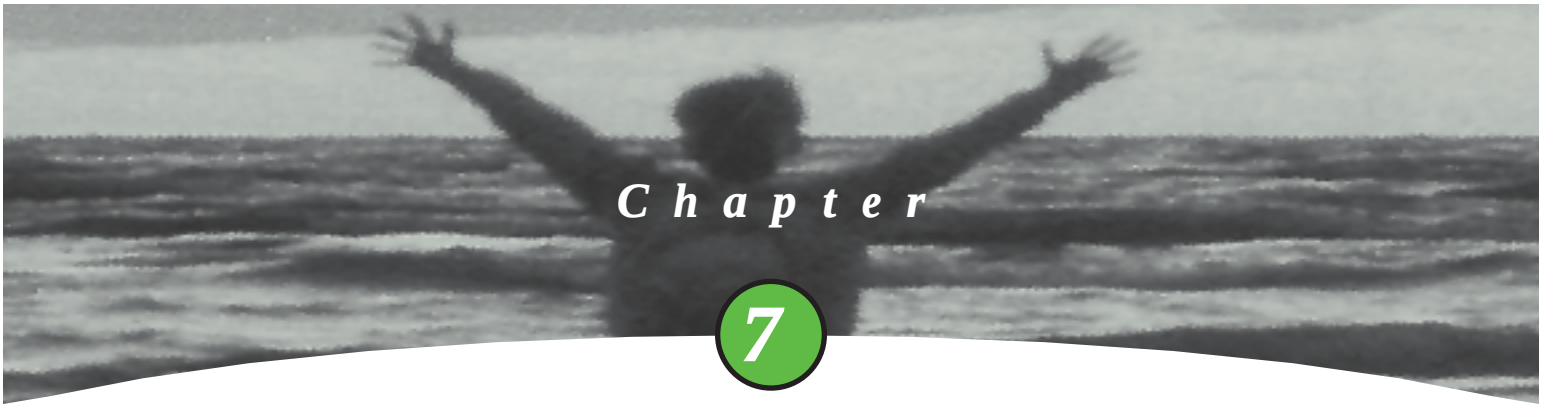


Chapter

7

Individual Capacity and Coping Skills

Overview

Individual capacity and coping skills include psychological characteristics such as personal competence and a sense of control and mastery over one's life. These characteristics play an important role in supporting mental and physical health — influencing people's vulnerability to such health problems as cancer and cardiovascular disease, and affecting their risk of unintentional injuries, mental disorders and suicide.

Coping skills enable people to be self-reliant, solve problems and make informed choices that enhance health. They help people to deal with the events, challenges and stresses in their day-to-day lives, without resorting to health risk-taking behaviours such as alcohol and drug abuse. People with a strong sense of their own effectiveness and ability to cope with the circumstances in their lives are likely to be most successful in adopting and sustaining healthy behaviours and lifestyles.

There is strong evidence that coping skills are acquired primarily in the first few years of life. Children are born with an innate ability to cope, meaning that they are resilient to stress and negative circumstances. However, this ability is profoundly influenced by early childhood experiences. Developing these skills to their fullest potential depends on a variety of protective and risk factors in the individual, family and community. Factors such as gender, temperament, parenting styles and family functioning, interaction with peers and significant adults, and the nature of community support interact to hinder or enhance children's mental health outcomes.

Relationship to Healthy Child Development

Early nurturing is important.

Children's early experiences contribute significantly to their ability to cope with stress. Effective parenting, which includes providing children with emotional security and strong and sensitive nurturing, is essential if children are to learn the coping skills they will need throughout their lives (Steinhauer, 1998). In the period from birth through the toddler years, it is likely that the strongest single familial factor protecting the potential for resiliency is the establishment of a secure attachment to a primary caregiver (Steinhauer, 1998, p. 57).

Findings of the National Longitudinal Survey of Children and Youth (NLSCY) support the theory that effective parenting skills and family functioning are important to young children's mental health. When parents have difficulty coping with life, work, family or parenting, they may be unable to provide their children with the necessary emotional, social and physical support (CCSD, 1996, p. 16; Landy and Tam, 1996).

Consistency in parenting is especially important for building social relationships for children in at-risk families (McKinnon and Ahola-Sidaway, 1997, pp. 38–39).

Ongoing support and stimulation from family, peers and significant others contribute to positive mental health.

Establishing trust and safety through caring relationships, providing guidance and challenge, and ensuring opportunities for meaningful participation in family and community are all protective factors in a child's environment. These factors can alter or even reverse negative outcomes and help children to develop resilience and positive coping skills (Benard, 1991).

Adults outside the immediate family also influence children's healthy development. Supportive adults in the school, neighbourhood and community are important protective factors in helping to offset the negative effects of perinatal stress, chronic poverty, parental psychopathology and disruptions in the family (Werner, 1993).

Successful peer relationships can provide children with the models and experience that help them develop coping mechanisms to counteract excessive anxiety.

Peers become an important source of support as children grow older. Successful peer relationships can provide children with the models and experience that help them develop coping mechanisms to counteract excessive anxiety (Manassis and Bradley, 1994). Conversely, peers can play a negative role by encouraging participation in high-risk behaviours (e.g. drinking and driving, drug experimentation) that may have long-term negative health and other consequences.

Stimulation and challenge are essential to healthy child development. As they move through the stages of childhood and adolescence, children require a certain amount of stress and risk taking. Achieving despite obstacles, competition, and coping with traumatic life events such as death or divorce can help children adapt and develop (McKinnon and Ahola-Sidaway, 1997, p. 44).

Physical and mental well-being are related.

How well people cope with the challenges in their living and working environments appears to be an important influence on their vulnerability to health problems. Although the exact pathways and mechanisms are not yet clear, there is strong evidence of a link between the central nervous system and the immune system (Dantzer and Kelly, 1998). Responding poorly to challenges can lead to persistently elevated steroid levels, which depress the host defence system and other body functions; this increases vulnerability to negative health outcomes (Keating and Mustard, 1996, p. 9).

Recent observations have created a better understanding of the mind-body relationship and of how the development of competence and coping skills in early life can influence a wide variety of causes of death in adult life (Keating and Mustard, 1996, pp. 8–9).

Children are born with innate resilience.

All children have the innate capacity for "self-righting," meaning that they can develop traits such as social competence, effective problem solving, autonomy and a sense of purpose and belief in a positive future. In fact, long-term studies show that 50% to 70% of children born into high-risk conditions (e.g. abusive families, war-torn communities) develop social competence and lead successful lives (Benard, 1996).

This in-born resilience to stress is not static; it varies over time as an individual's circumstances change. The level of resiliency depends on many environmental factors and requires support both internally and externally in order to contribute to healthy human development (Benard, 1991).

Resilience and Teens

Resilience has been defined as "... the process of healthy human development — a dynamic process in which personality and environmental influences interact in a reciprocal, transactional relationship" (Benard, 1996, p. 9).

Adolescents who overcome adversity, manifesting resilience despite the odds against them, typically have access to three sources of "protection": a cohesive and stable family, external support, and certain personal resources (Garmezy, 1983). The latter includes the following: personality assets such as self-esteem and autonomy; intellectual skills such as problem-solving abilities; social skills such as cooperation, social engagement and responsiveness; a sense of self-efficacy; and an easygoing temperament (Garmezy, 1983; Rutter, 1983).

Other factors affect capacity and coping skills.

Culture and ethnicity can also affect people's social and economic well-being, which in turn can impact their physical and mental health. For example, members of cultural and ethnic minorities may experience harassment in school or in the workplace; language differences can isolate parents and children; prejudice may deny people educational and employment opportunities, or access to housing; misunderstandings based on cultural or linguistic differences can interfere with access to social services and other benefits, and these people may feel cut off or isolated from the community (Health Canada, 1996, p. 19).

Coping mechanisms can be positive or negative.

Well-being, or positive health, consists of those physical, mental and social attributes that permit an individual to cope successfully with the challenges to their health and functioning. People use a variety of coping mechanisms to meet life's challenges; some contribute to health and equilibrium, while others place the individual at even greater risk of negative health.

For example, physical activity contributes to physical and mental health: in addition to being more physically fit, active people tend to have greater self-esteem and a positive body image (Health Canada, 1999). Similarly, hobbies such as music and art provide a positive outlet for stress and teach children practical skills for coping.

Negative coping mechanisms include smoking and drug and alcohol use. An early reliance on these behaviours often persists into adulthood and may result in associated health problems.

Conditions and Trends

Children's lives can be stressful. They experience rapid physical, emotional and mental change and must face the challenges of academic requirements, peer relationships and entry into the work force. While most gain the necessary skills and tools for coping, some experience a range of mental disorders that may affect them well into their adult lives.

Mental Disorders

Most Canadian children are free of psychiatric disorders. Yet, research in this field suggests that between 17% and 22% of Canadian children and adolescents suffer from one or more psychiatric disorders (Davidson and Manion, 1996, p. 42). A survey of Ontario youth revealed that 25% of youth aged 15 to 24 reported having a mental health disorder (Ontario Ministry of Health, 1994, p. 10).

Children are at risk of a range of mental disorders.

The onset of some psychiatric disorders in children may generate later negative psychosocial outcomes. For example, research suggests that children with conduct disorder or antisocial behaviour may have increased tendencies towards criminal and substance abuse behaviours and psychological difficulties in adolescence and adulthood (Offord, Boyle and Racine, et al., 1992; Offord and Bennett, 1994).

Attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) appear to be most prevalent during preschool and early elementary years (Loeber and Keenan, 1994). These conditions, along with learning disorders, can compromise social development as a result of learning problems at school and difficulties in interpersonal relations (McKinnon and Ahola-Sidaway, 1997).

Gender plays a role.

There are significant gender and age differences in children's emotional and behavioural disorders. According to the NLSCY, in 1994–95, the highest rate of emotional and behavioural problems was among boys aged 8 to 11 (26%) and the lowest was among girls aged 4 to 7 (16%). Among boys of both age groups, hyperactivity was the most common disorder, followed by conduct disorder. The incidence of emotional disorders increased significantly from younger to older boys (from 6.1% to 11.8%). In girls, conduct disorder was more common than hyperactivity for both age groups, but the occurrence of emotional disorder was most prevalent among 8- to 11-year-olds (11.3%). All prevalence rates of disorders were higher for boys than for girls (Offord and Lipman, 1996, p. 123). See **Exhibit 7.1**.

7.1 Frequency of emotional and behavioural problems among 4- to 11-year-olds, by age and sex, Canada, 1994–95

	Emotional and behavioural problems						
	A. Conduct disorder (%)	B. Hyper-activity (%)	C. Emotional disorder (%)	D. One or more disorders (%)	E. Repeated a grade[a] (%)	F. Impairment in social relationships (%)	G. One or more problems[a] (E. or F.) (%)
Boys							
4–7	10.6	14.0	6.1	21.9	2.9	2.7	27.4
8–11	11.3	14.0	11.8	26.0	8.1	4.2	31.0
4–11	11.0	14.0	9.0	24.0	6.5	3.5	29.9
Girls							
4–7	8.3	6.1	5.8	16.0	2.1	1.5	19.1
8–11	8.2	6.7	11.3	18.8	5.8	2.9	24.0
4–11	8.3	6.4	8.6	17.4	4.6	2.3	22.4
Boys and girls							
4–7	9.5	10.2	6.0	19.0	2.5	2.1	23.3
8–11	9.8	10.4	11.6	22.4	6.9	3.6	27.5
4–11	9.6	10.3	8.8	20.7	5.6	2.9	26.2

a. Data available for 6- to 11-year-olds only.

Source: Adapted from D.R. Offord and E.L. Lipman (1996). "Emotional and Behavioural Problems." In *Growing Up in Canada: National Longitudinal Survey of Children and Youth*. Catalogue No. 89-550-MPE, No. 1. Ottawa: Human Resources Development Canada and Statistics Canada, p. 123.

Females are much more likely than males to experience "internalized disorders." For example, young women aged 15 to 19 are the most likely of any age-sex group to exhibit symptoms of depression (14%); women aged 20 to 24 are also well above average (10%) in their experience of depression (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996, p. 317).

Other factors affect mental health.

Environment also appears to influence behavioural problems. In Ontario, the rates of all psychiatric disorders were higher for children living in an urban environment (16.7%) than for those living in rural areas (12.3%) (Offord, Boyle and Racine, 1989, p. 4).

A shortage of mental health services is a problem in many areas of Canada. It is estimated that only one in six Canadian children with mental health problems is reached by mental health services (Children's Hospital of Eastern Ontario, 1993).

Stress

Adolescence can be a time of high stress. The rapid physiological changes of puberty interact with other stress factors, with potentially significant effects on the mental health of adolescents.

Sources of Stress

Many children have experienced events that cause anxiety and worry. Findings of the NLSCY show that, according to the parents surveyed, roughly one third of the children under age 12 had experienced great unhappiness. The most common causes cited, regardless of the age or sex of the child, are listed below:

- *death in the family — 27%*
- *parents' divorce or separation — 25%*
- *family move — 8%*
- *family member's illness or injury — 8%*
- *child's illness or injury — 6%*
- *conflict between parents — 6%*
- *hospital stay — 5%*
- *abuse or fear of abuse — 4%*
- *change in household members — 4%*
- *separation from parents, excluding divorce — 4%*
- *death of a parent — 3%*
- *alcoholism or mental health disorder in the family — 2%*
- *a stay in a foster home — 1%*
- *other — 29%*

(CCSD, 1997, p. 38).

Young people can experience a high degree of social, academic and work stress.

School was cited as the greatest source of stress by 65% of youth respondents to the 1992 Canadian Mental Health Survey, a joint effort of the Canadian Psychiatric Association and Canadian Mental Health Association (Canadian Psychiatric Association, 1993, p. 15). Adolescents and young adults also experience higher levels of work stress than do older workers, with work stress and job satisfaction being inversely related. Youth aged 15 to 24 are the least likely to indicate that they are "very satisfied" with their job (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996, p. 242). Work stress is highest among employed teens and declines with age, reaching its lowest level among employed seniors (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996, p. 314). See **Exhibit 7.2.**

7.2 Work stress and job satisfaction of employed persons age 15+, by age, Canada, 1994–95

Source: Federal, Provincial and Territorial Advisory Committee on Population Health (1996). *Report on the Health of Canadians: Technical Appendix*. Catalogue No. H39-385/1-1996E. Ottawa: Health Canada, p. 315.

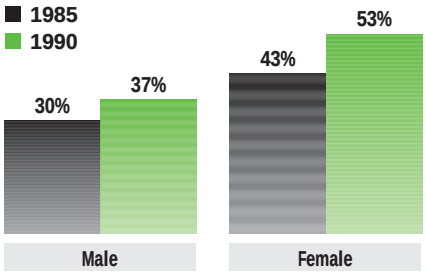
Changes in family structure cause stress.

Death and family break-up can also be sources of stress for children. Data from the NLSCY reveal that, based on parents' reports, roughly 33% of the children under age 12 had experienced "great unhappiness." The most common causes, regardless of the age or sex of the child, were death in the family (27%) and parents' divorce or separation (25%) (CCSD, 1997, p. 38).

Males and females are different.

There is evidence that males and females experience stress differently during adolescence. Adolescent females are less likely to feel good about themselves and more likely to perceive their lives as stressful than adolescent males (CICH, 1994, p. 96). See **Exhibit 7.3**.

7.3 Perceived level of stress,[a] of 15- to 19-year-olds, by sex, Canada, 1985 and 1990



a. Very stressful and somewhat/fairly stressful.

Source: Canadian Institute of Child Health (1994). *The Health of Canada's Children: A CICH Profile*, 2nd edition. Ottawa: CICH, p. 96.

Suicide

Young people are at increased risk for suicide.

From 1970 to 1992, there was a steady and significant increase in the suicide rate for 15- to 19-year-olds, from a low of 7 per 100,000 population to a peak of 14 per 100,000 in 1983. The rate of 13 per 100,000 in 1992 was almost twice that of 1970.

Youth between the ages of 20 and 24 have a higher rate of suicide than 15- to 19-year-olds, but they have not experienced the same increases as the younger cohort. The rate for the former group has remained at 18 per 100,000 since 1989 (Federal, Provincial and Territorial Advisory Committee on Population Health, 1996, p. 328). See **Exhibit 7.4**.

7.4 Numbers and rates of suicide, by age and sex, and by province/territory, Canada, 1992

	Suicides	
	Number	Rate (per 100,000 population)
Canada, all ages	3,709	13
Male	2,923	21
Female	786	5
Age, total	34	1
Male	26	1
Female	8	0
Age 5–19, total	249	13
Male	198	20
Female	51	5
Age 20–24, total	374	18
Male	306	29
Female	68	7

Source: Federal, Provincial and Territorial Advisory Committee on Population Health (1996). *Report on the Health of Canadians: Technical Appendix*. Catalogue No. H39-385/1-1996E. Ottawa: Health Canada, p. 330.

There are limited data on the incidence of suicide among younger children. Suicides among children aged 0 to 9 are rarely recorded. For males aged 10 to 14, the rate rose from 0.6 to 2.6 per 100,000 between 1960 and 1992; for females, the increase was much less significant, rising from 0.1 to just 0.8 during the same period (Health Canada, 1994).

Rates for attempted suicide vary greatly. It has been estimated that for every suicide there are between 10 and 100 attempted suicides (Dyck, Mishara and White, 1998, p. 311).

More teenage males than females die from suicide attempts.

While young women are more likely to attempt suicide, young men are much more likely than women to complete a suicide attempt (CICH, 1994, pp. 75, 89). The leading cause of hospitalization for females 15 to 19 years old is suicide attempts — in 1989–90, their rate of hospitalization was more than twice that of males the same age (295 per 100,000 compared with 127 per 100,000) (CICH, 1994, p. 93).

Suicide rates are higher among Aboriginal youth.

Aboriginal youth are at a higher risk of suicide than are young people in the general population. The suicide rate for Status Indians (aged 0 to 19) is almost five times higher than the national average (Health Canada, 1997, p. 55).

Capacity, Coping and Other Determinants

Income

Evidence is mounting that it is both the combined effects of multiple environmental stresses and the clustered effects of psychosocial deprivations that often coexist with poverty (particularly maternal depression, parental substance abuse, parental violence and paternal criminality) that undermine competence and resiliency, rather than just low income (Steinhauer, 1998).

Youth from families that receive family benefits are less likely to feel good about themselves than youth from families that do not receive such benefits. In Ontario, young people between the ages of 12 and 19 whose families receive benefits were less likely to rate themselves as happy (Ontario Health Survey analysis in CICH, 1994, p. 125).

Social Environment

Spousal abuse may affect children's mental health. Children who witness familial violence are at risk for many emotional and behavioural problems. These difficulties may include anxiety, depression, peer conflicts, non-compliance and, in extreme cases, post-traumatic stress disorder (Suderman and Jaffe, 1997).

Genetic and Biological Factors

Research suggests that children who experience chronic illness or functional disability are at higher risk of mental health problems (Cadman et al., 1986).

Gender

The results of the NLSCY show that in 1994–95 the highest rate of emotional and behavioural problems was among boys aged 8 to 11 and the lowest was among girls aged 4 to 7. In fact, all prevalence rates for disorders were higher for boys (CICH, 1994, pp. 75, 89).

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