample (The Youth and Mental Health Study; N = 2,538) (Sund, 2004) were compared to a clinical sample of adolescents (N = 129)

referred to the BUP services. Comparisons were made on frequent sleep problems according to scores on the Youth Self-Report (YSR), the Mood and Feelings Questionnaire (MFQ), and instruments assessing dysfunctional attitudes, self-concept, coping styles, stresses, attachment, family climate, and sociodemographics. Half of the adolescent patients (50 %) from Nordland reported to have sleep problems, and almost one third (31.3 %) had frequent sleep problems. In comparison, 5.2 % of the adolescents in the community reported frequent sleep problems. The most common problems in both samples were sleeping less than others and being overtired. Sleep abnormalities seem to be associated with emotional difficulties as well as by accompanying behavioural problems. In both samples sleep problems were correlated with depression and ruminative coping combined with depression. Associations between sleep problems and the self-perception scales “global self-worth” and “physical appearance” also reflected low self-esteem in this study. Sleep problems were multivariately associated with internalising problems in both samples. Altogether, apart from this common factor, multivariate associations differed. Among adolescent patients, sleep problems were associated with poor family functioning and with distractive coping combined with stress. Among community adolescents sleep problems were correlated with depressive symptoms.

In conclusion, sleep disturbances are far more common among adolescent psychiatric patients than in the general adolescent population. Clinicians should ask children and adolescents about sleep disturbances and consider therapeutic interventions. Sleep disorders in children and adolescents are often harmful to development and well-being. The clinical services available to affected children and their families need to be improved.

4 DISCUSSION

4.1 Methods – strengths and limitations

4.1.1 The clinical sample

The advantage of using large representative samples is the increased external validity of the results. The size increases power for statistical analyses and hence the validity. However, the challenge in this study was to recruit a large enough clinical sample of youths that was representative of the clinical population of adolescent patients in the BUP services in Nordland County.

CONSECUTIVE SAMPLING

In this study a consecutive sampling method was preferred. This is the best choice among the non-probability techniques since by studying everybody available a good representation of the overall clinical population is possible during a reasonable period of time. The goal was to include as many of the adolescent patients as possible that were referred to the 9 BUP services in Nordland County in the defined period of time. However, several problems emerged. The secretaries at the 9 clinics had the responsibility for the administration of the questionnaire, but some of them left their job or had protracted sick leave during the study period. At the clinics where this occurred the study was partially discontinued. Another problem was that many clinicians gave the study little priority. Clinicians were supposed to inform the adolescent patients and their parents about the study and request their consent. However, some of the clinicians may have considered the study to interfere with their clinical work. As a consequence many adolescents were not asked to participate in the study. The participating adolescents usually would have to make an extra visit to the clinic with possible inconveniencies in terms of use of time, school absence, and cost of travel. For financial reasons no incentives for recruitment were made available in the study.

THE TARGET POPULATION

The target population was all the adolescent patients 12 to 18 years of age referred to the 9 child and adolescent out-patient mental health service clinics (BUP) in Nordland County during the period 1st July 2000 to 31st December 2001 (N = 685).

External validity. No differences in ICD-10 diagnoses or referral problems between patients from Nordland (N = 685) and patients in the same ages from the rest of Norway (N = 6,692) were found. However, patients in the BUP services in Nordland were more often girls (61.4% vs. 55.2%), and were 14 days older than patients from the rest of the country.

THE NON-RESPONDERS

In all, 331 patients were invited to participate in the study, and 129 filled in the questionnaire (participation rate = 39%). The non-responders were slightly younger than the study sample (14.8 years vs. 15.2 years; t = -2.02, p = 0. 04) and contained fewer girls (60.4% vs. 70.5%; p = 0.04). Because boys and younger girls are, generally, less often referred for depressive symptoms, age and gender could represent a bias. Internalising problems such as depressive symptoms, self-harm, and suicide attempts are more often related to girls and to increasing age (Allgood-Merten et al., 1990; Angold et al., 1998; Wichstrøm & Rossow, 2002; Ystgaard et al., 2003; Hawton et al., 2003). The age and gender differences may have biased the results. Likewise, numerous studies have documented a higher prevalence of childhood sexual abuse among girls than boys (Pedersen & Aas, 1995; Putnam, 2003; Ystgaard et al., 2003), and the gender bias in the present study may have resulted in higher rates of sexual abuse in the clinical sample compared with the non-responders. Additionally, the participation rate in the present study is low. However, no differences were found with respect to referral problems and ICD-10 axis 1 diagnoses between those who did not participate and those who participated. The clinical sample thus seems to be fairly representative, although it is still possible that important differences did exist between the participators and the non-responders with respect to unmeasured variables.

SIZE OF THE SAMPLE

The sample included 18.8 % of the total clinical adolescent population in Nordland County during the relevant period of time. The small size of the sample limits the statistical power in analysis of relatively infrequent reported occurrences as some of the referral problems and diagnoses (i.e. alcohol/drug abuse, eating disturbances, anxiety problems, school absence, personality disorders, a.o.).

4.1.2 Comparisons with other samples/ populations

The community sample. The sample of 129 adolescent outpatients from Nordland was compared with a community sample from Trøndelag (paper II and V). The community sample stems from a representative sample of 2,538 adolescents attending schools during 1999 in South- and North-Trøndelag (The Youth and Mental Health Study) (Sund, 2004). Mean age was 15.0 years. The two samples received identical measures. However, questions about sexual and physical abuse and neglect were not included in the Trøndelag community survey, and comparison with the clinical sample from Nordland thus was not possible on these issues.
The clinical sample and the community sample come from different counties. Possible differences according to urbanity, geography, health, educational opportunities, social mobility etc. are not controlled for, and may have influenced the results. Symptoms and mental disorders are associated with age and gender. A somewhat wider range of age and more girls in the clinical sample than in the community sample have been controlled for and thus should not have biased the results. The differential attrition in the population sample may have resulted in underestimation of adolescents receiving help for mental health problems, particularly among those with externalising problems. This would, however, most likely also be the case for the clinical sample.

The national clinical population. Data from all the child and adolescent outpatients in Norway during the period 1992 to 2001 was analysed (paper I). From 1996 onwards databases have been available for each referral. In 1997 the ICD-10 diagnostic system was implemented in the BUP services in Norway. The databases from 1997 to 2001 were therefore used for more detailed analyses. Diagnoses were only analysed from closed cases (N = 40,274). ICD-10 diagnoses are set according to clinical judgment. We have, unfortunately, no information on the reliability and validity of either the use of the standardised referral problem categories used in the BUP data patient registration system or the ICD-10 diagnoses set. Some evidence has been reported of improved inter-rater reliability of child and adolescent psychiatric disorders on the ICD-10 axis 1, compared with the earlier ICD-9 version (Steinhausen & Erdin, 1991). As a part of the WHO international field trial on adult psychiatric patients, applicability and inter-rater reliability of the ICD-10 were examined in 7 German speaking centers where diagnoses on axis I with an average

agreement of 65.6% and a mean kappa of 0.50 showed a moderate inter-rater reliability (Siebel et al., 1997). In another field study operational criteria for the diagnosis of mental disorders were evaluated for further refinement, and the study was carried out in field trials at 151 clinical centers in 32 countries by 942 clinician/researchers who conducted 11,491 individual assessments of patients (Sartorius et al., 1995). They found high inter-rater agreement for most diagnostic categories, but for some categories such as milder forms of affective disorders, the criteria were rated as somewhat more difficult to use, and reliability was lower. We do not know if there are differences in reliability of ICD-10 axis 1 diagnoses between adult and child psychiatry, but we have no reason to expect so.

In the BUP national database we have recordings of sexual and physical abuse from the ICD-10 diagnostic system, axis 5. Indicators for the validity of National data files for the years 2000 and 2001 were analysed to cover this information compared to the clinical sample from Nordland County (paper III). In 2000 and 2001 half (50%; N=10,326) of the closed cases in the national clinical population (N=20,652) received an ICD-10 diagnosis on axis 5. Validity of axis 5 stress ratings was found in a comparison between two university departments of child psychiatry in Germany where the validity of the clinical data was analysed for 593 patients seen in Cologne and for 685 patients seen in Berlin (Mollman et al., 1998). High inter-rater reliability (kappa = 0.8 to 1.0) on axis 5 diagnoses was reported in a study on psychiatric in-patient adolescents, and the conclusion was that it was possible to make reliable and relevant psychosocial axis 5 diagnoses (Zalsman et al., 2001). However, in a day-to-day practice in a Dutch multicenter study the reliability of axis 5 diagnoses on children was reported not to be satisfactory (kappa= 0.07 to 0.80) compared with other reliability studies (Willemse et al., 2003). They concluded that the absence of adequate information to code the psychosocial axis may be a fundamental problem in obtaining sufficient inter-rater agreement, and that the classification of axis 5 requires information that is often not available in common practice. Even though clinicians in the BUP services in Norway are mandatory obliged to use axis 5, only half of those in the national clinical population who received an axis 1 diagnosis also received an axis 5 diagnosis in the present study. A possible explanation could be lack of priority of axis 5 as well as lack of relevant information due to a lack of routines or guidelines for collection of such information. However, other factors, like

clinicians' discomfort with axis 5 diagnoses that relate to family difficulties which could put them in risk of confrontations with parents, may be at work. Likewise, clinicians may be concerned about confidentiality when the child is under 16 years of age because of the parents' lawful right to see the medical notes with the diagnoses. Such factors could represent an axis 5 selection bias, but we have no data of whether this could be the case in the present study. To our knowledge no studies have investigated validity and/or reliability of axis 5 diagnoses in Norway.

4.1.3 Assessment of emotional and behavioural problems

Emotional and behavioural symptoms in adolescent patients may be assessed and evaluated in different ways. Written information from the referring professional, including category of referral problem, will usually provide the basis for the first evaluation of the mental health condition of the patient. A clinical interview or a semi-structured interview will often be the next step together with a clinical observation of the adolescent. Comparative information from parents and schools are likewise important elements in the evaluating process. Emotional and behavioural symptoms can also be measured by standardised self-report scales such as the Mood and Feelings Questionnaire (MFQ) or the ASEBA scales such as the Youth Self-Report (YSR). All assembled elements of information are supposed to be evaluated in a diagnostic process where fulfilment of the different criteria in ICD-10 or DSM-IV will decide whether the patient qualifies for a diagnosis of a psychiatric disorder.

4.1.4 Validity and reliability of the main instruments

The Youth Self-Report (YSR)

The instrument used in the present study is the Youth Self Report (YSR) covering the ages 12 to 18 years. It is developed by Achenbach and Edelbrock to obtain adolescents' self-reports on their problems and competencies in a standardised way. For the YSR total problem score the mean 7-day test-retest reliability was r = .70 for 11- to 14-years-olds and r = .91 for 15- to 18-years-olds. On the YSR total problem score, the 6-month stability r was .69 for the total problem score over in a clinical sample. Content validity as well as criterion-related validity of the YSR is supported, and the YSR has shown its ability to discriminate between referred and non-referred children and adolescents (Achenbach, 1991). The YSR items are based on the Child

Behavior Checklist (CBCL) items. The CBCL is the parent version containing the same questions and covering 4 to 18 years of age.
The Norwegian version of the YSR was translated and adapted by Spurkland and Nøvik (1993). A Norwegian study supported the predictive validity of the CBCL as judged by its ability to distinguish between children with psychiatric disorders and non-disordered children (Nøvik, 1999). In a Swedish standardisation study of the YSR (Broberg et al., 2001) the total problem scores were found to be similar to those of Norwegian (Kvernmo & Heyerdahl, 1998), American (Achenbach, 1991), and German (Lösel et al., 1991) youths, but Swedish adolescents scored higher than Dutch (Verhulst et al., 1989) and Danish (Bilenberg & Hørder, 1998) youths. In another Swedish study, the YSR correlated with other measures of depression and the discriminant validity of the YSR was assessed and showed ability to predict suicidality (Ivarsson et al., 2002).
Helstela and Sourander (2001) found significant differences on all YSR scales between maladjustment and non-maladjustment groups of Finnish adolescents. Hannesdottir et al. (2001) reported support to the discriminative validity of the YSR as part of a structured global assessment of substance-abusing Icelandic adolescents, in particular to identify the frequently present psychiatric comorbidities as conduct disorders, depressive disorders, or posttraumatic stress disorders.

Beside parents and teachers, adolescents themselves are valuable informants about their own psychological functioning. Sourander et al. (1999) in a study of parent-adolescent agreement found that Finnish adolescents on the YSR reported significantly more problem behaviours than their parents on the CBCL, and that internalising problems among girls seem especially likely to remain unnoticed by adults. Zukauskiene et al. (2004) in a longitudinal population study of Lithuanian adolescents' behavioural and emotional problems found longitudinal stability of parents' ratings on the CBCL, and that adolescents on the YSR reported higher levels of anxiety/depression, withdrawal, somatic complaints, aggression and delinquency, but lower levels of attention problems than their parents. Studies have shown significant associations between the YSR and psychiatric diagnoses (Weinstein et al., 1990; Morgan & Cauce, 1999; Hannesdottir et al., 2001).
Conclusion: The YSR is widely used for assessment of emotional and behavioural problems, and congruence between different subscales as well as subscale profiles

and different child psychiatric disorders are documented. Good test-retest reliability and content validity are reported.

The Mood and Feelings Questionnaire (MFQ)

In a clinical sample of adolescents the self-report version of the MFQ was found to have acceptable reliability and was a satisfactory screen for major depressive disorder diagnosed by a standardised interview with the child. It was also a useful measure of clinical remission (Wood et al., 1995). The MFQ used in the present study is the same as the translation that was used in The Youth and Mental Health Study (Sund, 2004) where the MFQ showed a good internal consistency (alpha), and test-retest correlations (r) for three-week and three-month intervals were 0.84 and 0.80 respectively. Convergent and discriminative validity were also assessed. The mean total MFQ score for the whole community sample was 10.6 (SD 9.5) (Sund et al., 2001).

Conclusion: The MFQ has acceptable reliability and has been validated as a satisfactory screen for major depressive disorder in clinical samples.

The Family Assessment Device

The McMaster Family Assessment Device (FAD) is a short self-report measure of family functioning that describes emotional relationships and functioning within the family. The FAD has been validated with a number of clinical populations (Epstein et al., 1983; Clark et al., 2000; Miller et al., 1994; Dancyger et al., 2005). Discriminative validity has also been demonstrated by clinical ratings. FAD scores of families were compared to clinicians' ratings, with the results indicating that families rated by the clinicians as unhealthy also had significantly higher family mean FAD scores, representing poorer functioning (Miller et al., 1985). In the Ontario Child Health Study (OCHS) validity was assessed by hypothesising the relationships expected between the General Functioning subscale (GF) scores and other family variables included in the OCHS data set (Byles et al., 1988). The results indicated good reliability, and all hypotheses of validity were supported. The brevity and ease of administering the GF subscale recommended it for further use in survey research in which a global assessment of family functioning is required. Miller et al. (2000) contended that the

FAD could be used in its original format based on the FAD's theoretical foundation. Ridenour et al. (2000) argued that subscale factor analyses (exploratory and confirmatory), item-level factor analysis, and the clinical and psychometric studies suggest a more parsimonious FAD configuration. However, Ridenour et al. (1999) concluded that the results of their study suggested that the conservatively best use of the FAD is using the GF as a summary score of family functioning. This scale has suitable psychometric properties for use as a summary instrument with young people (McDermott et al., 2002).

Conclusion: The General Functional subscale of FAD is a widely used device, and is short, easy to administer, and has adequate psychometric properties.

The Inventory of Parent and Peer Attachment (IPPA)

The IPPA (Armsden & Greenberg, 1987) is a self-report questionnaire designed to measure affective and cognitive components in adolescents' relationships to parents and to peers. The inventory is suitable for individuals 12-18 years old, and assesses degree of trust, quality of communication, and degree of anger. The IPPA has good test-retest reliability and predictive validity, with perceived quality of attachment to parents being positively correlated with self-esteem, psychological well-being, family functioning and adolescent proximity seeking of both mothers and fathers in times of need (Armsden & Greenberg, 1987; Armsden et al., 1990; Cotterell, 1992; Paterson et al., 1995; Peterson et al., 1986; Soucy & Larose, 2000). Attachment has been related to adolescent depression and suicide. Armsden et al. (1990) examined the security of parent and peer attachment among four groups of adolescents: clinically depressed adolescents, non-depressed psychiatric controls, non-psychiatric controls, and adolescents with resolved depression. They found that the depressed adolescents reported significantly less secure parent attachment than either of the control groups and less secure peer attachment than the psychiatric control group. Children and adolescents with high levels of insecure attachment are also reported to have high levels of current depressive symptoms (Sund & Wichstrøm, 2002; Abela et al., 2005).

The IPPA is based on Bowlby's and Ainsworth’s theory of attachment (Bowlby, 1980) which devides attachment into three types: secure, avoidant, and resistant. However, attachment theory is criticised for being based on momentary stressful situations, for

being limited to behaviours related to the primary attachment figure, for including only overt behaviours in its paradigm, and for failing to consider multiple attachments at different stages of life (Field, 1996; Harris, 1998).

Conclusion: The IPPA is a widely used instrument that is found useful to evaluate relationships, and is reported to have good reliability and validity.

The Self-Perception Profile for Adolescents (SPPA)

A shortened version of the revised Norwegian SPPA was used in this study (Harter, 1988; Wichstrøm, 1995). The revised version is reported to have better reliability, better convergent validity, and better factorial validity than the original version (Wichstrøm, 1995). The subscales "Physical Appearance", Global Self-Worth" and Social Acceptance" were used in the present study and included 15 items.

Conclusion: The revised shortened version of the SPPA shows good reliability and good convergent and factorial validity, and has been used in community surveys in Norway.

The Early Adolescence Stress Questionnaire (EASQ)

The EASQ was constructed for The Youth and Mental Health Study (Sund et al., 2003; Heisel et al., 1973; Swearingen & Cohen, 1985). It covers areas of stressful life events and chronic stressors in family, school and peers. The individual is asked whether a stressor or event had occurred during the last 12 months. Some possible difficulties with the validity and reliability have been reported (Sund, 2004). The ability to recall relevant events over a period of 12 months may be limited, and answers may be coloured by the present stresses. Additionally, some questions may be interpreted in different ways when an incidence occurred only once as opposed to a more chronic situation. An interview could have elicited more valid and reliable answers. However, Duggal et al. (2000) reported that stressful life events generated by self-reports as well as by interview, predicted depression in a clinical sample of adolescent.

Conclusion: At the present time the reliability and validity of the EASQ are tentative. However, the use of the instrument in a large community survey makes a preliminary

comparison with a clinical sample possible. The same considerations are relevant for the measurement of daily hassles (Sund, 2004).

Abuse and neglect

The questions about physical abuse and neglect were used in an epidemiological study by Brown et al., (1999), whereas the question about sexual abuse lacks a clear definition. We did not have a measure of severity of sexual abuse, and neither did we ask about relationship, sex, or age of the perpetrator. However, a similar question about sexual abuse was asked in a community study of Norwegian adolescents (Pedersen & Aas, 1995). In this study the subjects were instructed to describe the incident(s) in more detail in their own words and also provide information about the perpetrator(s). In all, 17% of the girls in the study responded affirmatively to a question of being subjected to involuntary sexual acts, of which 60% were classified as grave or serious incidents. “Involuntary sexual acts” might be considered a less serious term than “sexual abuse”, thus we expect that only a minority of the sexual abuse cases in the present study were minor or trivial. In clinical practice information about neglect and abuse will mostly be based on retrospective reports. However, it must be taken into account that retrospective reports in adulthood of major adverse experiences in childhood, involve a substantial rate of false negatives, and substantial measurement error (Hardt & Rutter, 2004). Although the time span between reporting of abuse during childhood or adolescence and the acts is considerable shorter than in studies of adults, reliability and validity problems are expected to be similar to those of studies of adults, but possibly of a lesser magnitude. Widom et al. (1999) matched substantiated cases of child abuse/neglect on gender, age, race, and approximate social class with non-abused/ non-neglected children and followed them prospectively into young adulthood. They found that retrospective reports of childhood victimisation were associated with increases in risk for drug abuse, but not prospectively. Raphael et al. (2001) found similar results in a study of pain using a prospective cohort design where cases of early childhood abuse or neglect documented and demographically matched controls were followed into young adulthood. The number of medically explained and unexplained pain complaints reported at follow-up was examined. They found that assessed prospectively, physically and sexually abused and neglected individuals were not at

risk for increased pain symptoms. However, unexplained pain symptoms were significantly associated with retrospective self-reports of all specific types of childhood victimization.
Conclusion: Retrospective self-reports of abuse and neglect are associated with uncertainty. However, the risk of false negatives may be greater than of false positives.

Pain

Pain is an experience that is difficult to define because of lack of objective measures, and that it must be assessed through self-report. A developmental perspective is important in evaluating children with pain. Several studies have reported that younger children are more distressed and exhibiting more stress behaviours by medical procedures than older children (Craig et al., 1984; Fradet et al., 1990; Ritchie et al., 1990). Age differences in reaction to pain are probably related to development of coping strategies. School-age children can, however, clearly specify levels of pain intensity and link emotions to pain. Pain disorder is a new diagnosis in both in ICD-10 and DSM IV. It has the following characteristics: (1) the patient experiences clinically significant pain that causes distress and /or functional impairment; (2) psychological factors are judged to play a major role in pain's onset, severity, or maintenance; and (3) the pain is neither feigned nor part of a mood, anxiety, or psychotic disorder.

Patients in the present study were asked whether they currently had pain (Larsson & Sund, 2005; 2006). Those who reported at least weekly pains were regarded as frequent pain sufferers. However, neither measures of pain intensity nor of age of onset were included in the study. Information concerning these issues might be of interest in investigation of the aetiology of pain problems and their associations with emotional and behavioural problems.

Conclusion: Self-reports of current pain are associated with some uncertainty.

Sleep problems

Most of the studies of sleep problems have used measures idiosyncratic to the particular study. Because studies have used different definitions or measures, the rates of sleep problems have varied widely (Ohayon et al., 2000). Self-reports of

sleep problems may be more reliable then parents' reports. Sleep problems in children and adolescents may be easily overlooked. Paavonen et al. (2002) found in a Finnish epidemiological study based on both parents' and children's reports that over 95% of severe sleep problems were reported only by the children themselves. Types and frequency of sleep problems were rated with four items from the Youth Self-Report (YSR) and one item from the Mood and Feelings Qestionnaire (MFQ). Self-reports on hours of sleep were also obtained. Similar sleep scales based on the CBCL sleep items have been used in previous research (Stoleru et al., 1997; Gregory & O'Connor, 2002). It is a general scale composed of different kinds of sleep problems. The pattern of findings obtained here may therefore not extend to specific and isolated disorders of sleep, such as insomnia or sleep terror.

Conclusion: The self-report scale of sleep used in the present study is associated with some uncertainty, and may need further psychometric evaluation.

4.2 Discussion of selected findings

4.2.1 Referrals to the BUP services

Changing or stable rates of referral for different mental health problems in childhood and adolescence to the BUP services cannot necessarily be seen as a manifestation of changing or stable patterns of occurrence of these problems in the community. However, the increases found in this study in shares of referrals for depressive and hyperactive/attention problems to the BUP services in Norway during the last decade may be attributed to such social factors as increased awareness of, more knowledge of, and increased media attention on these problems. The proportions of referrals for hyperactivity/attention problems and for sadness/depression increased from very low frequency to being among the most frequent reasons for referral during the study period. Such large increases in rates are certainly not due to equivalent increases in these problems in the child and adolescent population in Norway, although an increase in depressive problems among adolescents during the last decade has been reported (Rossow et al., 2005). We have no corresponding information about hyperactivity/attention problems in Norway. Still, there has been a noteable stability over the last decade in the proportions of referrals for a range of other problems such as autistic and psychotic problems, suicidal risk, anxiety/phobic problems, compulsive problems, and eating problems. One explanation could be differences in media attention concerning these kinds of problems over time, and/or that changes in

society during the last decade do not affect children and adolescents who are in danger of developing these kinds of problems in the same distressing ways as for those with hyperactivity/attention problems and sadness/depression. Parents may be more concerned about problems that have received a greater amount of recent media coverage, and may therefore more readily label particular behaviours in these terms than they did in the past (Collishaw et al., 2004). However, increases in referrals of sadness/depression and hyperactivity/attention problems are also necessarily related to decreases in other referral categories. Three other categories, “inhibited behaviour”, “other” and “unanswered”, decreased considerably during the study period. Other underlying conditions that are not accounted for may also be at work.

Hyperactivity/attention problems. Few studies have examined time trends in prevalence of hyperkinetic/ADHD disorders (Mandell et al., 2005), although, some studies based on parent and teacher rated measures suggest little change in rates over time (Achenbach et al., 2003; Collishaw et al., 2004; Sourander et al., 2004). Nevertheless, there has been a strong increase in diagnosis and treatment of ADHD among school children the last couple of decades (Olfson et al., 2003; Robinson et al., 2002; Mandell et al., 2005). Andersson et al. (2004) in a Norwegian national study estimated that approximately 2.5% of the child and adolescent population had a hyperactive disorder/ADHD diagnosis, and that in a national sample with this diagnosis (N = 3,160) more boys (4.3 : 1) suffered from this disorder. They found that, except for educational school counselling (PPT), local agencies reported limited knowledge about these disorders. This seems to be in accordance with another Norwegian study where Hundevadt (2000) found that parents of children with hyperkinetic disorders felt there was a lack of sufficient information to the family from professionals. Parents from a sample (N = 1,206) of members of the Norwegian ADHD organisation reported that their first contact concerning the hyperactivity/attention problem of their child was with kindergarten/school (44%), health nurses (27%), school consultants (PPT) (13%), GP’s (6%), and BUP services (4%) (Andersson et al., 2004). The mean age of the first contact was 4.6 years, and the mean age for receiving a diagnosis was 8.4 years. Sixty-six percent of the parents reported to have been much concerned about the child’s behaviour before the age of 4. The early age at which the first contact for these problems took place,

indicates that school problems may not be the primary reason for referral to the BUP services, although, problems in day-care could be important as well. On the other hand, Schneider and Eisenberg (2006) in a national representative US study of school children found that increased pressures for school performance seemed to be associated with increase in ADHD diagnoses.

Nevertheless, parents as well as professionals in the local services seem to be increasingly well informed of and more alert to hyperactivity/attention problems. National data from the present study suggest that increases in referrals to the BUP services of hyperactivity/attention problems could statistically be attributed to increased media attention.

Sadness/depression. A smaller part of the increased proportion of referrals for sadness/depression could be attributed to a more depressed mood in the Norwegian adolescent population during the study period (Rossow et al., 2005). Population data converge in reporting that twice as many girls as boys are getting depressed during adolescence. Angold et al. (1998; 1999) found that girls were more likely than boys to be depressed only after the transition to mid-puberty (Tanner Stage III and above) and that effects of the timing of puberty appeared less important in increase for risk of depression than pubertal status. They suggested that causal explanations of the increase in depression in young females need to focus on factors associated with changes in androgen and oestrogen levels rather than the morphological changes of puberty. However, changes in hormone level alone do not explain that rates of depressive conditions in adolescents probably have increased during recent decades (Lewinsohn et al., 1993; Fombonne, 1995b; Prosser & McArdle, 1996; McArdle et al., 2003; Collishaw et al., 2004; Sourander et al., 2004; Rossow et al., 2005). Several writers have suggested an association between dissatisfaction with physical appearance and depressive problems (Rierdan & Koff, 1997; Allgood-Merten et al., 1990; Holsen et al., 2001). Physical appearance is highly related to global self-esteem among adolescents (Harter, 1988; Wichstrøm, 1998), and poor self-esteem is considered to be one of the very few factors that are specific to depressive disorders (Lewinsohn et al., 1997). Moreover, the gender difference in depressed mood is substantially reduced when self-esteem has been accounted for (Allgood-Merten et al., 1990; Avison & McAlpine, 1992). Wichstrøm (1999) suggested that gender differences partly could be explained by increased developmental challenges for girls

such as pubertal development, dissatisfaction with weight, and increased feminine sex role identification. He found no associations between depressed mood and masculinity. Holsen et al. (2001) in a longitudinal study of Norwegian adolescents (N = 645) reported that body image predicted change in depressive mood both for boys and girls, although at a later age for boys. They found no causal effects of depressed mood upon body image. Media play an important role in defining feminine sex roles. The young feminine sex role is strongly and continuously emphasised in different kinds of media as TV, newspapers, magasines, films, music videos, and in different kinds of advertising. Media-portrayed idealised images have been found detrimental to the body image of young women (Monro & Huon, 2005). According to the self-objectification theory of Fredrickson and Roberts (1997), individuals may see themselves from a critical, external perspective and, in turn, compare their own bodies to an unrealistic ideal that encompasses social norms and stigmas. The sexual objectification of women that derives from mass media and personal encounters may lead women to objectify themselves. Hebl et al. (2004) found that young men also were vulnerable to the negative effects of induced self-objectification but to a lesser degree than young women. Self-objectification theory is found to provide a useful framework for identifying predictors of depressed mood (Tiggeman & Kuring, 2004).

Suicidal risk. The stability of rates of referral for suicidal risk may seem surprising considered the strong increase in referrals for depressive problems during the same period. Suicide ideation or attempts and depression are reported to be strongly associated in numerous studies (Rossow & Wichstrøm, 1994; Grøholt et al., 2000; Fergusson et al., 2005; Konick & Gutierrez, 2005). One explanation could be that the increase in proportions of referrals for depressive problems mainly comprises milder and less severe levels of depression that are not so strongly associated with suicidal risk. Kessing (2004) found that the risk of depressive relapse and the risk of suicide were significantly different for three ICD-10 types of depression increasing from mild to moderate to severe depressive episode.

Alcohol/drug problems. Proportions of referrals for alcohol/drug problems to the BUP services in Norway stayed at an astonishingly low level throughout the study period although we know that the use of alcohol has increased sharply in the adolescent population during the nineties (Bye, 2003). A possible explanation for the low referral

rates could be that parents and referral agencies are not aware of, or do not experience the amount of use of alcohol and/or cannabis as problematic enough to qualify for referral to the BUP services. Adult social norms regarding alcohol consumption in general and among youths may have become more liberal. Another explanation could be that referral agencies do not consider the BUP services to be the relevant services, or suspect that these services have little competence in treating such problems. Bakken (2004) in a study of alcohol and drug abusers in treatment (N = 291) in the counties of Hedmark and Oppland found that 20% of those had received treatment from the BUP services, and of those less than 30 years of age 39% had been treated in BUP. Ninety-one percent of those treated at BUP had received an alcohol or drug related diagnosis before the age of 18, compared to 60% of those who not were treated in BUP. He also reported that 76% of those in treatment had a primary psychiatric disorder and secondarily developed alcohol and/or drug dependency, and that only 17% had developed dependency first. Bakken (2004) seem to lend some support to the assumption that parents and referral agencies often do not consider alcohol and drug problems in adolescence to be the primary problems or severe enough for referral, and that this partly can explain the low proportion. The high percentage of alcohol or drug related diagnoses before the age of 18 of those who had been treated in the BUP services reported by Bakken (2004) indicates that these problems are severe. Moreover, a relatively high share of those in treatment under the age of 30 had been treated at the BUP services. It is important to take into account, however, that three quarters of those in treatment for alcohol and drug dependency primarily had a psychiatric disorder. These findings correspond with results from other studies (Compton et al., 2000). Results from prospective studies indicate that behavioural and emotional problems in childhood predispose to smoking, regular use of alcohol, and use of drugs in adolescence (Ebeling et al., 1999; Kaplow et al., 2001; King et al., 2004). This implies that clinicians need to be alert to the fact that adolescents referred for other kinds of problems also may be in risk of developing alcohol/drug problems. About one third (32.1%) of the adolescents in the clinical sample in the present study reported to have been drunk more than eleven times during the last year, about the same amount (34.6%) reported to have used cannabis, and about a quarter (23.2%) reported to have used solvents. Some of these adolescents will probably be in danger, over time, of developing alcohol/drug problems. Strong associations were

found in the clinical sample between physical abuse and use of alcohol/drugs, and alcohol intoxication was found to be one of the strongest predictors of concurrent frequent pain complaints. These results indicate that alcohol/drug problems are complex, and that clinicians in the BUP services need to see such problems in a larger context related to other main or/and co-occurring conditions.

4.2.2 Co-occurring conditions

Abuse and neglect. In Norway, little is known about epidemiology of physical and sexual abuse and neglect in clinical child and adolescent psychiatric populations. In the present study low rates of ICD-10 axis 5 diagnoses of physical (0.4%) and sexual abuse (3.5%) were found in the total national clinical population of adolescents. Conversely, high rates of self-reported abuse and neglect (60%) were found in the present clinical sample of adolescents. Ystgaard et al. (2004) reported, from a sample of 74 patients admitted to a general hospital in Norway after having made a suicide attempt, that 35% had experienced severe sexual abuse, 18% severe physical abuse, and 27% neglect. Physical and sexual abuse were independently associated with repeated suicide attempts after controlling for the effects of the other childhood adversity factors. No other childhood adversity was related to chronic suicidal behaviour. Sixty-five percent of this selected sample of suicide attempters were girls, and the results from this study seem to correspond with findings in the present study where physical abuse was significantly associated with repeated suicide attempts. We have no information of how clinicians in the BUP services relate to the question of abuse and neglect, or whether routines for collecting this information exist. Results from the present study indicate that such procedures may be practically non-existent. It is difficult to understand/interpret the reason for the lack of professional attention to such serious problems. Clinicians may feel uncomfortable with the possible implications of such information, such as the risk for family confrontations with accusations and denials, and with what might be experienced as a professional burden if the case is brought to court. The media have recently reported several stories of “perpetrators” being sentenced for child sexual abuse on the basis of professional testimonies, only to have their cases reconsidered by court and to be found not guilty. Another issue is that children and adolescents are

reluctant to talk about abuse and neglect out of fear of possible consequences for themselves and their family, and out of fear of stigmatisation.

At the same time, childhood abuse and neglect need to be considered in context with other life stressors. In a prospective study, substantiated cases of abuse and neglect with a matched control group were interviewed 20 years later (Horwitz et al., 2001). The researchers found more psychiatric disorders among those who were abused and neglected. However, after controlling for stressful life events, they found that childhood victimisation had little direct impact on any life time mental health outcome.

Pain. Pain has usually been defined as a somatic problem, and has generally received little attention in the mental health services. Because of this little is known, in Norway as well as internationally, about prevalences of pain among child and adolescent psychiatric patients. In the present study more than half of the adolescent patients (54%) reported to be bothered currently with frequent pain. Larsson and Sund (2006) reported from The Youth and Mental Health Study that 18.3% of adolescents from the community were bothered by frequent pain. These results are comparable with results from the present study when the same pain measures were used. Significant associations were found in the present study with depression, self-harm and repeated suicide attempts. Correlations between pain and depression have also been reported from many community surveys and selected clinical samples (Fishbain et al., 1997; Harma et al., 2002; Ohayon & Schatzberg, 2003; Larsson & Sund, 2005). More than 80% of children with recurrent abdominal pain and headache have been found to carry a psychiatric diagnosis, primarily anxiety and depressive disorder, compared with15% of controls (Liakopoulou-Kairis et al., 2002). The presence of recurrent pain is also reported to increase the duration of depressive mood (Ohayon & Schatzberg, 2003). However, various behavioural or emotional problems do not seem to be related to specific pain locations, but rather to frequency and co-occurence with other frequent pains (Larsson & Sund, 2006). Still, the question of cause and effect may be difficult to answer. Hotopf et al. (1998) reported from a 7-year longitudinal study that the presence of multiple physical symptoms was predictive of onset of depression, and, conversely, subjects with depression were more likely to develop multiple physical symptoms than were subjects who were not depressed. Pain may possibly intensify depressive mood, feelings of hopelessness, and lower thresholds for self-harm and suicide attempts. Pain has been considered

as a contributory factor in episodes of deliberate self-harm, and patients suffering from pain have also been found to have higher suicide intent scores (Theodoulou et al., 2005). In a review study chronic pain was found at least to double the risk of death by suicide (Tang & Crane, 2006).

Liakopoulou-Kairis et al. (2002) found that the families of children with recurrent abdominal pain were considerably more dysfunctional in regard to overall family functioning. Relationships between pain suffering and childhood abuse in adult women have been reported in several studies (Walling et al., 1994; Romans et al., 2002; Lampe et al., 2003), and such significant associations were also found in the present study of adolescent psychiatric patients. However, Raphael et al. (2001) reported from a prospective study that pain was associated with childhood abuse and neglect retrospectively but not prospectively. Memory and interpretation of past events may well be affected by pain suffering. These results indicate that the relationship between childhood victimisation and pain symptoms in adulthood are multifaceted and complex, but intervening variables such as hopelessness, depression, and personality factors may also be at work. In a prospective study Asghari and Nicholas (2006) found neuroticism to be the personality dimension that was strongest associated with pain-related variables. Neuroticism can be conceived of as a vulnerability factor which seems to lower the threshold for perception of pain as threatening (Goubert et al., 2004). Recurrent frequent pain will often have negative consequences academically as well as socially. In the present study adolescent patients with frequent pain more often reported dissatisfaction with school, reduction or ending of leisure activities, and having fewer friends than adolescent patients without such pains. This is similar to results from other studies (Robinson et al., 1990; Larsson & Sund, 2006). Chronic pain is related to lower quality of life as reported by children as well as by parents (Youssef et al., 2006).

Sleep problems. Ohayon and Guilleminault (1998) reviewed all epidemiological surveys of sleep disorders published over a 20-year period and found that not even one had sleep problems in adolescents in focus. However, knowledge of the epidemiology of adolescent sleep problems and their co-morbidities seems to have increased since then (Patten et al., 2000; Ohayon et al., 2000; Gregory & O'Connor, 2002; Gibson et al., 2006; Liu & Buisse, 2006). Still, little is known about these problems among child and adolescent psychiatric patients. In the present study

frequent sleep problems was reported by 31% of adolescent patients, whereas only 5% of the community adolescents reported such problems. The latter figure is low when compared to other community studies (Kahn et al., 1989; Ohayon et al., 2000; Patten et al., 2000; Johnson et al., 2006). The prevalences reported in the present study probably do not overestimate the actual situation. The prevalences reported from sleep studies are diverse, reflecting diverse samples, study designs and measures of sleep, and accordingly, the rates of sleep problems vary widely.
In the present study, sleep problems and depression, self-harm and suicide attempt were strongly related among adolescents in the clinical sample as well as in the community sample. These results are consistent with data from other studies. Morrison et al. (1992) reported that sleep problems among adolescents in the general population were associated with DSM-III disorders. Sleep problems have been found to be a significant predictor of major depression in a longitudinal epidemiological study of young adults (Breslau et al., 1996), and insomnia is reported to be connected to a high risk of depression (Roth & Roehrs, 2003). Sleep problems are also found to be associated with increased risk for suicide attempts in adolescence (Liu, 2004; Barbe et al., 2005; Agargun & Beisoglu, 2005; Bernert et al., 2005; Liu & Buisse, 2006)., These associations are to be expected, however, as sleep problems are among the the diagnostic criteria of several psychiatric disorders such as depression, post-traumatic reactions, neurasthenia, and anxiety disorders.

In the present study depressive symptoms were multivariately associated with sleep problems in community adolescents, whereas poor family functioning was multivariately associated with sleep problems among adolescent patients. Family issues have been reported to be a common precipitating factor of sleep problems (Sadeh et al., 2000; Bastien et al., 2004). Sleep problems among adolescents in the community are found to be highly related to personal and family disruption (Vignau et al., 1997). Infant sleep problems are reported to be associated with maternal depression (Zuckerman et al., 1987; Hiscock & Wake, 2001; Lam et al., 2003), and toddlers with sleep problems more often have mothers who are insecurely attached to their children (Benoit et al., 1992). Negative or insecure family relations may thus become stressors related to sleep problems in childhood as well as in adolescence. Confounding variables such as personality traits like neuroticism may also cause

spurious relationships between family functioning and sleep (Gau, 2000; Ellenbogen & Hodgins, 2004).

Gregory and O'Connor (2002) found, in a prospective study of children from 4 years to mid-adolescence, that early sleep problems were associated with an increase in depression/anxiety, attention problems, and aggression, but not the other way round, with the exception for attention problems. Accordingly, from childhood to adolescence there seems to be a developmental change in the overlap between sleep problems and behavioural and emotional problems. Sleep problems of a later age seem to be far more often associated with psychosocial difficulties or a psychiatric disorder.

Sleep disturbances have been described in adult patients with chronic pain, but little is known about sleep in adolescents with chronic pain. However, sleep problems were reported by 54% of children and adolescents with pain in a community survey (Roth-Isigkeit et al., 2005). Bruusgaard et al. (2000) found a strong association between pain, mental distress, and sleep problems among Norwegian schoolchildren. Palermo and Kiska (2005) suggest that a relationship between the experience of sleep disturbances and recurrent and chronic pain exists for adolescents, and that these sleep disturbances are linked to mood disturbances and reductions in daily functioning and quality of life. They suggest that mood is strongly related to sleep and might share common pathophysiologic or behavioural origins in adolescents with chronic pain. In the present study significant associations between sleep problems, pain and mood disturbances were found among adolescent psychiatric patients as well as among adolescents from the community sample. Reduced sleep quality may have negative academic consequences for children and adolescents. Fallone et al. (2005) reported from an experimental study of boys in ages 6 to 12 years screened for medical and psychological health that reducing sleep opportunity had a direct effect on academic performance, as rated by teachers, even among healthy boys with no history of behavioural problems or academic difficulty. The authors also found that insufficient sleep was a direct source of variability in the manifestation of attention problems, but not hyperactivity. In a cross-sectional Canadian school survey, 23% of the students reported that they felt that their grades had dropped because of sleepiness (Gibson et al., 2006).

4.2.3 Mental health service use

Not only severity of symptoms and type of mental health problems in children and adolescents, but also family stress and characteristics play an important role in the referral pathway to mental health services (Sourander et al., 2001; Zwaanswijk et al., 2003a, 2003b). Several findings have confirmed that help seeking is more related to family factors and parental experience of family burden symptoms, than severity of psychopathology per se (Angold et al., 1998, 2002; Verhulst & van der Ende, 1997; Wu et al., 1999; Farmer et al., 1999; Logan & King, 2002; Gunther et al., 2003). Results from the present study are in line with these findings. However, this is, to our knowledge, the first study where reports from adolescent patients themselves would seem to confirm the results of family significance from other studies. The impact of other family characteristics was also underlined in the present study. The adolescent's attachment to their parents, and especially to the father, was correlated with service use, as was parental divorce. There may be a need for a clearer picture of adolescent perception of family relations, however. Millikan et al. (2002) found that adolescent perception of the family was linked with their depressive symptoms and associated with neuroticism. Adolescents who are depressive and high in neuroticism may perceive ther families more negatively. Grant et al. (2006), in a review study, found substantial evidence for the mediating role of family relationship in the relation between stressors and child and adolescent psychopathology. Harland et al. (2002) reported that family characteristics and recent life events were correlated with with risks of behavioural and emotional problems in children, while time seemed to diminish the impact of life events. In the present study a number of changes and stressors during the last year, such as having moved, living in lodgings, and having lost a friend, or a girlfriend or boyfriend strongly differentiated adolescent patients in the BUP services from those who were treated locally. Such recent changes may entail a decline in social support and a weakened family and social network, leaving the adolescent more vulnerable and less able to cope with stressful life events or to face mental health problems. Children and adolescents are dependent upon their families and parental understanding and support is crucial when they struggle with emotional and behavioural problems.

Results from the present study may raise the question of whether referrals to the BUP services function according to the LEON-principle, that is, if degree of

psychopathology is the basis for referrals from local services. Local services are supposed to be able to deal with less severe problems on their own, without referring. On the other hand, our results signify that adolescent patients from the BUP services do have more symptoms and more internalising problems such as anxiety/ depression, and also more attention problems than adolescents who are treated locally. On the other hand, family dysfunction may also complicate treatment. Severe symptoms in the adolescent combined with family distress may be experienced as difficult to deal with by professionals in the local services. Local professionals may consider themselves as less qualified to work with such compound problems, and therefore choose to refer to the specialty mental health services.

4.2.4 Overall clinical implications

In addition to the main referral problem among child and adolescent psychiatric patients, clinicians should be more alert to co-occurring conditions that may be at risk of going unnoticed. Results from the present study indicate that co-occurring conditions as childhood abuse, neglect, pain, and sleep problems are prevalent among adolescent patients in the BUP services in Norway, and that they are related to severe problems as depression, self-harm and suicide attempts, as well as being interrelated.

The BUP services should consider implementing routine questions/inquiries where children and adolescents, parents and other informants are asked about childhood adversities such as abuse and neglect. These problems seem to be frequent among child and adolescent patients and are found to be associated with a wide range of severe psychiatric symptoms. Better and more quality controlled diagnostic routines on the ICD-10 axis 5 could have secured a more systematic collection of information related to questions of physical and sexual abuse, as well as other childhood stressors and adversities. In two studies, the implementation of routines for collecting such information raised the rates of self-reported sexual abuse sharply (Briere & Zaidi, 1989; Read & Fraser, 1998). Childhood abuse and neglect may have an adverse effect on development, and are in numerous studies found to be strongly related to mental health problems. Both abuse and neglect need to be targeted in therapy. Physical abuse in particular needs to be more focused upon, but neglect

also seems to be grossly overlooked. Garland et al. (1996) found, in a study of mental health service use by children in foster care, that sexually abused youths received a higher number of outpatient visits than neglected youths, regardless of level of psychopathology. Behl et al. (2003) examined the development of the child maltreatment literature over a 22-year period, and found that the annual percentage of articles examining child physical abuse decreased, whereas the annual percentage of articles examining child sexual abuse increased. The percentages of articles examining child neglect or child emotional abuse remained consistently low.

Implementation of routines for enquiring about pain problems should also be considered as a part of the evaluation of depressive symptoms, self-harm and suicidal risk (Tang & Crane, 2006). Reduction of pain may reduce depression (Arnstein et al., 2001; Wells-Federman et al., 2002), but treatment of depression may also lessen pain (Lin et al., 2003). Chronic pain is identified as a risk factor for suicidality (Tang & Crane, 2006). In clinical work, not only pain problems also but their interference with daily activities should be given notice (Larsson & Sund, 2005). In the present study, pain complaints were related to such social dysfunctions as absence from school, ending of leisure activities, and having few friends. Different kinds of pain may have different consequences for family life, school functioning, and spare time activities, and such information may provide a basis for therapeutic interventions on different social arenas. A number of well-defined behavioural and relaxation interventions now exist that are effective treatment methods of chronic pain and insomnia (JAMA, 1996). Therapeutic interventions as relaxation training, biofeedback, stress management, etc. have been shown to be effective in a remarkable number of patients (Oelkers-Ax & Resch, 2002). Larsson et al. (2005) in a school-based replication series study found that relaxation training was an effective treatment for adolescents suffering from frequent tension-type headache or migraine. Haythornthwaite et al. (1998) reported that, regardless of pain severity, the use of specific cognitive pain coping strategies may increase perceptions of control over pain.

In the present study, lack of sleep and not sleeping as well as usual, were the most commonly reported sleep problems among adolescents both in the community and in

the BUP services. Reduced sleep or insomnia, whether classified as primary (without any obvious cause) or secondary to other disorders, may have devastating impact on the life of children and adolescents. However, effective treatment methods of sleep problems do exist. Direct therapeutic interventions targeted at sleep problems might be crucial for better daily functioning in many cases, and may also alleviate depressive mood. Bjorvatn (2000) recommended non-pharmacological treatment (i.e. sleep restriction, stimulus control treatment) in chronic primary insomnia, but believed that this kind of treatment was unknown to most Norwegian health-care providers. Morin et al. (1994), in a meta-analysis of treatment efficacy in 59 treatment outcome studies, found that non-pharmacological interventions produced reliable and durable changes in the sleep patterns of patients with chronic insomnia. Treatment of sleep problems at an early age might possibly also prevent the development of potential depressive problems in adolescence (Gregory & O'Connor, 2002).

It is important to map out feasible connections between the traditional primary problems that are referred to the BUP services and co-occurring conditions as childhood abuse, neglect, pain, and sleep problems. These conditions may well turn out to be key problems out of which depression, self-harm, and suicidality secondary might develop. Alleviating pain suffering and sleep problems will, whatever, have a positive impact on children's and adolescents' daily living, in the family as well as at school and at leisure time, and thus improve quality of life. Therapeutic interventions targeted more directly at these problems might alleviate depression and anxiety, and reduce the risk of self-harm and suicide attempts, and thereby add to the treatment of problems. Implementation of "new" methods of treatment in the BUP services is needed to deal with these challenges.

Results from the present study underline the need for the therapist to have a family and network perspective in working with children and adolescents in the BUP services. Poor family functioning, having moved recently, and/or living in lodgings, may result in weaker family and social networks. In the present study these were significant factors related to referral to specialty mental health service. Clinicians in the BUP services need to hold a high degree of competence to work with families and social networks. A varied range of family therapy approaches have, over the

years, been developed and used in treatment of children and adolescents with mental health problems (Haley, 1973; Minuchin & Fishman, 1979; Palazzoli Selvini et al., 1978; Andersen, 1991; White & Epston, 1990; Anderson & Goolishian, 1992). Many of these approaches have been found to be very useful in clinical work, but have not been systematically evaluated. Some of the more recently developed family treatment programs are evidence based and targeted toward children suffering from specific kinds of behavioural problems and at different ages (Webster-Stratton, 1994; Patterson & Narrett, 1990; Henggeler et al., 1996). These three programs have, for a while, been under implementation in Norway. Emotional and behavioural problems among children and adolescents also manifest themselves in different social arenas outside the family. Working with the social networks of children and adolescents at school and in the neighborhood is a therapeutic challenge, and more attention should be directed toward these concerns.

4.2.5 Directions for future research

In Norway, as well as internationally, most scientific knowledge of behavioural and emotional problems and their relationships among children and adolescents comes from community studies, often from school surveys, or is based on paediatric groups, or on patients in the primary care setting. However, knowledge from such samples as these is not necessarily valid for, and may not apply to, child and adolescent psychiatric patients. More knowledge is needed from clinical samples from the child and adolescent specialty mental health services. The present investigation of a clinical sample of adolescent patients from the BUP services must, however, be considered as a pilot study and the results as preliminary and tentative, when the sample is small and not fully representative. Nevertheless, the study raises a range of questions that deserve more attention as well as further research.

- More knowledge is needed of potential risk factors for referral to the BUP services such as family burden, having moved recently, and living in lodgings. The impact of these psychosocial strains that was found in the present study should be further analysed.
- There is a strong call for more detailed investigations of prevalences of physical and sexual abuse and neglect among patients in the BUP

services. More knowledge is needed of possible different effects of physical and sexual abuse and neglect. Prospective studies of trajectories of these adversities related to mental health and quality of life should be implemented.

- There is a need for studies on validity and reliability of ICD-10 diagnoses axis 1 and 5 made in the BUP services. Today we have little or no information about these issues, and research based on ICD-10 diagnoses suffers from a degree of uncertainty.
- Further investigations of concurrent frequent pain and relationships with self-harm, suicidality, and depression should be conducted among patients in the BUP services. In prospective studies pain as a risk factor for social dysfunction related to quality of life, such as family functioning, school absence, participation in leisure activities, and relationships with friends, could be investigated.
- More knowledge of prevalence of sleep problems is needed among patients in the BUP services, and of associations with symptoms and risk of depression, self-harm and suicide attempts. We know little about possible consequences of sleep problems in daily life and for academic functioning.
- The present investigation indicates that the use of alcohol, cannabis and solvents among BUP patients is prevalent in spite of low rates of referral of these problems, and that substance use is associated with psychiatric symptoms and psychosocial problems. More knowledge of prevalences and associations of these problems are needed in the BUP services, and attention should also be given to the family context.

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Appendix

The Invitation Letters

Scheme of Procedure

Scheme of Registration

The Questionnaire

Psykisk helsevern for barn og unge i Nordland

Forespørsel om deltakelse i forskningsprosjekt

Til ungdom/foreldre/foresatte

Dette brevet går til all ungdom som kommer til Barne- og ungdomspsykiatrisk poliklinikk (BUP), eller som for tiden er på institusjon for ungdom i Nordland.
Vi gjennomfører en undersøkelse om ungdom og psykisk helse, og har valgt å spørre de unge selv gjennom et spørreskjema.

Vi ønsker å gjøre undersøkelsen fordi:

- Det virker som om stadig flere unge får psykiske problemer.
- Vi vet for lite om hva som kan ligge bak dette.
- Vi ønsker å vite mer om hvordan de unge prøver å mestre disse vanskene.
- Kunnskap er nødvendig både for å forebygge og å hjelpe unge på en bedre måte..

Hva vil vi finne ut av?
Vi ønsker å finne mer ut av hvordan ungdommer har det, og dere blir bedt om å svare på spørsmål om dere selv, om hverdagslivet, og om hvordan dere prøver å løse problemer ungdom strever med.

Du fyller ut spørreskjemaet alene, men en kontaktperson vil være tilgjengelig under utfyllingen for å svare på spørsmål hvis det er noe du lurer på underveis. De fleste bruker ca 1 time å svare på spørreundersøkelsen som foregår på BUP, utekontor, eller institusjonen hvor du er.

Det er ingen andre enn forskerne som får vite hva du har svart i spørreskjemaet, med unntak av en egen brunfarget del av spørreskjemaet (YSR) som er skilt ut. YSR brukes ofte som en del av undersøkelse/ behandling på BUP. For at ungdommen senere skal slippe å svare på dette på nytt, så vil BUP/institusjon få en kopi av YSR. Vi trenger også å få tilgang til informasjon fra BUP/ institusjon da dette vil være nødvendig for undersøkelsen.

Hva skal vi spørre om?
Vi vil spørre om forhold til venner, til familie, hva du liker å holde på med i fritiden, om forhold til rusmidler, og om sterke og svake sider ved deg selv. Vi vil spørre om viktige ting har hendt deg den siste tiden, om humøret ditt, om hvordan du ser på framtiden, og om hva du gjør når du har det vanskelig. Noen av spørsmålene utover i spørreskjemaet vil ligne på spørsmål som er stilt tidligere.
Frivillighet
Alle som deltar i undersøkelsen skal gjøre dette frivillig. Dersom noen ønsker å trekke seg fra undersøkelsen står de helt fritt til å gjøre dette når som helst, både underveis og etterpå, uten å måtte begrunne dette. Det får ingen konsekvenser for tilbud om hjelp. De kan også be om å få utfylt spørreskjema slettet dersom de senere skulle ønske det.

Ungdommene vil senere bli spurt om å svare på et tilsvarende spørreskjema om 3 år, men vil ikke være forpliktet til å svare på dette selv om de har besvart det første spørreskjemaet.
Spørreskjemaet vil være tilgjengelig på hver enkelt BUP/institusjon slik at dere kan se hva vi vil spørre om.

Hvis du har noe å spørre oss i prosjektledelsen om, så bare ring daglige prosjektledere Bjørn Reigstad og Kirsti Jørgensen på **telefon 75 50 18 00**.

Vennlig hilsen

Bjørn Reigstad psykolog	Kirsti Jørgensen psykolog	Anne Mari Sund lege/barnepsykiater	Lars Wichstrøm professor i psykologi

Samtykke til å delta i undersøkelsen

Ungdommens navn .....……. (Vennligst bruk store bokstaver)

Jeg har lest informasjonen, og er villig
til å delta i undersøkelsen.

…….
Ungdommens signatur

For de som er under 16 år:

Jeg har lest informasjonen og gir tillatelse
til at min sønn/datter deltar i undersøkelsen

…….
Foresattes signatur

Dere vil få en kopi av dette brevet.

Fremmøte for utfylling av spørreskjema:

Dato ……..…… kl.:…….

Fremmøtested/adresse: ……..

Kontaktperson: ……..

Telefon:……

Psykisk helsevern for barn og unge i Nordland

Til dere som ikke har møtt eller svart på vår henvendelse

Dato,

SPØRRESKJEMA-UNDERSØKELSE

Vi avtalte tid for å delta i et forskningsprosjekt om ungdom og psykisk helse.

Da du/dere ikke møtte, og vi heller ikke har hørt noe fra dere, sender vi forslag om ny tid.

Vennlig hilsen

……
kontaktperson

Fremmøte for utfylling av spørreskjema:

Dato ……..…… kl.:…….

Fremmøtested/adresse: ……..

Kontaktperson: ……..

Telefon:……

Psykisk helsevern for barn og unge i Nordland

PROSEDYRER FOR ADM. AV SPØRRESKJEMAUNDERSØKELSE

Hvem omfatter undersøkelsen:

- Omfatter alle i alderen 12 – 18 år som henvises til en BUP i Nordland i ett år fra 1. juli 2000, og hvor undertegnet samtykkeerklæring foreligger.
- Ungdommen skal være fylt 12 år ved tidspunkt for henvisning.
- Sjekk at ungdom over 16 år ikke har reservert seg mot at foreldre skal vite om henvisningen.

Presentasjon ev. utsendelse av "Forepørsel om deltakelse i forskningsprosjekt" (info-skriv):

- Vi går over til å bruke bare **ett** felles **revidert** info-skriv til ungdommen/foreldre/foresatte. For ungdom **under** 16 år må også foresatte undertegne.
- Tidspunkt og prosedyre for presentasjon ev. utsendelse av **info-skriv** med **samtykkeerklæring** og **avtale** om utfylling av spørreskjemaet, må være tilpasset øvrige rutiner på BUP.
- Mange BUP'er foretrekker å dele ut info-skriv når ungdommen kommer til inntaks-/vurderings-samtale, og ved samtykke å gi tilbud om å fylle ut spørreskjemaet umiddelbart etter samtalen, eller avtale tid som passer for utfylling. De fleste bruker ca én time på utfyllingen.
- Utfylling av spørreskjema må skje **før** eventuell behandling begynner (inntaks-/vurderingssamtale regnes her ikke som behandling).
- I **akuttsake**r presenteres info-skriv etter avtale med behandler, og spørreskjema fylles ut så snart det passer.

Utfylling av spørreskjemaet:

- Den enkelte BUP vurderer hvor spørreundersøkelsen skal finne sted – på BUP eller på et utekontor hvor annen person enn kontaktperson kan administrere utfyllingen.
- Kontaktperson skal:
  1) Ta i mot og vise ungdommen til rette.
  2) Gi denne kopi av medbrakt undertegnet samtykke og info-skriv.
  3) Være tilgjengelig, og kontakte leder/stedfortreder hvis behov.
  4) **Først gis YSR (brunt skjema), så spørreskjemaet** (bruk penn).
  5) Når ungdommen er ferdig så spør om det er noe han/hun lurer på.
  6) Gi ungdommen en konvolutt hvor spørreskjema (**ikke YSR**) legges
  7) Ungdommen limer konvolutten igjen, og ref.nr/jour.nr. påføres.

Etter utfylling av spørreskjemaet:

- Kontaktansvarlig kopierer og skårer YSR. Original og profilark legges i journalen.
- Reg. tiltak i BUP-data på undersøkelse med leder som refusjonsberettiget. Avtal med leder.
- Info fra BUP-data fylles ut på registreringsskjema.
- Følgende legges i **samlekonvolutt** med **institusjonsnavn og ref.nr/j.nr på deltaker**:
  1) Undertegnet samtykkeerklæring.
  2) Kopi av YSR og profil-ark.
  3) Konvolutt med spørreskjema.
  4) Reg.skjema med info fra BUP-data.
- Samlekonvoluttene sendes fortløpende til prosjektlederne i Bodø.

Rutiner for purring:

- Hvis noen ikke møter, og heller ikke melder avbud, sendes purrebrev inntil 1 gang.

Etter avslutning av spørreundersøkelsen:

- Lage liste over deltakere med navn og ref.nr./j.nr. som sendes til prosjektlederne i Bodø.
- Lage samleliste med bare ref.nr./j.nr. på de som ikke har deltatt i undersøkelsen.

Psykisk helsevern for barn og unge i Nordland

Prosjekt Tristhet/depresjon: Informasjon fra henvisning/journal

(fylles ut av kontaktansvarlig for hver klient)

Hvilken institusjon eller BUP: **Kontaktansvarlig:**

Fødselsdato/nr: **Gutt/jente:**

Referansenr./journalnr.: **Henv.dato:**

Re-henvisning/vært innlagt tidligere?: **Innleggelsesdato:**

Øyeblikkelig hjelp ? **Kommune/nr.:**

Henvisningsgrunn (Velg ***inntil 3 henvisningsgrunner*** fra hver liste slik oppgitt fra henviser. Sett den viktigste først. Skriv nummer i rutene:

Ungdommen

1 ☐ **2** ☐ **3** ☐

1 Autistiske trekk
2 Psykotiske trekk
3 Suicidalfare
4 Hemmet atferd
5 Angst/fobi
6 Tvangstrekk
7 Tristhet/depresjon/sorg
8 Skolefravær
9 Atferdsvansker
10 Hyperaktiv/ konsentrasjonsvansker
11 Rusmiddelmisbruk
12 Asosial/ kriminalitet
13 Lærevansker
14 Språk/ talevansker
15 Syn/ hørselproblem
16 Spiseproblem
17 Andre somatiske symptomer
18 Annet
19 Ingen

Ungdommens miljø

1 ☐ **2** ☐ **3** ☐

1 Belastninger i familien
2 Belastninger i nærmiljø/samfunn
3 Belastninger i skole
4 Akutte livshendelser
5 Belastende hendelser/forhold som er resultat av ungdommens egen forstyrrelse/ funksjonshemning
6 Ingen

(snu arket)

Hvem har henvist klienten til institusjon/BUP? **Kodenr.:** ☐ ☐

Henvisningsinstans/nr:
11 Pasienten
12 Foreldre/ foresatte
13 Fosterhjem
14 Andre fra nærmiljø
21 Skole/ fritidsordning
23 PP-tjeneste
24 Spesialskole
25 Statlig kompetansesenter
26 Annet innen skolesektor
31 Lege
32 Skolehelsetjenesten
33 Helsestasjon
34 Habiliteringstjenesten barn
35 Somatisk sykehus
36 Flyktningehelsetjeneste
37 Annen somatisk helsetjeneste
41 Rusmiddelomsorg
42 Habiliteringstjeneste voksne
43 BUP poliklinikk/ avdeling
44 Voksenpsykiatri
45 Psykolog/ psykiater privat
46 Annen helsetjeneste
51 Sosialkontor
52 Barnevern (kommunen)
53 Barnevern (fylkeskommunen)
54 Barnevernsinstitusjon
55 Flyktning/ innvandrertjeneste
56 Annen sosialtjeneste
61 Hjelpetjenesten for barn og unge
71 Familievernkontor
72 Utekontakt/ uteseksjon
74 Krisesenter
75 Kriminalomsorg
76 Politi/ lensmann/ rettsvesen
77 Arbeidsmarkedsetat
78 Andre

Spørreskjema
til ungdom i Nordland

Dette spørreskjemaet går til ungdommer som er henvist til Psykisk helsevern for barn og unge i Nordland (BUP) og/eller bor på institusjon for ungdom. Hensikten med undersøkelsen er å få bedre kunnskap om hvordan unge mennesker takler problemer i hverdagen, slik at vi kan tilby bedre hjelp til de som trenger det.

Alle svarene vil være konfidensielle (hemmelige). Det er bare fagfolk med taushetsplikt som får se svarene dine. Vi vil be deg om å svare på et nytt spørreskjema om tre år, og vil derfor oppbevare nedlåst en liste med referansenummer uten navn. Ingen andre enn forskerne har lov til å se denne listen.

Dette er en frivillig undersøkelse. Det betyr at du ikke behøver å være med. Dersom du ønsker å trekke deg fra undersøkelsen senere, så gi beskjed til OSS, så svarene dine kan bli slettet.

Hvis det er noen spørsmål du synes er for personlige, eller som du ikke vil svare på, så kan du hoppe over dem. Men vi vil helst at du svarer på alle spørsmålene.

De fleste stedene setter du et kryss i den ruta som passer best for deg. Noen steder står det bare prikker. Da må du skrive ut svaret selv.

Når du har fylt ut skjemaet, legger du det i den konvolutten du har fått utlevert og limer den igjen selv.

Dersom det er noe du lurer på eller har lyst til å snakke om etter at du har fylt ut skjemaet, kan du ta kontakt med oss på telefonnr. 75501800.

Takk for hjelpen.

Vennlig hilsen

Bjørn Reigstad	Kirsti Jørgensen	Anne Mari Sund	Lars Wichstrøm
psykolog	psykolog	lege/barnepsykiater	professor i psykologi

Er du jente eller gutt? ☐ Jente ☐ Gutt

Hvilken klasse går du i? ……

Når er du født? ……Dato ……..Måned ……..År

Hvem har søkt om hjelp for deg til BUP (Barne- og ungdomspsykiatrisk poliklinikk) /eller til institusjon?

☐ Du selv
☐ Foreldrene dine
☐ Lege
☐ Helsesøster
☐ Sykehus
☐ BUP
☐ Sosialkontor/barnevern
☐ PPT
☐ Skole
☐ Andre (hvem)…….
☐ Vet ikke

Var du enig i henvisningen? ☐ Ja ☐ Nei ☐ Kanskje ☐ Vet ikke

Hvilket problem(er) er det søkt hjelp for?
(beskriv)……

…….

Hvor lenge har problemet(ene) vart? ☐ Mindre enn 2 uker
☐ Mer enn 1 mnd.
☐ Mer enn ½ år
☐ Mer enn 1 år
☐ Mer enn 2 år
☐ Mer enn 5 år

Vet du hva som er årsak til problemet(ene) ? ☐ Ja ☐ Nei ☐ Kanskje ☐ Vet ikke

Hvis svaret er **Ja** eller **Kanskje**, hva tror du årsaken(ene) er? ……..

…….

Tror du at du vil få hjelp for problemet(ene)? ☐ Ja ☐ Nei ☐ Kanskje ☐ Vet ikke

Hvordan tror du at problemet(ene) vil være om 3 år? ☐ Mye bedre
☐ Noe bedre
☐ Som før

☐ Noe verre

☐ Mye verre

Er du født i Norge? ☐ Ja ☐ Nei

Hvis nei, hvor mange år har du bodd i Norge? ...…..År

Hvor kommer dine foreldre fra?

Mor:	**Far:**
☐ Norge	☐ Norge
☐ Annet land	☐ Annet land
nemlig…….	nemlig…….

Hvor lenge har du bodd der du bor? (samme skolekrets)

Jeg har alltid bodd der ☐

Mer enn fem år ☐

Mellom ett og fem år ☐

Under ett år ☐

Hvor mange ganger har du flyttet? (i løpet av livet ditt)?..... antall ganger

---

Er du adoptert? ☐ Ja ☐ Nei

Hvis **Ja**, fra hvilket land……..

Min etnisitet er (skriv et eller flere av numrene nedenfor)……

1. Norsk 2. Samisk 3. Annet (skriv hvilken)…….

Fars etnisitet er (bruk numrene ovenfor)…….

Mors etnisitet er (bruk numrene ovenfor)…….

Hvem bor du sammen med nå?

☐ Mor og far

☐ Mor

☐ Far

☐ Mor/far og hennes/hans nye samboer eller ektefelle

☐ Omtrent like mye hos mor og far

☐ Fosterforeldre

☐ Besteforeldre, andre slektninger

☐ Annet

Hvor mange søsken har du? Jeg har…….. (antall) søsken

Går du på internatskole/bor du på hybel? ☐ Ja ☐ Nei

Hvis du ikke bor sammen med begge foreldrene dine, hvor ofte treffer du dem/den av foreldrene som du ikke bor sammen med?

Mor:		**Far:**	
En eller flere ganger i uka	☐	En eller flere ganger i uka	☐
En til to ganger i måneden	☐	En til to ganger i måneden	☐
En til to ganger i halvåret	☐	En til to ganger i halvåret	☐
Sjeldnere	☐	Sjeldnere	☐

Er dette ofte nok?

Mor:	☐ For sjelden	☐ Passelig	☐ For ofte
Far:	☐ For sjelden	☐ Passelig	☐ For ofte

Lever begge dine foreldre? ☐Ja ☐ Nei

☐ Mor er død
Da jeg var _____ år gammel

☐ Far er død
Da jeg var _____ år gammel

Er dine foreldre skilt eller har flyttet fra hverandre?

☐ Nei

☐Ja, da jeg var _____ år gammel

Tror du moren din har problemer? ☐ Ja ☐ Nei ☐ Vet ikke

Hvis **Ja,** Hvilke?……..

Tror du faren din har problemer? ☐ Ja ☐ Nei ☐ Vet ikke

Hvis **Ja,** Hvilke?……..

Hva er den høyeste utdanningen moren og faren din har?

	Mor	**Far**
7-årig grunnskole (eller kortere……	☐	☐
Ungdomsskole/realskole…….	☐	☐
Videregående allmennfaglig (gymnas)……	☐	☐
Videregående yrkesfaglig (yrkesskole)……	☐	☐
Fagopplæring innen håndverk, industri, landbruk el. l. ……..	☐	☐
Høyskole (lærer, sykepleier, distriktshøyskole el. l.) …….	☐	☐
Universitet eller annen langvarig utdanning……	☐	☐
Annen utdanning …….	☐	☐
Usikker/vet ikke …….	☐	☐

Hvordan har familien din det økonomisk? ☐ Dårlig råd ☐ Alminnelig råd ☐ God råd

Andre voksne

1. Hvem ville du snakket med/søkt hjelp hos hvis du hadde et personlig problem eller følte deg utenfor og trist?

☐ Ville ikke ha gått til noen
☐ Mor
☐ Far
☐ Andre slektninger
☐ Nabo
☐ Lærer/rådgiver
☐ Idrettstrener
☐ Leder for fritidsaktivitet
☐ Støttekontakt
☐ Helsesøster/lege
☐ Psykolog/psykiater/PP-rådgiver
☐ Andre

2. Hvor ofte møter du denne personen?

☐ Hver dag
☐ Hver uke
☐ Ca. én gang i måneden
☐ 1-2 ganger i halvåret
☐ 1-2 ganger i året
☐ Sjeldnere

Humøret ditt

De følgende spørsmålene handler om hva du har følt og gjort de siste to ukene. Hvis en setning stemte om deg mesteparten av tiden, kryss av "riktig". Hvis den bare stemte noen ganger, kryss av "noen ganger riktig". Hvis en setning ikke stemte om deg, kryss av "ikke riktig".

	Riktig	**Noen ganger riktig**	**Ikke riktig**
Jeg var lei meg eller ulykkelig			
Jeg var ikke glad for noe			
Jeg var mindre sulten enn vanlig			
Jeg spiste mer enn vanlig			
Jeg følte meg så trøtt at jeg bare ble sittende uten å gjøre noen ting			
Jeg beveget meg og gikk langsommere enn vanlig			
Jeg var veldig rastløs			
Jeg følte meg lite verdt			

	Riktig	Noen ganger riktig	Ikke riktig
Noen ganger følte jeg meg skyldig for noe som ikke var min feil			
Det var vanskelig for meg å bestemme meg for noe			
Jeg var sur og gretten mot mine foreldre			
Jeg hadde ikke lyst til å snakke så mye som vanlig			
Jeg snakket langsommere enn vanlig			
Jeg gråt mye			
Jeg tenkte at fremtida ikke hadde noe positivt å by meg			
Jeg tenkte at livet ikke var verd å leve			
Jeg tenkte på døden eller på å dø			
Jeg tenkte at familien ville greie seg bedre uten meg			
Jeg tenkte på å ta livet mitt			
Jeg hadde ikke lyst til å treffe vennene mine			
Jeg syntes det var vanskelig å tenke klart eller å konsentrere seg			
Jeg tenkte at det ville skje noe fælt			
Jeg hatet meg selv			
Jeg følte meg som et dårlig menneske			
Jeg syntes at jeg så stygg ut			
Jeg bekymret meg for smerter i kroppen			
Jeg følte meg ensom			
Jeg tenkte at ingen egentlig var glad i meg			
Jeg hadde det ikke noe morsomt på skolen			
Jeg tenkte at jeg aldri kunne bli så god som andre barn			
Jeg gjorde alt galt			
Jeg sov ikke så godt som jeg vanligvis sover			
Jeg sov mye mer enn vanlig			
Jeg var ikke så glad som jeg bruker å være, selvom jeg fikk ros eller belønning			
Jeg følte at jeg hadde tatt livet mitt hvis jeg hadde visst en måte å gjøre det på			

Folk tenker og gjør mange forskjellige ting når de er lei seg. Vær så snill og kryss av hvor ofte du tenker eller gjør noe, når du føler deg trist, lei deg eller deprimert. Husk å krysse av for det du gjør <u>i virkeligheten,</u> ikke det du tror du burde gjøre.

Når du er lei deg, gjør du:

	Nesten aldri	Noen ganger	Ofte	Nesten bestandig
-tenker jeg "Hvorfor har jeg problemer som andre unge ikke har ?"	□	□	□	□
-er jeg sammen med gode venner	□	□	□	□
-tenker jeg at ting kan endre seg i framtida	□	□	□	□
-tenker jeg på hvor alene jeg føler meg	□	□	□	□
-tenker jeg på hvor lei meg jeg er	□	□	□	□
-lytter jeg til musikk som passer til å være trist	□	□	□	□
-tenker jeg at jeg tross alt har mange bra sider	□	□	□	□
-analyserer jeg (tenker på) ting som har skjedd for å prøve å forstå hvorfor jeg er lei meg	□	□	□	□
-gjør jeg noe sammen med andre som får meg i bedre humør	□	□	□	□
-ler jeg og prøver å se det humoristiske i situasjonen	□	□	□	□
-oppsøker jeg bestevennen/venninnen min	□	□	□	□
-spiller jeg fin musikk, ser TV eller spiller spill	□	□	□	□
-er jeg for meg selv	□	□	□	□
-trener jeg	□	□	□	□
-unngår jeg å tenke på at jeg er trist	□	□	□	□
-er jeg sammen med familien	□	□	□	□
-finner jeg ut hvorfor jeg er lei meg – og prøver å gjøre noe med det	□	□	□	□
-tenker jeg at jeg ikke har lyst til å gjøre noe som helst	□	□	□	□
-prøver jeg å se positivt på ting	□	□	□	□
-blir jeg hissig og irritert	□	□	□	□
-slapper jeg av, prøver å roe meg ned	□	□	□	□
-det bare godtar jeg, jeg kan likevel ikke gjøre noe med det	□	□	□	□
- snakker jeg med noen om at jeg er lei meg	□	□	□	□
- skriver jeg ned tanker og følelser (i dagbok e.l.)	□	□	□	□
- spiser jeg noe godt	□	□	□	□
- driver jeg med en hobby, lager ting etc.	□	□	□	□

Om selvmordsforsøk

A: Har du med vilje noen gang tatt en overdose av piller eller på annen måte forsøkt å skade deg selv ?

□ Nei, aldri
□ Ja, en gang
□ Ja, flere ganger

Dersom du besvarte "ja" på spørsmål A over, vil vi gjerne at du besvarer spørsmålene fra B til D nedenfor. Dersom du svarte "nei" kan du hoppe over disse spørsmålene.

B: Hvor lenge er det siden du sist forsøkte å skade deg selv ? _____ år _____måneder siden

C: Har du noen gang forsøkt å ta ditt eget liv ?

□ Nei, egentlig ikke
□ Ja, en gang
□ Ja, flere ganger

D: Hvis du svarte "ja" på C, hvor lenge er det siden du sist forsøkte å ta ditt eget liv ? _____ år _____måneder siden

Alle svarer på følgende:

Kjenner du noen som har prøvd å ta livet sitt/tatt livet sitt ? Ja Nei

Hvis **ja**, hvem var det?
(Sett så mange kryss som passer)

Mor
Far
Søsken
Andre i familien
Venn
Andre

Hvor lenge var det siden ? _____ år og _____ måneder siden

Om mishandling/overgrep

Har noen som står deg nær skadet deg fysisk slik at du hadde skader eller merker dagen etter? Nei, aldri Ja, èn gang Ja, flere ganger

Hvis **Ja**, hvor lenge er det siden siste gang? _____år _____måneder siden

hvor lenge er det siden første gang? _____år _____måneder siden

Har du noen gang før du var 10 år vært overlatt til deg selv om natten eller lengre uten tilsyn av voksne? Nei, aldri Ja, èn gang Ja, flere ganger

Har du noen gang vært utsatt for seksuelle overgrep? Nei, aldri Ja, èn gang Ja, flere ganger

Hvis **Ja**, hvor lenge er det siden siste gang? _____år _____måneder siden

hvor lenge er det siden første gang? _____år _____måneder siden

Om venner

Omtrent hvor mange nære venner har du? (Ta ikke med søsken)	Ingen	1	2–3	4 eller flere
Omtrent hvor mange ganger i uka er du sammen med dem utenom skolen?	Færre enn 1	1 eller 2	3 eller flere	

Er noen av dine beste venner eldre enn deg?

- Ingen
- Noen
- Omtrent halvparten
- Alle eller nesten alle

Hvis du har kjæreste, hvor gammel er hun/han?

- Har aldri hatt noen kjæreste
- Har hatt kjæreste før
- Har kjæreste. Hun/han er _____ år

Hvilket forhold har du til vennene dine?

	Aldri eller nesten aldri sant	Sjelden sant	Noen ganger sant	Ofte sant	Alltid eller nesten alltid sant
Å snakke med vennene mine om mine problemer får meg til å føle meg skamfull eller dum					
Vennene mine hjelper meg til å snakke om vanskelige ting					
Vennene mine forstår ikke hvordan jeg har det nå om dagen					
Jeg synes at vennene mine er gode venner					
Jeg stoler på vennene mine					
Vennene mine respekterer mine følelser					
Det virker som om vennene mine er irritert på meg av en eller annen grunn					
Jeg forteller vennene mine om mine problemer og vanskeligheter					
Hvis vennene mine ser at noe plager meg, så spør de meg om det					

Hvordan har du det på skolen ?

	Stemmer bra	Stemmer nokså bra	Stemmer nokså dårlig	Stemmer dårlig
Kommer du godt overens med lærerne dine?	☐	☐	☐	☐
Gruer du deg for å gå på skolen?	☐	☐	☐	☐
Har du språkproblemer? (fordi du har et annet morsmål enn norsk f.eks.) ?	☐	☐	☐	☐
Får du støtte fra lærerne dine?	☐	☐	☐	☐

Hvordan har du det i klassen din?

	Stemmer bra	Stemmer nokså bra	Stemmer nokså dårlig	Stemmer dårlig
Jeg trives i klassen	☐	☐	☐	☐
Jeg har mye til felles med andre i klassen	☐	☐	☐	☐
Jeg føler meg utenfor i klassen	☐	☐	☐	☐
Jeg føler meg knyttet til klassen	☐	☐	☐	☐
Jeg er redd for å dumme meg ut i klassen	☐	☐	☐	☐
Klassen legger rimelig vekt på mine meninger	☐	☐	☐	☐

Lese- og skrivevansker

Har du hatt spesielle lese-og skrivevansker (dysleksi)
de siste 12 månedene? ☐ Nei ☐ Ja

Hvis **ja** :

	Store problemer	Noen problemer	Ingen problemer
Lesing	☐	☐	☐
Skriving	☐	☐	☐
Har du problemer med matematikk?	☐	☐	☐

Har du noen form for talevansker ? ☐ Nei ☐ Ja

Hvordan greier du deg faglig på skolen? ☐ Langt under gjennomsnittet / til stryk
☐ Under gjennomsnittet
☐ Gjennomsnittet
☐ Over gjennomsnittet

Har du det siste året (de siste 12 måneder) skulket skolen? ☐ Nei
☐ Ja, noen få timer
☐ Ja, 1 hel dag
☐ Ja, 2-5 dager
☐ Ja, 1-4 uker
☐ Ja, mer enn 1 måned

Har du spesialundervisning på skolen (spes.ped. tiltak)? ☐ Nei ☐ Ja

Hvordan er du ?

Nedenfor ser du en liste over egenskaper folk kan ha.
Vennligst kryss av for om det stemmer eller ikke stemmer for deg.

	Stemmer ikke i det hele tatt	Stemmer nokså dårlig	Stemmer omtrent	Stemmer nokså godt	Stemmer helt
Forsvarer mine meninger	☐	☐	☐	☐	☐
Tar hensyn til andre	☐	☐	☐	☐	☐
Sterk personlighet	☐	☐	☐	☐	☐
Forståelsesfull	☐	☐	☐	☐	☐
Har lederegenskaper	☐	☐	☐	☐	☐
Trøster gjerne andre	☐	☐	☐	☐	☐
Villig til å ta sjanser	☐	☐	☐	☐	☐
Varm	☐	☐	☐	☐	☐
Sier hva jeg mener	☐	☐	☐	☐	☐
Vennlig	☐	☐	☐	☐	☐

Har dette skjedd deg det siste halve året?

Jeg er blitt gjort narr av, ertet på en vond måte eller noen har sagt stygge ting til meg på skolen eller på skoleveien:

☐ Det har aldri skjedd det siste halve året
☐ Det har skjedd 1 - eller 2 ganger det siste halve året
☐ Det har skjedd omtrent en gang i uken
☐ Det har skjedd omtrent 2 eller -3 ganger i uken
☐ Det har skjedd enda oftere

Jeg er blitt plaget, slått, lugget, sparket eller angrepet på en stygg måte på skolen eller på skoleveien
☐ Det har aldri skjedd det siste halve året
☐ Det har skjedd 1 - eller 2 ganger det siste halve året
☐ Det har skjedd omtrent en gang i uken
☐ Det har skjedd omtrent 2 eller -3 ganger i uken
☐ Det har skjedd enda oftere

Av og til blir man med vilje holdt utenfor av medelever, får ikke lov til å være med. Har det også hendt deg?
☐ Det har aldri skjedd det siste halve året
☐ Det har skjedd 1 - eller 2 ganger det siste halve året
☐ Det har skjedd omtrent en gang i uken
☐ Det har skjedd omtrent 2 eller -3 ganger i uken

☐ Det har skjedd enda oftere

Hvilken hjelp har du fått ?

Hvis man strever med noe, er engstelig, nedfor, trist el.l. (psykiske problemer) hender det at man ikke greier så mye som ellers. Har du hatt det slik det siste året?

☐ Ja
☐ Ja i en viss grad
☐ Nei

Har du måttet redusere eller slutte med fritidsaktiviteter på grunn av psykiske problemer i en periode det siste året ?

☐ Nei
☐ Ja

Hvis **ja**, hvor lenge ? ☐ < mindre enn 1 uke ☐ i 1-4 uker ☐ > mer enn 4 uker

Har du vært borte fra skolen på grunn av slike problemer i løpet av det siste året?

☐ Nei
☐ Ja

Hvis **ja**, hvor lenge? ☐< 1 uke ☐ i 1-4 uker ☐ > 4 uker

Har du brukt <u>medisiner</u> for psykiske problemer, evt. søvnproblemer, det siste året?

☐ Nei
☐ Ja

Hvis **ja**, hvor lenge? ☐ < 1 uke ☐ i 1-4 uker ☐ >4 uker ☐ Hele tiden

Har du mottatt hjelp for psykiske problemer det siste året? ☐ Nei ☐ Ja

Hvis **ja**, fra hvem?
(sett så mange kryss som passer)

☐ Lærer/Rådgiver
☐ Helsesøster
☐ Almenpraktiserende lege/kommunelege
☐ PP-tjenesten
☐ Psykiater
☐ Psykolog
☐ Annen

Hvor fornøyd var du med den hjelpen du fikk ?

☐ Svært misfornøyd ☐ Ganske misfornøyd ☐ Ganske fornøyd ☐ Svært fornøyd

Foreldre betyr mye for ungdommer, noen ganger går man godt sammen med foreldrene sine, noen ganger ikke så godt. Under skal du fylle ut hva du tenker om forholdet mellom dine foreldre og deg selv. Hvis det er flere voksne som er viktige for deg (eks. mor, stemor) så tenk ut fra den du føler har betydd mest for deg.

Hvordan har du det sammen med moren din?

	Aldri eller nesten aldri sant	Sjelden sant	Noen ganger sant	Ofte sant	Alltid eller nesten alltid sant
Moren min respekterer følelsene mine	□	□	□	□	□
Jeg synes at moren min gjør en god jobb som mor	□	□	□	□	□
Jeg skulle ønske jeg hadde en annen mor	□	□	□	□	□
Moren min godtar meg som den jeg er	□	□	□	□	□
Jeg vil gjerne høre hva mor mener om ting jeg er opptatt av	□	□	□	□	□
Det er ikke noen vits i å vise følelsene mine for mor	□	□	□	□	□
Moren min kan se når jeg er urolig over noe	□	□	□	□	□
Å snakke med moren min om mine problemer får meg til å føle meg skamfull eller dum	□	□	□	□	□
Mor venter for mye av meg	□	□	□	□	□
Jeg blir lett urolig når mor er tilstede	□	□	□	□	□
Jeg blir mye mer urolig enn mor vet om	□	□	□	□	□
Mor bryr seg om hva jeg mener når vi drøfter ting	□	□	□	□	□
Mor stoler på min vurderingsevne	□	□	□	□	□
Mor har sine egne problemer, så jeg plager henne ikke med mine	□	□	□	□	□
Mor hjelper meg til å forstå meg selv bedre	□	□	□	□	□
Jeg forteller moren min om mine problemer og vanskeligheter	□	□	□	□	□
Jeg er sint på moren min	□	□	□	□	□
Jeg får lite oppmerksomhet fra moren min	□	□	□	□	□
Mor hjelper meg å snakke om vanskelige ting	□	□	□	□	□
Mor forstår meg	□	□	□	□	□
Når jeg er sint, prøver moren min å forstå meg	□	□	□	□	□
Jeg stoler på moren min	□	□	□	□	□
Moren min forstår ikke hvordan jeg har det nå om dagen	□	□	□	□	□
Jeg kan regne med moren min når jeg trenger å snakke ut om noe	□	□	□	□	□
Hvis mor ser at noe plager meg, spør hun meg om det	□	□	□	□	□

Hvordan har du det sammen med faren din?

	Aldri eller nesten aldri sant	Sjelden sant	Noen ganger sant	Ofte sant	Alltid eller nesten alltid sant
Faren min respekterer følelsene mine	□	□	□	□	□
Jeg synes at faren min gjør en god jobb som far	□	□	□	□	□
Jeg skulle ønske jeg hadde en annen far	□	□	□	□	□
Faren min godtar meg som den jeg er	□	□	□	□	□
Jeg vil gjeme høre hva far mener om ting jeg er opptatt av	□	□	□	□	□
Det er ikke noen vits i å vise følelsene mine for far	□	□	□	□	□
Faren min kan se når jeg er urolig over noe	□	□	□	□	□
Å snakke med faren min om mine problemer får meg til å føle meg skamfull eller dum	□	□	□	□	□
Far venter for mye av meg	□	□	□	□	□
Jeg blir lett urolig når far er til stede	□	□	□	□	□
Jeg blir mye mer urolig enn far vet om	□	□	□	□	□
Far bryr seg om hva jeg mener når vi drøfter ting	□	□	□	□	□
Far stoler på min vurderingsevne	□	□	□	□	□
Far har sine egne problemer, så jeg plager ikke ham med mine	□	□	□	□	□
Far hjelper meg til å forstå meg selv bedre	□	□	□	□	□
Jeg forteller faren min om mine problemer og vanskeligheter	□	□	□	□	□
Jeg er sint på faren min	□	□	□	□	□
Jeg får lite oppmerksomhet fra faren min	□	□	□	□	□
Far hjelper meg å snakke om vanskelige ting	□	□	□	□	□
Far forstår meg	□	□	□	□	□
Når jeg er sint, prøver faren min å forstå meg	□	□	□	□	□
Jeg stoler på faren min	□	□	□	□	□
Faren min forstår ikke hvordan jeg har det nå om dagen	□	□	□	□	□
Jeg kan regne med faren min når jeg trenger å snakke ut om noe	□	□	□	□	□
Hvis far ser at noe plager meg, spør han meg om det	□	□	□	□	□

Hvordan har dere det i familien din? (regn med de du bor sammen med til daglig)

	Svært enig	Enig	Uenig	Svært uenig
Det er vanskelig å planlegge familieaktiviteter fordi vi misforstår hverandre	□	□	□	□
Når det er en krise, kan vi be de andre om støtte og hjelp	□	□	□	□
Vi kan ikke snakke sammen om den tristheten vi føler	□	□	□	□
Hver enkelt blir godtatt for den han eller hun er	□	□	□	□
Vi unngår å snakke om det vi er redd for og det vi er opptatt av	□	□	□	□
Vi kan uttrykke følelser overfor hverandre	□	□	□	□
Det er masse negative følelser i familien	□	□	□	□
Vi føler at de andre godtar oss	□	□	□	□
Det er vanskelig å ta beslutninger i vår familie	□	□	□	□
Vi greier å bestemme oss for hvordan vi skal løse problemer	□	□	□	□
Vi passer ikke godt sammen	□	□	□	□
Vi betror oss til hverandre	□	□	□	□

Barn og foreldre kan noen ganger være uenige. Kryss av om dette er sant eller ikke sant for deg og dine foreldre :

Deg og din mor :

	Alltid eller nesten alltid sant	Ofte sant	Noen ganger sant	Sjelden sant	Aldri eller nesten aldri sant
Mor og jeg ser aldri ut til å være enige	□	□	□	□	□
Mor og jeg snakker bare til hverandre når vi må	□	□	□	□	□
Mor og jeg blir sint på hverandre minst en gang i uken	□	□	□	□	□
Mor og jeg blir sint på hverandre minst en gang om dagen	□	□	□	□	□
Mor og jeg kan ha store diskusjoner om småting	□	□	□	□	□

Deg og din far:

	Alltid eller nesten Alltid sant	Ofte sant	Noen ganger sant	Sjelden sant	Aldri eller nesten aldri sant
Far og jeg ser aldri ut til å være enige	□	□	□	□	□
Far og jeg snakker bare til hverandre når vi må	□	□	□	□	□
Far og jeg blir sint på hverandre minst en gang i uken	□	□	□	□	□
Far og jeg blir sint på hverandre minst en gang om dagen	□	□	□	□	□
Far og jeg kan ha store diskusjoner om småting	□	□	□	□	□

Hva tenker du om deg selv ?

Nedenfor er det skrevet opp eksempler på ting ungdom kan tenke om seg selv.
Les utsagnene nøye og kryss av om dette stemmer for deg:

	Helt uenig	Ganske uenig	Hverken enig eller uenig	Ganske enig	Helt enig
Når jeg får til noe, så er det stort sett fordi jeg har hatt flaks	□	□	□	□	□
Jeg burde være istand til å gjøre alle til lags	□	□	□	□	□
Når jeg ser framover i tiden, venter jeg å bli lykkeligere enn jeg er nå	□	□	□	□	□
Hva andre syns om meg har alt å si for om jeg liker meg selv eller ikke	□	□	□	□	□
Jeg føler at jeg bør være lykkelig bestandig	□	□	□	□	□
Når jeg mislykkes er det alltid min egen feil	□	□	□	□	□
Når ting går galt er det godt å vite at det ikke vil være slik for bestandig	□	□	□	□	□
Å be andre om hjelp betyr egentlig at en er svak og uselvstendig	□	□	□	□	□
Jeg regner med at jeg får mer ut av livet enn gjennomsnittet	□	□	□	□	□

Setningene under gir flere eksempler på hvordan ungdommer noen ganger føler det. Kryss av for hvordan du føler :

	Helt uenig	Ganske uenig	Hverken enig eller uenig	Ganske enig	Helt enig
Jeg prøver stadig å finne ut av meg selv	□	□	□	□	□
Det tar alltid en god stund før jeg blir kvitt sjenertheten min når jeg møter nye mennesker	□	□	□	□	□
Jeg tenker mye på meg selv	□	□	□	□	□
Jeg er opptatt av hvordan andre opplever meg	□	□	□	□	□
Jeg blir lett flau	□	□	□	□	□
Jeg pleier ikke å bry meg med hva andre synes om meg	□	□	□	□	□
Jeg prøver alltid å forstå hvorfor jeg gjør som jeg gjør	□	□	□	□	□
Store grupper gjør meg nervøs	□	□	□	□	□

Hvor fysisk aktiv er du ?

Hva liker du å gjøre?
(sett kryss på aktuell linje)

□ Jeg sitter for det meste stille (jeg deltar nesten aldri i utendørs sportsaktiviteter)
□ Jeg er av og til fysisk aktiv (ute/inne)
□ Jeg er ganske ofte fysisk aktiv
□ Jeg er svært fysisk aktiv
□ Jeg er ofte fysisk aktiv (jeg er mye ute/trener flere ganger i uka)

Hvor mange timer trener du hver uke? (Regn med gym på skolen.)
□ < 1 time □ 1-2 timer □ 3 timer □ 3-6 timer □ 7-10 timer □ 11-14 timer □ > mer enn 14 timer

Hvor lang tid bruker du på å gå/sykle hver dag? (Regn med tid til og fra skolen, ballspill, rulleskøyter, rullebrett etc.) □< 1 timer □ 1-2 timer □ 3-4 timer □ > 4 timer

Hvor lang tid bruker du på sittende aktivitet hver dag? (Eksempel: Se på TV, lese lekser/bøker, spill, spise, etc. Regn ikke med tid på skolen) □ < 1 time □ < 3 timer □ 3-4 timer □ 5-6 timer □ > 6 timer

---

Hvor mye sover du?

Hvor mange timer sover du om natta på hverdager? □ < 7 timer □ 7- 7,5 timer □ 8-8,5 timer □ 9 timer □ > 9 timer

Hvor mange timer sover du om natta i helgen?

□ < 8 timer □ 8-8,5 timer □ 9-9,5 timer □ 10-10,5 timer □ 11 timer □ > 11 timer

---

Røyking og alkohol

Røyker du?

□ Jeg har aldri røykt
□ Jeg har prøvd
□ Røyker av og til
□ Røyker daglig, omtrent …… sigaretter

Har du noen gang smakt mer enn noen få slurker alkohol?

□ Ja, 5 ganger eller mere
□ Ja, mindre enn 5 ganger
□ Nei, aldri

Har du noen gang drukket så mye alkohol at du har vært tydelig beruset (full) i løpet av de siste 12 måneder?

□ Nei, aldri
□ 1 gang
□ 2 - 5 ganger
□ 6 -10 ganger
□ 11 -50 ganger
□ Mer enn 50 ganger

Har du noen gang brukt hasj eller marihuana?	☐ Ja	☐ Nei
Har du noen gang sniffet?	☐ Ja	☐ Nei
Brukt andre rusmidler (stoff)?	☐ Ja	☐ Nei

Hvilke rusmidler ……

Nedenfor er en del utsagn om mat og spisevaner.
Kryss av for hva som passer for deg:

	Alltid	Ofte	Sjelden	Aldri
Jeg er opptatt av å bli tynnere.....	☐	☐	☐	☐
Jeg prøver å holde diett	☐	☐	☐	☐
Jeg føler ubehag etter at jeg har spist søtsaker	☐	☐	☐	☐
Jeg trimmer for å gå ned i vekt	☐	☐	☐	☐
Jeg kaster opp for å holde eller gå ned i vekt	☐	☐	☐	☐

Helsen din

Hvordan er helsen din nå?	☐ Dårlig	☐ God
	☐ Ikke helt god	☐ Svært god

Har du noen sykdom? (som har vart > 3 måneder)

Kryss av det som passer

☐ Astma
☐ Allergi (Nese/øyne)
☐ Hudlidelse/eksem
☐ Migrene
☐ Sukkersyke
☐ Epilepsi
☐ Hjertesykdom

Bruker du medisiner nå? ☐ Nei ☐ Ja

Hvis ja, *kryss av*	*Av og til*	*Daglig/nesten dgl.*
1. Smertestillende/migrenemedisin	☐	☐
2. Sovemedisin	☐	☐
3. Nervemedisin	☐	☐
4. Astmamedisin	☐	☐
5. Allergimedisin	☐	☐
6. Eksemsalve	☐	☐
7. Epilepsimedisin	☐	☐
8. Hjertemedisin	☐	☐
9. Annet (for eksempel jern, homeopatmedisin eller annet	☐	☐

Hvis annet, hva……

Smerter

Plages du med hyppige smerter i kroppen? (utenom mens. smerter} ☐ Nei ☐ Ja

Hvis **ja**, prøv å fylle ut skjemaet under etter hvor du evt. har vondt. Hvis **nei**, hopp over:

	Hvor ofte har du vondt?	**Hvor lenge varer smertene?**
Hode	☐ Daglig, nesten daglig	☐ <1 time
	☐ 1-3 ganger pr.uke	☐ 1-4 timer
	☐ 1-3 ganger pr. måned	☐ > 4 timer
	Hvor ofte har du vondt?	**Hvor lenge varer smertene?**
Mage	☐ Daglig, nesten daglig	☐ <1 time
	☐ 1-3 ganger pr.uke	☐ 1-4 timer
	☐ 1-3 ganger pr. måned	☐ > 4 timer
	Hvor ofte har du vondt?	**Hvor lenge varer smertene?**
Rygg	☐ **Daglig, nesten daglig**	☐ **<1 time**
	☐ 1-3 ganger pr.uke	☐ 1-4 timer
	☐ 1-3 ganger pr. måned	☐ > 4 timer
	Hvor ofte har du vondt?	**Hvor lenge varer smertene?**
Armer/bein	☐ Daglig, nesten daglig	☐ <1 time
eller andre steder,	☐ 1-3 ganger pr.uke	☐ 1-4 timer
som …….	☐ 1-3 ganger pr. måned	☐ > 4 timer

Har du vært <u>borte fra skolen</u> pga sykdom/skade/smerter i løpet av de siste 12 månedene?

☐ Nei
☐ Ja, noen dager
☐ Ja, 1 – 3 uker
☐ Ja, 1 – 3 måneder
☐ Ja, > 3 måneder

Hvis **ja**, hvorfor? ……

Har du måttet trappe ned/ slutte med <u>fritidsaktiviteter/eller å treffe venner</u> pga sykdom/skade/smerte i løpet av de siste 12 månedene?

☐ Nei
☐ Ja, noen dager
☐ Ja, 1 – 3 uker
☐ Ja, 1 – 3 måneder
☐ Ja, > 3 måneder

Hvis ja, hvorfor? …….

Har du i løpet av **de siste 12 månedene** vært hos:

	Nei	Ja
Kommunelege/Almenpraktiserende lege (lege utenfor sykehus)	☐	☐
Lege på sykehus (uten at du var innlagt)	☐	☐
Helsesøster/skolelege	☐	☐
Fysioterapeut	☐	☐
Homøpat	☐	☐
Annen behandler (naturmedisiner, fotsoneterapeut, håndspålegger, "healer", "synsk" e.l.)	☐	☐
Har du vært innlagt på sykehus i løpet av de siste 12 månedene?	☐	☐

Hvis ja, for hva? ……

Er du funksjonshemmet på noen av disse måtene?
(sette så mange kryss som passer)

☐ Er bevegelseshemmet
☐ Har nedsatt syn (som ikke korrigeres med briller)
☐ Har nedsatt hørsel
☐ Hemmet på annen måte,
nemlig …….

Hvor høy er du? ……..cm

Hvor mye veier du? ……kg

Vil du si om deg selv at du er:

☐ Svært tykk .
☐ Ganske tykk
☐ Litt tykk
☐ Omtrent som andre
☐ Litt tynn
☐ Ganske tynn
☐ Svært tynn

Når du ser på deg selv nå, mener du at du er tidligere eller senere fysisk moden enn andre på din alder? (av samme kjønn)

☐ Mye tidligere
☐ Noe tidligere
☐ Lite granne tidligere
☐ Akkurat som andre
☐ Lite granne senere
☐ Noe senere
☐ Mye senere

Da du begynte å bli fysisk moden, mener du at dette startet tidligere eller senere enn hos andre på din alder?

- ☐ Mye tidligere
- ☐ Noe tidligere
- ☐ Lite granne tidligere
- ☐ Akkurat som andre
- ☐ Lite granne senere
- ☐ Noe senere
- ☐ Mye senere

Bare for jenter

Har du fått menstruasjon? (mensen)

- ☐ Ja
- ☐ Nei

Hvis **ja**, hvor gammel var du da fikk din første menstruasjon?

Jeg var…….. år og ……..måneder

Har du smerter når du har menstruasjon?

- ☐ Ja
- ☐ Nei

Hvis du har smerter, bruker du smertestillende tabletter/midler ?

☐ Nei ☐ Ja, av og til ☐ Ja, hver gang

Har du fravær fra gym. timene pga mensplager? ☐ Hver gang ☐ Av og til ☐ Aldri

Er du borte fra skolen pga mensplager? ☐ Hver gang ☐ Av og til ☐ Aldri

Jenter synes forskjellig om det å få menstruasjon. Kryss av for om du er enig eller ikke i disse utsagnene:

	Helt uenig	Litt uenig	Litt enig	Helt enig
Å ha menstruasjon er fint og betyr at man holder på å bli voksen	☐	☐	☐	☐
Det er flaut å ha menstruasjon	☐	☐	☐	☐
Å få menstruasjon er en stor hendelse i livet	☐	☐	☐	☐
Jeg ville heller forbli jente enn å bli voksen (kvinne)	☐	☐	☐	☐
Det er plagsomt og tungvint å ha menstruasjon	☐	☐	☐	☐
Å ha menstruasjon er spennende og får meg til å føle meg spesiell	☐	☐	☐	☐

Hva synes du om deg selv? (både gutter og jenter svarer)

	Stemmer svært godt	Stemmer nokså godt	Stemmer nokså dårlig	Stemmer svært dårlig
Jeg synes det er ganske vanskelig å få venner	☐	☐	☐	☐
Jeg er ikke fornøyd med utseendet mitt	☐	☐	☐	☐
Jeg er ofte skuffet over meg selv-	☐	☐	☐	☐
Jeg har mange venner	☐	☐	☐	☐
Jeg ønsker at kroppen min var annerledes	☐	☐	☐	☐
Jeg liker ikke den måten jeg lever livet mitt på	☐	☐	☐	☐
Andre ungdommer har vanskelig for å like meg	☐	☐	☐	☐
Jeg ønsker at jeg så anderledes ut	☐	☐	☐	☐
Jeg er stort sett fornøyd med meg selv	☐	☐	☐	☐
Jeg er populær blant jevnaldrende	☐	☐	☐	☐
Jeg synes jeg ser bra ut	☐	☐	☐	☐
Jeg liker meg selv slik jeg er	☐	☐	☐	☐
Jeg føler at jevnaldrende godtar meg	☐	☐	☐	☐
Jeg liker utseendet mitt veldig godt	☐	☐	☐	☐
Jeg er svært fornøyd med hvordan jeg er	☐	☐	☐	☐

Har dette hendt deg <u>det siste året</u> (de siste 12 månedene)?

	Nei	Ja
Du har mere lekser enn du greier	☐	☐
Læreren har dummet deg ut foran klassen	☐	☐
Du har begynt med spesialundervisning	☐	☐
Du får ikke nok igjen for innsatsen din på skolen (lite skryt/for dårlige karakterer)	☐	☐
Du får ikke nok hjelp med skolearbeidet (hjemme eller på skolen)	☐	☐
Du er ikke blitt tatt ut til laget (skole eller idrettslag) i konkurranser/kamper (håndball, fotball, ski etc.)	☐	☐
Foreldrene dine bekymrer seg for mye for skolearbeidet ditt	☐	☐
Du er blitt alvorlig syk/alvorlig skadet	☐	☐
Din mor har en kronisk sykdom	☐	☐

Har dette hendt deg det siste året?

	Nei	Ja
Din far har en kronisk sykdom	☐	☐
Noen av dine søsken har en kronisk sykdom	☐	☐
Din mor er blitt alvorlig syk/ alvorlig skadet	☐	☐
Din far er blitt alvorlig syk/ alvorlig skadet	☐	☐
En av dine søsken er blitt alvorlig syk/ alvorlig skadet	☐	☐
Dine foreldre separeres/skilles	☐	☐
Du må velge mellom hvilke av foreldrene du vil bo hos	☐	☐
En av dine foreldre gifter seg på nytt/får samboer	☐	☐
Du får søsken/stesøsken	☐	☐
Noen du er glad i er død (slektning, god venn)	☐	☐
Hvem? ……..		
Kjæledyret ditt er død	☐	☐
Du har flyttet	☐	☐
Familien har alvorlige økonomiske problemer	☐	☐
Din mor eller far har mistet jobben (ble arbeidsløs eller permittert)	☐	☐
Du har mistet en venn/venninne eller det ble slutt med kjæresten	☐	☐
Du har vært utsatt for seksuelt press	☐	☐
En av dine venner er ute i / har alvorlige vanskeligheter	☐	☐
En av dine søsken er ute i alvorlige vanskeligheter	☐	☐
Noen av dine søsken har flyttet hjemmefra	☐	☐
Foreldre er mye borte hjemmefra (p.g.a. arbeide eller annet)	☐	☐
Du har for mye ansvar hjemme (for småsøsken, husarbeid etc)	☐	☐
Du har hatt problemer med å komme fra et annet land (annen kultur)	☐	☐
Du er bekymret fordi noen i dine nærmeste omgivelser bruker for mye alkohol	☐	☐
Du hører at foreldrene dine krangler eller sloss	☐	☐
Du og foreldrene dine har hatt en eller flere voldsomme krangler	☐	☐
Du hører at søsken og dine foreldre krangler mye	☐	☐
Du eller en av dine nærmeste har vært utsatt for en kriminell handling, er blitt frastjålet noe verdifullt, overfalt el.l. ?	☐	☐
Du er blitt tatt for å ha gjort noe galt (stjålet noe el.l.)	☐	☐

Dette har skjedd meg i løpet av <u>de siste 4 ukene</u>:

	Ikke skjedd	1-3 ganger	En til flere ganger i Uken	Hver dag
Du er blitt holdt utenfor	☐	☐	☐	☐
Du er blitt kritisert	☐	☐	☐	☐
Du er blitt skuffet over noen (f.eks. at de brøt et løfte)	☐	☐	☐	☐
Du har ikke vært istand til å gjøre det du ønsket å gjøre	☐	☐	☐	☐
Du har mistet eller ødelagt noe	☐	☐	☐	☐
Du er blitt misforstått	☐	☐	☐	☐
Du har for liten tid (på skolen og /eIler i fritida)	☐	☐	☐	☐
Du har for lite penger (til fritid og/eller hobbier)	☐	☐	☐	☐
Du har savnet noen (venn, foreldre)	☐	☐	☐	☐

Hva skjer når du blir stresset ?

Av og til har man et problem som er vanskelig å løse, eller det skjer noe som er stressende eller vanskelig.

Når noe slikt vanskelig har skjedd, så:.....

	Stemmer ikke i det hele tatt	Stemme nokså dårlig	Stemmer nokså godt	Stemmer helt
- blir jeg sint	☐	☐	☐	☐
- konsentrerer jeg meg om problemet for å finne en løsning	☐	☐	☐	☐
- spiser jeg noe godt	☐	☐	☐	☐
- mister jeg fatningen (blir opphisset, urolig)	☐	☐	☐	☐
- tenker jeg på hvordan jeg har løst liknende ting før	☐	☐	☐	☐
- ser jeg på fjernsyn eller video	☐	☐	☐	☐
- blir jeg veldig anspent/stressa	☐	☐	☐	☐
- forsøker jeg å planlegge for å få kontroll over situasjonen	☐	☐	☐	☐
- går jeg og kikker i vinduer eller i butikker	☐	☐	☐	☐
- blir jeg lei meg	☐	☐	☐	☐
- grubler jeg over hva jeg kan gjøre	☐	☐	☐	☐
- prøver jeg å sove	☐	☐	☐	☐
- bebreider jeg meg for at dette skulle skje meg	☐	☐	☐	☐
- prøver jeg å forstå situasjonen	☐	☐	☐	☐
- prøver jeg å tenke på noe annet	☐	☐	☐	☐
- føler jeg at det må være noe galt med meg	☐	☐	☐	☐
- er jeg sammen med gode venner	☐	☐	☐	☐

SELV-RAPPORT-SKJEMA FOR UNGDOM I ALDEREN 11–18 ÅR

Fylles ikke ut
ID NR.

DITT NAVN

DITT KJØNN ☐ Gutt ☐ Pike

DIN ALDER

NASJONALITET

DAGENS DATO

FØDSELSDATO

KLASSETRINN

GÅR IKKE PÅ SKOLE ☐

HVIS DU ER I ARBEID, ANGI TYPE

FORELDRENES YRKE – selv om p.t. ikke i arbeid (Vær vennlig og spesifisier: f.eks. bilmekaniker, ungdomsskolelærer, husmor, arbeider, ekspeditør, ingeniør, osv. – selv om foreldrene ikke bor sammen med barnet)

FARS YRKE/STILLING: .....

MORS YRKE/STILLING: .....

Fyll ut formularet slik at det gjenspeiler **ditt** syn, selv om andre ikke ville være enig i beskrivelsen. Skriv gjerne utfyllende kommentarer.

I. Hvilke sportsgrener liker du best å være med på? F.eks. svømming, fotball, ski, håndball, sykling, ridning, etc.

☐ Ingen

a. _____
b. _____
c. _____

Sammenlignet med jevnaldrene hvor mye tid bruker du på hver type?

	Mindre enn gjennom-snittet	Gjennom-snittlig	Mer enn gjennom-snittet
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

Sammenlignet med jevnaldrende hvor bra synes du at du gjør disse sportsaktivitetene?

	Dårligere enn gjennom-snittet	Gjennom-snittlig	Bedre enn gjennom-snittet
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

II. Hvilke favoritt hobbier, aktiviteter, spill har du utenom sport? F.eks. bøker, frimerker, piano, sløyd, etc. (Å se TV regnes ikke)

☐ Ingen

a. _____
b. _____
c. _____

Sammenlignet med jevnaldrende hvor mye tid bruker du på hver type?

	Mindre enn gjennom-snittet	Gjennom-snittlig	Mer enn gjennom-snittet
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

Sammenlignet med jevnaldrende hvor bra synes du at du gjør disse aktivitetene?

	Dårligere enn gjennom-snittet	Gjennom-snittlig	Bedre enn gjennom-snittet
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

III. Hvilke foreninger, klubber, lag eller lignende er du med i?

☐ Ingen

a. _____
b. _____
c. _____

Sammenlignet med jevnaldrende hvor aktiv er du i disse?

	Mindre enn gjennom-snittet	Gjennom-snittlig	Mer enn gjennom-snittet
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

IV. Hvilke plikter eller jobber har du? F.eks. rydde, re sengen, gå med avisen, sitte barnevakt (ta med både betalte og ubetalte jobber og plikter)

☐ Ingen

a. _____
b. _____
c. _____

Sammenlignet med jevnaldrende hvor bra synes du at du klarer disse oppgavene?

	Dårligere enn gjennom-snittet	Gjennom-snittlig	Bedre enn gjennom-snittet
a.	☐	☐	☐
b.	☐	☐	☐
c.	☐	☐	☐

Oversatt av I. Spurkland m.fl. 1986/1988. Revidert av T.S. Nøvik 1993. Oversatt etter tillatelse fra T.M. Achenbach.
Statens senter for barne- og ungdomspsykiatri 1993.
3. opplag 1993
Graf. produksjon: AB Trykk – Arendal

V. 1. **Omtrent hvor mange nære venner har du?** (Ta ikke med søsken) ☐ Ingen ☐ 1 ☐ 2 eller 3 ☐ 4 eller flere

2. **Omtrent hvor mange ganger i uken er du sammen med dem utenom skolen?** (Ta ikke med søsken). ☐ Færre enn 1 ☐ 1 eller 2 ☐ 3 eller flere

VI. **Sammenlignet med jevnaldrende, hvor bra synes du at du:** ☐ Jeg har ikke søsken

	Dårligere	Omtrent likt	Bedre
a. Kommer overens med søsknene dine?	☐	☐	☐
b. Kommer overens med andre barn/unge?	☐	☐	☐
c. Kommer overens med foreldrene dine?	☐	☐	☐
d. Gjør ting på egen hånd?	☐	☐	☐

VII. **Aktuelle skoleprestasjoner** ☐ Jeg går ikke på skolen fordi _____

_____

		Langt under gjennomsnittet/ til stryk	Under gjennom-snittet	Gjennom-snittlig	Over gjennom-snittet
	a. Norsk	☐	☐	☐	☐
	b. Historie/samfunnsfag	☐	☐	☐	☐
	c. Matematikk	☐	☐	☐	☐
	d. Naturfag	☐	☐	☐	☐
Andre fag (f.eks. fremmende språk, geografi, data/EDB. Ta ikke med gym.)	e. Engelsk	☐	☐	☐	☐
	f. _____	☐	☐	☐	☐
	g. _____	☐	☐	☐	☐

Har du noen sykdom eller funksjonshemning?

☐ Nei ☐ Ja – vennligst beskriv:

Beskriv gjerne bekymringer eller problemer du måtte ha når det gjelder skolen

Vennligst beskriv andre bekymringer du måtte ha:

Beskriv dine sterke sider:

VIII. Her er en liste over egenskaper som barn og ungdom kan ha i større eller mindre grad. For hver egenskap som passer på deg **nå eller siste 6 måneder,** sett en ring rundt **2** hvis beskrivelsen **passer bra eller ofte.** Sett en ring rundt **1** hvis beskrivelsen **passer til en viss grad eller iblant**. Hvis beskrivelsen **ikke passer** på deg, sett en ring rundt **0**. Vennligst svar så godt du kan på alle spørsmålene selv om noen ikke passer på deg.

0 = Passer ikke **1 = Passer til en viss grad eller iblant** **2 = Passer bra eller ofte**

0 1 2 1. Jeg oppfører meg som yngre enn min alder
0 1 2 2. Jeg er allergisk (beskriv): _____
_____
_____
0 1 2 3. Jeg krangler mye
0 1 2 4. Jeg har astma
0 1 2 5. Jeg oppfører meg som det motsatte kjønn
0 1 2 6. Jeg liker dyr
0 1 2 7. Jeg skryter
0 1 2 8. Jeg har vanskelig for å konsentere meg eller være oppmerksom
0 1 2 9. Jeg får ikke visse tanker ut av hodet (beskriv): _____
_____
_____
0 1 2 10. Jeg har vanskelig for å sitte stille
0 1 2 11. Jeg er for avhengig av voksne
0 1 2 12. Jeg føler meg ensom
0 1 2 13. Jeg føler meg forvirret eller fjern
0 1 2 14. Jeg gråter mye
0 1 2 15. Jeg er ganske ærlig
0 1 2 16. Jeg er slem mot andre
0 1 2 17. Jeg dagdrømmer mye
0 1 2 18. Jeg prøver å skade meg selv med vilje eller har forsøkt å begå selvmord
0 1 2 19. Jeg prøver å få mye oppmerksomehet
0 1 2 20. Jeg ødelegger mine egne ting
0 1 2 21. Jeg ødelegger ting som tilhører andre
0 1 2 22. Jeg er ulydig overfor foreldrene mine
0 1 2 23. Jeg er ulydig på skolen
0 1 2 24. Jeg spiser ikke så godt som jeg burde
0 1 2 25. Jeg kommer ikke overens med andre barn/unge
0 1 2 26. Jeg har ikke skyldfølelse etter å ha gjort noe jeg ikke burde gjøre
0 1 2 27. Jeg er sjalu på andre
0 1 2 28. Jeg er villig til å hjelpe andre når de trenger hjelp
0 1 2 29. Jeg er redd for visse dyr, situasjoner eller steder utenom skolen (beskriv): _____
_____
_____
0 1 2 30. Jeg er redd for å gå på skolen
0 1 2 31. Jeg er redd for å tenke eller gjøre noe galt
0 1 2 32. Jeg føler jeg må være perfekt
0 1 2 33. Jeg føler at ingen er glad i meg
0 1 2 34. Jeg føler at andre er ute etter meg
0 1 2 35. Jeg føler meg mindreverdig eller underlegen
0 1 2 36. Jeg slår meg mye, ulykkesfugl
0 1 2 37. Jeg kommer ofte i slagsmål
0 1 2 38. Jeg blir ofte ertet
0 1 2 39. Jeg henger sammen med kamerater som kommer opp i bråk
0 1 2 40. Jeg hører lyder eller stemmer som andre ikke synes er der (beskriv): _____
_____
_____
0 1 2 41. Jeg handler uten å stoppe for å tenke
0 1 2 42. Jeg vil heller være alene enn sammen med andre
0 1 2 43. Jeg lyver eller jukser
0 1 2 44. Jeg biter negler
0 1 2 45. Jeg er nervøs eller anspent
0 1 2 46. Deler av kroppen rykker eller lager nervøse bevegelser (beskriv): _____
_____
_____
0 1 2 47. Jeg har mareritt om natten
0 1 2 48. Jeg blir ikke likt av andre barn/unge
0 1 2 49. Jeg kan gjøre enkelte ting bedre enn de fleste barn/unge
0 1 2 50. Jeg er for redd eller engstelig
0 1 2 51. Jeg føler meg svimmel
0 1 2 52. Jeg har for mye skyldfølelse
0 1 2 53. Jeg spiser for mye
0 1 2 54. Jeg føler meg overtrett
0 1 2 55. Jeg er overvektig
56. Kroppslige plager uten kjent medisinsk årsak:
0 1 2 a. Smerter eller vondt (ikke hodepine)
0 1 2 b. Hodepine
0 1 2 c. Kvalme, føler meg uvel
0 1 2 d. Plager med øynene (beskriv): _____
_____
_____
0 1 2 e. Utslett eller andre hudplager
0 1 2 f. Magesmerter
0 1 2 g. Brekninger, kaster opp
0 1 2 h. Annet (beskriv): _____
_____
_____
0 1 2 57. Jeg kan gå løs på andre fysisk
0 1 2 58. Jeg plukker på huden eller andre deler av kroppen min (beskriv): _____
_____
_____
0 1 2 59. Jeg kan være ganske hyggelig
0 1 2 60. Jeg liker å gjøre nye ting
0 1 2 61. Skolearbeidet mitt er dårlig
0 1 2 62. Jeg er klosset og har dårlig samordning av bevegelsene mine
0 1 2 63. Jeg vil heller være sammen med barn/unge som er eldre enn meg enn dem på min egen alder

Vennligst bla om til neste side

0 = Passer ikke **1 = Passer til en viss grad eller iblant** **2 = Passer bra eller ofte**

0 1 2 64. Jeg vil heller være sammen med barn/unge som er yngre enn meg enn dem på min egen alder

0 1 2 65. Jeg nekter å snakke

0 1 2 66. Jeg gjentar visse handlinger om og om igjen (beskriv): _____

_____

_____

0 1 2 67. Jeg rømmer hjemmefra

0 1 2 68. Jeg skriker mye

0 1 2 69. Jeg er hemmelighetsfull eller holder ting for meg selv

0 1 2 70. Jeg ser ting som ikke andre synes er der (beskriv): _____

_____

_____

0 1 2 71. Jeg blir lett flau eller forlegen

0 1 2 72. Jeg tenner på - lager brann

0 1 2 73. Jeg er flink med hendene mine

0 1 2 74. Jeg gjør meg til eller spiller bajas

0 1 2 75. Jeg er sjenert

0 1 2 76. Jeg sover mindre enn andre barn/unge

0 1 2 77. Jeg sover mer enn andre barn/unge om dagen og/eller om natten (beskriv): _____

_____

_____

0 1 2 78. Jeg har god fantasi

0 1 2 79. Jeg har talevansker (beskriv): _____

_____

_____

0 1 2 80. Jeg står på rettighetene mine

0 1 2 81. Jeg stjeler hjemme

0 1 2 82. Jeg stjeler borte, utenfor hjemmet

0 1 2 83. Jeg samler opp ting som jeg ikke har bruk for (beskriv): _____

_____

_____

0 1 2 84. Jeg gjør ting som andre synes er underlige (beskriv): _____

_____

0 1 2 85. Jeg har tanker som andre ville synes var underlige (beskriv): _____

_____

_____

0 1 2 86. Jeg er sta

0 1 2 87. Humøret eller følelsene mine forandrer seg plutselig

0 1 2 88. Jeg liker å være sammen med andre

0 1 2 89. Jeg er mistenksom

0 1 2 90. Jeg banner eller bruker stygge ord

0 1 2 91. Jeg har tanker om å ta livet av meg

0 1 2 92. Jeg liker å få andre til å le

0 1 2 93. Jeg prater for mye

0 1 2 94. Jeg erter andre mye

0 1 2 95. Jeg har et heftig sinne

0 1 2 96. Jeg tenker for mye på sex

0 1 2 97. Jeg truer andre med å skade dem

0 1 2 98. Jeg liker å hjelpe andre

0 1 2 99. Jeg er altfor opptatt av å være ren og ordentlig

0 1 2 100. Jeg har søvnproblemer (beskriv):

_____

_____

0 1 2 101. Jeg skulker skolen eller timer på skolen

0 1 2 102. Jeg har dårlig med energi

0 1 2 103. Jeg er ulykkelig, trist eller deprimert

0 1 2 104. Jeg bråker mer enn andre ungdommer

0 1 2 105. Jeg bruker alkohol eller vanedannende stoff (beskriv):

_____

_____

0 1 2 106. Jeg prøver å være ærlig og grei mot andre

0 1 2 107. Jeg liker en god spøk

0 1 2 108. Jeg liker å ta livet lettvint

0 1 2 109. Jeg prøver å hjelpe andre når jeg kan

0 1 2 110. Jeg skulle ønske jeg var av motsatt kjønn

0 1 2 111. Jeg passer meg for å engasjere meg med andre

0 1 2 112. Jeg er mye bekymret

Vennligst notér andre ting som beskriver følelsene, atferden eller interessene dine

VENNLIGST KONTROLLER AT DU HAR GITT SVAR PÅ ALLE PUNKTENE