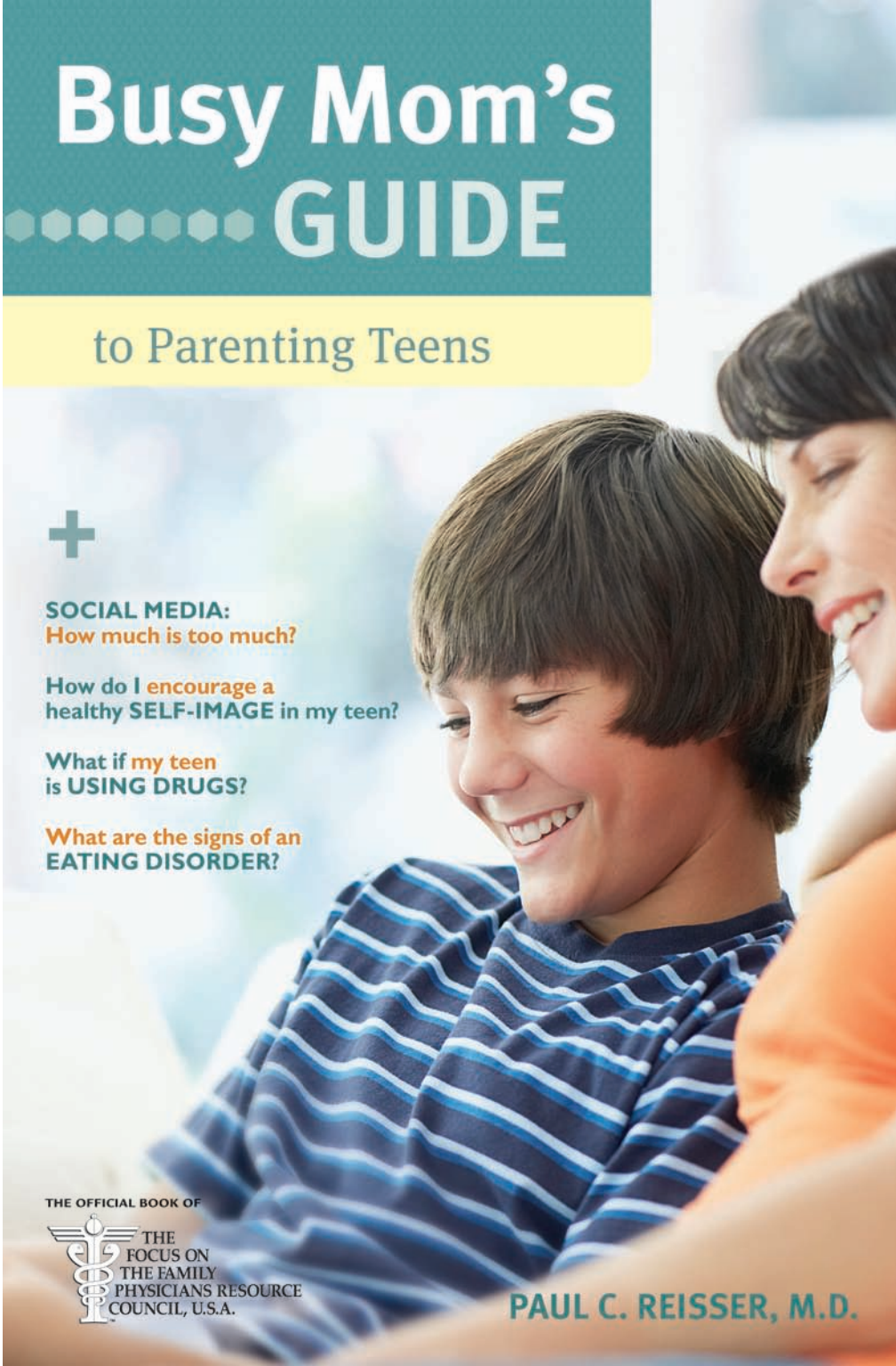
Busy Mom's GUIDE

to Parenting Teens



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SOCIAL MEDIA:
How much is too much?

How do I encourage a healthy SELF-IMAGE in my teen?

What if my teen is USING DRUGS?

What are the signs of an EATING DISORDER?

THE OFFICIAL BOOK OF

THE FOCUS ON THE FAMILY PHYSICIANS RESOURCE COUNCIL, U.S.A.

PAUL C. REISSER, M.D.

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to Parenting Teens

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Tyndale House Publishers, Inc.
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The information contained in this book provides a general overview of many health-related topics. It is not intended to substitute for advice that you might receive from your child's physician, whether by telephone or during a direct medical evaluation. Furthermore, health-care practices are continually updated as a result of medical research and advances in technology. You should therefore check with your child's doctor if there is any question about current recommendations for a specific problem. No book can substitute for a direct assessment of your child by a qualified health-care professional.

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Busy Mom's Guide to Parenting Teens

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FOREWORD

Fifty years ago popular visions of the "world of tomorrow" included not only flying cars and routine trips to outer space, but also twenty- to thirty-hour workweeks and a bounty of leisure time for everyone by the end of the twentieth century.

Instead, more than a decade into the twenty-first century, we are dealing with exponential increases in the complexity of our lives. We're working harder than ever to earn a living while juggling family responsibilities and a multitude of other commitments. Even when we're supposedly "off duty," there are always dozens of e-mails to wade through, cell phones sounding off at all hours, and social networking sites beckoning night and day. Furthermore, if we need information about anything, Google will be happy to summon more websites than we can possibly visit. Yet this overabundance of information sources doesn't always satisfy our need for wisdom and insight, especially when dealing with issues concerning some of the most important people in our lives: our teenage children.

For more than three decades Focus on the Family has been a trusted resource for mothers and fathers as they have navigated the entire journey of parenting, from the first baby's cry in the delivery room to the release of their last young adult to (hopefully)

responsible independence. Several years ago Focus on the Family's Physicians Resource Council prepared the *Complete Guide to Baby and Child Care*, and in 2007 a revised and expanded edition of this book was released. I had the privilege of serving as the primary author for both editions and can say without hesitation that the book was definitely *complete*, weighing in on virtually every topic related to parenting and the health of infants, children, and teens. At nine hundred pages, this was not a book to tuck into a handbag for a casual read over lunch.

Teens never fail to give parents plenty to think about (or lose sleep over), and busy schedules aren't always compatible with the task of sifting through the good and bad parenting advice on the Internet, or wading through the contents of a large book. We thus thought it would be helpful to distill the *Complete Guide*'s core concepts about parenting teens into a smaller volume.

We have framed key ideas in the form of questions and answers, and have included a lot of practical advice, while trying to avoid a cookbook approach to parenting. Teenagers are not built like cars or computers; they do not come with instruction manuals that guarantee that *B* will happen if you do *A*. Furthermore, what may work like a charm for one teen may prove to be an utter failure with another. Nevertheless, parenting is too important a task to approach without spending some time studying a basic road map and reviewing some trustworthy traveler's advisories.

This book is one in a series of Busy Mom's Guides, all of which are intended to provide help and hope for important concerns of family life. By the way, we would be very pleased if these guides would prove useful to some busy dads as well.

Paul C. Reisser, M.D.
November 2011

INTRODUCTION

Listen, my son, accept what I say,
and the years of your life will be many.
I guide you in the way of wisdom
and lead you along straight paths.
PROVERBS 4:10-11

BETWEEN THE TWELFTH and twenty-first birthdays, your child will undergo rapid and intense physical, psychological, and social changes, and at the end of this period he will no longer be a child. Just as you probably approached the "terrible twos" (sometimes called the first adolescence) with a combination of eager anticipation and a little apprehension, you may now have a similar mix of positive expectation and growing concern as the "real thing" arrives. Without a doubt, adjustments and challenges are ahead for everyone in the family.

Indeed, the years ahead may at times feel like a canoe trip down a mountain river. The scenery is constantly changing; the ride is always interesting and often pleasant; but choppy waters, roaring rapids, and an occasional waterfall may await you around the next bend. Your job will be to stabilize the family canoe as much as possible and by all means prevent it from turning over before your adolescent reaches the calmer waters of adulthood.

It won't all be trials and turbulence. These are highly rewarding years for many families, full of accomplishments, commitments to worthwhile causes, and experiences that weren't possible when your child was younger. You can't expect your two-year-old to appreciate a basketball game, a performance of your favorite stage

production, or a great sermon, but your sixteen-year-old can share these experiences with you and be as interested or enthralled as any adult.

This book will begin with a look at the physical aspects of this remarkable transformation from child to adult. Emotions, relationships, the desire for independence, and other growing pains will be discussed in the next chapter. In subsequent chapters we will address a number of areas of concern for parents and teens alike: the wise use of electronic media; sexuality; alcohol and drug abuse; bullying; eating disorders; and depression. We will conclude with a look at the important process of molding character and preparing a teenager for life as a responsible, independent adult.

Fasten your seat belt, hold on tight, and enjoy the ride.

CHAPTER 1

BODIES IN MOTION

> You created my inmost being;
> you knit me together in my mother's womb.
> I praise you because I am fearfully and wonderfully made;
> your works are wonderful,
> I know that full well.
>
> PSALM 139:13-14

FROM A PHYSICAL STANDPOINT, the main event of adolescence is puberty, which serves as the physiological bridge between childhood and adulthood.

> *Puberty*: the stage of maturation in which an individual becomes physiologically capable of sexual reproduction (from the Latin *puber*: "adult").

Rapid growth and body changes during these years are to a large degree brought about by interactions between several hormones: biochemical compounds created in one part of the body and sent via the bloodstream to have a specific effect somewhere else in the body. These chemical messages provoke an impressive number and variety of responses. Hormones and the glands that secrete them are collectively known as the *endocrine system*.

Not all hormones are related to reproduction. Thyroid hormone, for example, plays an important role in the body's metabolic rate. Insulin, which is secreted by the pancreas, escorts glucose (or blood sugar) into the cells that need and use this basic fuel. Growth hormone, as its name implies, is necessary for the attainment of normal adult height.

Speaking of growth hormone, a major growth spurt is one hallmark of adolescence, usually occurring between the ages of ten and fourteen in girls, and twelve and sixteen in boys. (Perhaps "spurt" isn't the most accurate term for this event, which actually lasts between two and three years.) The rate of growth can vary, but it tends to be fastest during spring and summer. Weight increases as well, and bones progress through their final stages of maturation. In addition, the percentage of body fat increases in girls and decreases in boys.

What physical changes can I expect in my son at puberty?

Male sexual development usually begins between the ages of ten and thirteen (the average age is eleven or twelve), and the process is usually completed in about three years, though it can range anywhere from two to five years. The timing and speed of bodily changes can vary greatly between boys of the same age, and boys who develop more slowly may need extra encouragement and continued reassurance that they will eventually reach the goal of manhood. A boy should be checked by his physician if he begins to show pubertal changes before age nine or has none of these developments underway by age fourteen.

The first physical sign of puberty in boys is enlargement of the testicles and thinning of the scrotum. Hair appears under the arms, on the face and chest, and in the genital area. His voice starts to deepen, although it may pass through an awkward phase of breaking, especially when he is excited or nervous.

The testicles begin manufacturing sperm, which are transported

through a structure called the epididymis (one of which sits adjacent to each testicle) and then onward to the penis through a pair of flexible tubes called the vas deferens. The prostate begins to produce seminal fluid, which carries sperm out of the body during ejaculation.

The newly functioning sexual equipment will at times carry out its functions unexpectedly during the middle of the night in what is called a nocturnal emission or "wet dream," a normal event that an uninformed adolescent might find alarming. Along the same lines, boys may be concerned or embarrassed by unexpected erections, which can occur at very inopportune times (for example, just prior to giving a report in front of a class). Neither of these events should be interpreted as a sign of impending moral failure. In fact, it's best to brief your son about these normal occurrences before puberty arrives so he's not taken by surprise.

If you are a single mother who feels uncomfortable discussing these matters with your son, consider seeking help from an adult male who not only shares your values but has enough rapport to talk with your son about these topics.

Some boys develop a small, button-sized nodule of breast tissue directly under the nipple. This is a common response to changing hormones, although it may cause a minor panic when first discovered ("Is this a tumor?" "Am I going to develop breasts like a woman?"). This area may become a little tender but should return to normal within twelve to eighteen months. If you have any questions, or if breast tissue appears to be increasing in size (a phenomenon known as gynecomastia), have it checked by your son's doctor.

What physical changes can I expect in my daughter at this stage?

While pubertal development and the reproductive process are relatively straightforward in boys, the changes that take place as

a girl progresses to womanhood are in many ways much more complex. (As you will see, they also take quite a bit longer to explain.) Not only does she undergo significant changes in her outward appearance, but inside her body a delicate interplay of hormones eventually leads to a momentous occasion: her first menstrual period (also called menarche), announcing her potential to reproduce.

The first visible sign of puberty in girls is the development of breast buds, which usually appear about two years before the first menstrual period. Each breast bud is a small, flat, firm button-like nodule that develops directly under the areola (the pigmented area that surrounds the nipple). This tissue eventually softens as the breasts enlarge. Occasionally a bud will develop on one side before the other, which might lead to the mistaken impression that a tumor is growing. But the passage of time and (if necessary) a doctor's examination will confirm that this growth is normal.

As the breasts continue to develop, hair begins to grow under the arms, on the legs, and in the genital area. The contour of the hips becomes fuller, and the internal reproductive organs grow and mature. Glands within the vagina produce a clear or milky secretion, which may appear several months before the onset of menstrual bleeding.

Finally, at the conclusion of an intricate sequence of hormonal events, the first menstrual flow arrives. This typically occurs around twelve or thirteen years of age, with a range between nine and sixteen. As with boys, girls who begin this process earlier or later than average will need some information and reassurance. In general, a girl should be checked by her physician if she develops breast buds before age eight or has her first period before age nine. At the opposite end of the spectrum, the absence of pubertal changes by thirteen or menstrual periods by sixteen should prompt a medical evaluation.

What goes on in my daughter's body during the menstrual cycle?

Under normal circumstances, each month a woman's body performs a three-act play titled *Preparing for a Baby*. What you are about to read is a summary of the essential characters and plot. (As with many other aspects of human physiology, there are thousands of other details that will not be spelled out here and thousands more yet to be discovered. The design of this process is indeed exquisite.)

The main characters in the play are:

- *The hypothalamus*: a multifaceted structure at the base of the brain that regulates basic bodily functions such as temperature and appetite. It also serves as the prime mover in the reproductive cycle.
- *The pituitary*: a small, punching-bag-shaped structure that appears to dangle from the brain directly below the hypothalamus. It has been called the "master gland" because it gives orders to many other organs. But it also takes important cues from the hypothalamus.
- *The ovaries*: a matched pair of organs in the female pelvis that serve two critical functions—releasing one or more eggs (or ova) each month and secreting the hormones estrogen and progesterone. At birth, the ovaries contain about two million eggs, a woman's lifetime supply. During childhood, the vast majority of these gradually disappear, and by the time a girl reaches puberty, only about 300,000 will be left. During a woman's reproductive years, she will release between three hundred and five hundred eggs; the rest will die and disappear.
- *The uterus*: a pear-shaped organ consisting primarily of muscle and containing a cavity where a baby grows during pregnancy. This cavity is lined with delicate tissue called

endometrium, which changes remarkably in response to the estrogen and progesterone produced by the ovaries. The uterus, also called the womb, is located at the top of the vagina and positioned in the middle of the pelvis between the bladder and the rectum.

- *The fallopian tubes*: a pair of tubes, about four to five inches (10 to 13 cm) long, attached to the upper corners of the uterus and extending toward each ovary. Their job is to serve as a meeting place for egg and sperm and then to transport a fertilized egg to the uterus.

Act I: Preparing an egg for launch (the follicular phase). The hypothalamus begins the monthly reproductive cycle by sending a "message" called *gonadotropin-releasing hormone* to the pituitary gland. The message says, in effect, "Send out the hormone that prepares an egg to be released by the ovaries." The pituitary responds by secreting into the bloodstream another biochemical message known as *follicle-stimulating hormone (FSH)*, which prepares an egg to be released by the ovaries. Each egg within an ovary is covered with a thin sheet of cells, and the term *follicle* (which literally means "little bag") refers to the entire package of egg and cells together. Under the influence of FSH, eight to ten follicles begin to grow and "ripen." Usually only one becomes dominant and progresses to full maturity.

This follicular phase of the cycle lasts about two weeks, during which the dominant follicle fills with fluid and enlarges to about three-quarters of an inch (2 cm). The egg contained within it will soon be released from the ovary. At the same time, this follicle secretes increasing amounts of estrogen, which (among other things) stimulates the lining of the uterus to proliferate and thicken. This is the first stage of preparation of the uterus for the arrival of a fertilized egg.

Act II: The egg is released (ovulation). As in Act I, this part of the story also begins in the hypothalamus. In response to rising levels of estrogen, the hypothalamus signals the pituitary to release a brief but intense surge of luteinizing hormone (LH) into the bloodstream. This hormone sets off a chain reaction in the ovaries. The dominant follicle enlarges, its outer wall becomes thin, and finally it ruptures, releasing egg and fluid. This mini-eruption, called ovulation, takes only a few minutes and occurs between twenty-four and forty hours after the peak of the LH surge. Sometimes a tiny amount of blood oozes from the ovary as well. This may irritate the lining of the abdomen, producing a discomfort known as *mittelschmerz* (German for "middle pain," because it occurs about halfway through the cycle).

Act III: The voyage of the egg and the preparation of the uterus (the luteal phase). The egg is not left to its own devices once it is set free from the ovary. At the end of each fallopian tube are structures called *fimbriae* (Latin for "fingers"), whose delicate tentacles move over the area of the ovary. As soon as ovulation takes place, the fimbriae gently escort the egg into the tube, where it begins a journey toward the uterus. The cells that line the fallopian tube have microscopic hairlike projections called *cilia*, which move in a synchronized pattern and set up a one-way current through the tube. If sperm are present in the outer portion of the tube, and one of them is successful in penetrating the egg, fertilization takes place and a new life begins.

The fertilized egg will incubate in the tube for about three days before arriving at its destination, the cavity of the uterus, where it floats for approximately three more days before implanting. Around the seventh day, it "rests," implanting in the cavity of the uterus. If the egg is not fertilized, it will live only twelve to twenty-four hours and then disintegrate or pass through the tube and uterus into the vagina. (Since sperm live for forty-eight

to seventy-two hours, there are three or four days in each cycle during which intercourse could lead to conception.)

Meanwhile, a lot of activity takes place in the ovary after ovulation. The newly vacated follicle has another job to do: prepare the uterus to accept and nourish a fertilized egg should one arrive. The follicle turns into a gland called the *corpus luteum* (literally, "yellow body," because cells lining the inside of the follicle develop a yellowish color), which secretes estrogen and, more important, progesterone, which dominates this luteal phase of the cycle, promoting growth and maturation of the uterine lining. This layer of tissue eventually doubles in thickness and becomes stocked with nutrients. Progesterone not only prepares the uterine "nursery" for a new arrival, but also relaxes the muscles of the uterus, decreasing the chance of contractions that might accidentally expel the egg. Progesterone also temporarily stops the preparation of any other eggs within the ovaries.

If a fertilized egg successfully implants and continues its growth within the uterus, it secretes a hormone called *human chorionic gonadotropin (HCG)*, which sends an important message to the corpus luteum: "Keep the hormones flowing!" The corpus luteum obliges and for nine or ten weeks continues to provide the hormonal support that allows the uterus to nourish the baby growing inside. After ten weeks, the placenta (the complex organ that connects the baby to the inner lining of the uterus) takes over the job of manufacturing progesterone, and the corpus luteum retires from active duty.

If there is no fertilization, no pregnancy, and thus no HCG, the corpus luteum degenerates. Progesterone and estrogen levels fall, resulting in a spasm of the blood vessels that supply the lining of the uterus. Deprived of the nutrients it needs to survive, the lining dies and passes from the uterus, along with blood and mucus, in what is called the menstrual flow (also referred to as a girl's "period" or menses).

Though the menstrual period might seem to be the end of the story, the first day of flow is actually counted as day one of a woman's reproductive cycle. For while the flow is taking place, the three-act play is starting over again as a new set of follicles begins to ripen in the ovaries. This "circle of life" will normally continue month after month throughout a girl's or woman's reproductive years, until menopause, unless it is interrupted by pregnancy or a medical condition that interferes with this cycle.

What is normal during menstrual periods?

The words *menstrual* and *menses* are derived from the Latin word for "month," which refers to the approximate frequency of this event. A typical cycle lasts from twenty-seven to thirty-five days, although for some women normal menses occurs as frequently as every twenty-one days or as infrequently as every forty-five days. Most of the variability arises during the first (follicular) phase leading up to ovulation. Assuming that a pregnancy does not begin, the luteal phase (from ovulation to menses) is nearly always fourteen days, with little variation.

For a year or two after a girl's first menstrual period, her cycles may be irregular because of anovulatory cycles, meaning an egg is not released. If ovulation does not take place, the cycle will remain stuck in the first (follicular) phase. Estrogen will continue to stimulate the lining of the uterus until some of it becomes so thick that it outgrows its blood supply. The shedding of this tissue resembles a menstrual period, but it is unpredictable and usually occurs with very little cramping. When ovulation finally takes place, the lining of the uterus will mature and then be shed all at once if a pregnancy has not started.

After a girl's first menstrual period, several months may pass before her endocrine system matures to the point of producing regular ovulation. During this time, it is not unusual for two or three months to pass between cycles. Because cramping doesn't

normally occur unless ovulation has taken place, menstrual pains may not be noticed for months (or even one or two years) after the first cycle.

Menstrual flow typically lasts for three to six days, although very short (one-day) or longer (seven- or eight-day) periods may be normal for some women. One to three ounces (about 30 to 90 ml) of blood is usually lost during each cycle, though more or less than this amount may be a regular occurrence without any ill effects.

What should I tell my son if he asks about the menstrual cycle?

A boy should acquire some basic information about the female reproductive cycle in the course of learning how to treat the women in his life with care and respect. In order to protect boundaries of modesty (and prevent potential embarrassment), be careful about what is said and who is listening when discussing what is going on inside the body of your teenager. Generic comments ("When a woman is having her menstrual period . . .") are more appropriate than naming names ("When Jessica is having her menstrual period . . .").

What can be done to help menstrual cramps?

Menstrual cramps (the medical term is dysmenorrhea) most often are a by-product of the normal breakdown of the endometrium (lining of the uterus) at the end of a cycle. Chemicals, called prostaglandins, are released into the bloodstream by the endometrium, often with unpleasant effects. The most obvious response is a series of contractions of the muscles of the uterus, which may actually be as forceful as contractions during labor. During a strong contraction, blood may be inhibited from circulating throughout the uterine muscle, which, like any other muscle temporarily deprived of oxygen, will sound off with genuine pain. Prostaglandins may affect other parts of the body during a

menstrual period, causing diarrhea, nausea, headaches, and difficulty with concentration. One bit of good news in connection with menstrual cramps is that they do *not* predict the level of pain a woman will feel during childbirth. In other words, a teenager with severe menstrual cramps will not necessarily have equally severe labor pains.

Menstrual cramps can be relieved in a variety of ways:

- Heating pads or warm baths are often helpful, for reasons that are unclear. (These may increase blood flow within the pelvis, improving the supply of oxygen to the uterine muscle.)
- Exercise and good general physical condition are often helpful in reducing cramps. Walking is a good exercise during this (or any) time of the month.
- Specific prostaglandin-inhibiting medications work well for many teens and older women alike. These are formulated to reduce the pain and inflammation of arthritis but have been found to also have a significant effect on menstrual cramps. Several are now available without prescription: ibuprofen (Advil, Motrin, Nuprin, and other brands), naproxen (Aleve), and ketoprofen (Orudis and others). These anti-inflammatory drugs should be taken with food to decrease the chance of stomach irritation. They are most effective if taken at the first sign of cramping and then continued on a regular basis (rather than "here and there" in response to pain) until the cramps stop. Your daughter's physician may recommend one of these medications (sometimes with a dosage schedule different from what is written on the package) or prescribe one of several other anti-inflammatory medications. Individual responses vary. If one type doesn't work well, another may seem like a miracle.

- Other pain-relief medications that may be helpful include the following:
  - Acetaminophen (Tylenol and others), which does not inhibit prostaglandins but can be quite effective nonetheless. Some women have found that alternating medications is helpful—for example, starting with ibuprofen, using acetaminophen for the next dose a few hours later, then switching back, and so on. *Note*: You should be aware that acetaminophen can be found in more than six hundred products (both prescription and over-the-counter), and that the total amount taken in any given day by an adult should not exceed 4000 mg. For children younger than twelve, or who weigh less than 110 pounds (50 kg), the maximum dose will be lower, based on weight. Check the label of any acetaminophen product for both the recommended dose and the amount of acetaminophen it contains—especially if this drug is present in more than one preparation you or other family members are using.
  - Midol has been marketed for decades as a treatment for discomforts associated with menstruation. Traditionally, it has included acetaminophen, caffeine, and the antihistamine pyrilamine, which not only may be mildly sedating, but may also have a modest diuretic effect (to reduce fluid retention). Today, Midol is a product line with several different formulations. Some of these substitute an anti-inflammatory drug (ibuprofen or naproxen) for acetaminophen. Some Midol products also contain pamabrom, another mild diuretic. If you plan to buy one of these products, *check the label* to be sure that its ingredients are not duplicating those found in other nonprescription remedies you may already be using.
  - If the discomfort of menstrual cramps cannot be

controlled by other measures, stronger pain relievers may be prescribed by a physician.

If menstrual cramps become disruptive and are unresponsive to home remedies and nonprescription medications, it is important that they be evaluated medically. Abnormalities of the cervix (the opening of the uterus) or the uterus itself, or a syndrome called *endometriosis* (in which tissue that normally lines the uterus grows in other parts of the body, usually in the pelvis) can on rare occasion be the cause of significant menstrual pain in an adolescent. If a medical examination finds no sign of endometriosis, the physician may prescribe diuretics and/or birth control pills (oral contraceptives).

Diuretics decrease fluid retention but do not directly relieve cramps; however, the discomfort may be less annoying if fluid retention is relieved.

Birth control pills may be helpful in reducing or eliminating significant cramps not adequately controlled by other means. In fact, for many teens, this may be the only type of medication helpful in reducing severe cramps that regularly interfere with normal activity. Each four-week cycle of pills provides three weeks of estrogen and progesterone in a specified amount. This prevents the LH surge and ovulation, and also usually results in less proliferation of the lining of the uterus than occurs during a normal cycle. During the fourth week, no hormones are present in the pills, allowing the lining to shed as in a normal cycle. However, the smaller amount of tissue involved usually generates less cramping. A variation on this approach, known as continuous oral contraception, extends the length of each cycle beyond twenty-eight days in order to reduce the number of menstrual periods.

A decision to use birth control pills should not be made casually. A medical evaluation to rule out other causes of pain may be necessary. (Indeed, if severe menstrual cramps continue while a

woman is taking oral contraceptives, she should be reevaluated by her physician. Endometriosis is a definite possibility if this occurs.) Nausea, headaches, bloating, and/or worsening of acne are unpleasant side effects experienced by some users. (On the other hand, certain oral contraceptives can also improve acne.) The pills must be taken consistently each day to be effective.

The use of birth control pills may raise another concern, as well: Could taking them for menstrual cramps (or any other therapeutic purpose) indirectly lower your daughter's resistance to sexual activity? If you don't know the answer to this question, now is the time for candid conversation about sexuality. For a girl who is fervently committed to remaining abstinent, it would be unfortunate to withhold a treatment that might reduce debilitating pain just because of a parent's vague mistrust. Furthermore, the decision to postpone sex until marriage should be built on a strong, multilayered foundation. If the absence of contraceptives is the only reason your daughter is avoiding intercourse, she needs to hear and understand many more reasons.

Should I be concerned if my daughter has irregular periods?

Irregular menstrual periods may be a cause for concern if they are

- too rare, occurring every three or four months after more than a year has passed since the first period.
- too frequent, with bleeding or spotting occurring throughout the month.
- too long, lasting more than seven or eight consecutive days.
- too heavy, soaking through more than six to eight pads or tampons per day.

For any of these problems, a medical evaluation is usually indicated to discover the underlying cause. In many instances, the

diagnosis will be anovulatory cycles resulting from an immature endocrine system. But other physical or even emotional events can also interfere with the complex interaction of hormones that brings about the monthly cycle. These include:

- *Medical disorders.* These could include malfunctions of the endocrine system (including pituitary, adrenal, or thyroid glands) or abnormalities of the ovaries, uterus, or vagina.
- *Significant changes in weight.* Obese teens can generate enough estrogen in their fat cells to affect the lining of the uterus. At the opposite extreme, stringent diets or the severe reduction of food intake seen with anorexia nervosa will effectively shut down the menstrual cycle (see the questions on eating disorders, beginning on page 158).
- *Extreme levels of exercise.* Female athletes with demanding training programs may have infrequent periods, or their cycles may stop altogether.
- *Stress.* Stormy emotional weather is not uncommon during the adolescent years, and personal upheavals can cause a teenage girl to miss one or more periods.
- *Pregnancy.* In some cases, an unexpected absence of menstrual cycles indicates that pregnancy has begun.

It is important that extremes in menstrual flow (whether too much or too little) be evaluated. Not only may the underlying cause have great significance, but the menstrual irregularity could also have damaging consequences of its own. For example, very frequent or heavy bleeding may outstrip an adolescent's ability to replenish red blood cells. Iron deficiency can develop when there is an inadequate amount of iron in the diet to keep up with what is being lost in menstrual blood flow each month. This not only can cause ongoing fatigue and poor concentration in school, but may also lead to anemia—a shortage of red blood cells (which are also

smaller and contain less hemoglobin, the oxygen-carrying molecule) that can result in light-headedness or even fainting episodes.

Absence of menstrual periods related to a continual failure to ovulate may result in months or years of nonstop estrogen stimulation of the uterus. Without the maturing effect of progesterone, the lining of the uterus may be at increased risk for developing precancerous abnormalities. This scenario is one of the concerns for women (of all ages) with *polycystic ovary syndrome*, a metabolic disturbance usually characterized by infrequent menstrual periods as well as excessive weight and body hair.

Teens whose cycles stop because of weight loss or intense physical training (or both) may suffer an irreversible loss of bone density, known as *osteoporosis*. Normally a problem faced by women much later in life (typically well after menopause), osteoporosis can lead to disabling fractures of the spine, hips, wrists, and other bones.

It is impossible to state a single course of action that will resolve all the various forms of menstrual irregularity. However, if there appears to be no underlying disturbance that needs specific treatment and the problem is determined to be irregular ovulation, a doctor may recommend hormonal treatment to regulate the cycle. This may take the form of progesterone, which can be given at a defined time each month to bring on a menstrual period. As an alternative, birth control pills may be recommended to restore order by overriding a woman's own cycle and establishing one that is more predictable. As mentioned earlier, the decision to use this type of medication in an adolescent must be made with particular care and discernment.

What are PMS and PMDD?

Prior to menstruation, most women experience some degree of discomfort, which may occur for a day or two or may extend over the entire two-week period following ovulation. Mild physical or

emotional distress during this time, sometimes called *premenstrual tension*, is very common. But 20 to 40 percent of women experience symptoms severe enough to disrupt normal activities. This is commonly called *premenstrual syndrome*, or *PMS*.

A specific cause for PMS has not been identified, but the effects are all too familiar for many women, including teens. Physical symptoms can include bloating and fullness in the abdomen, fluid retention (with tightness of rings and shoes), headaches, breast tenderness, backache, fatigue, and dizziness. More dramatic are the emotional symptoms: irritability, anxiety, depression, poor concentration, insomnia, difficulty making decisions, and unusual food cravings. These can occur in various combinations and levels of severity. The most striking feature is usually the instability and intensity of negative emotions, which can send other family members running for cover. Some teenagers and older women feel like Dr. Jekyll and Ms. Hyde—calm and rational for the first two weeks of the cycle and out of control for the second two weeks, with dramatic improvement once the menstrual flow commences. Between 3 and 5 percent of women have premenstrual emotional storms severe enough to cause significant disturbances at home, school, or work, a condition designated in recent years as *premenstrual dysphoric disorder*, or *PMDD*.

What treatments are useful for PMS or PMDD?

A few decades ago, PMS was considered primarily a psychological event, an "adjustment reaction" to reproductive issues or life in general. This is no longer the case. PMS should be taken as seriously as any other physical issue. Though no quick-fix remedies or lifetime cures exist for PMS, a number of measures can help your adolescent (and others at home) reduce its impact:

Make sure the emotional and physical symptoms are, in fact, PMS. Adolescent emotions are often intense and variable, and

other life issues (involving school, friends, family, etc.) may be at the heart of the problem. If there is any question, symptoms can be charted on a calendar, along with menstrual periods, for two or three months. You should see an improvement for at least a week following menses. Symptoms that continue well after a period is over or throughout the cycle involve something other than (or in addition to) PMS, including possible depression. Keep in mind that PMS, or PMDD, can be superimposed on an ongoing depression, and turbulent emotions can take a marked turn for the worse—even including suicidal thoughts—during the week or two prior to menses. Anyone whose thinking turns to self-harm, even if it occurs only during certain times of the month, should be evaluated and treated immediately. (For more information about this important topic, see the questions on depression, starting on page 166.)

Keep the lines of communication open and plan ahead. Once your daughter's cycle is well established, she will be able to predict when the more troublesome days are coming. This may give others at home advance "storm warning," enabling them to respond to her with an extra measure of TLC, or at least to cut her a little slack. This is particularly important if more than one person at home has difficulty with PMS, because the collision of two unstable moods can be quite unpleasant. If your daughter is currently irritable because of the time of the month, and a change for the better is likely in the immediate future, you would be wise to postpone any conversations about emotionally charged issues for a few days if possible. At the same time, while it is important to acknowledge the reality of PMS symptoms, they shouldn't be allowed to become a blanket excuse for blatant disrespect, acting out, or abandonment of responsibilities.

Encourage sensible eating and exercise. Frequent, smaller meals may help prevent bloating, and avoiding salt can reduce

fluid retention. Caffeine may increase irritability, so decaffeinated drinks (and medications) are more appropriate. All-around physical conditioning through the entire month can improve general well-being and play a major role in helping a woman navigate more smoothly to the end of a cycle.

In addition, a variety of remedies, nutritional supplements, and medications have been recommended at one time or another for this problem. Some have a more consistent track record (and better scientific support) than others, and your adolescent should consider getting advice from her physician before trying any of these. Keep in mind that megadoses of any vitamin or mineral—quantities that greatly exceed the recommended dietary allowance (RDA)—are not advised for this condition. The bottom line for any PMS treatment is an honest assessment of the effectiveness, safety, and side effects for the individual taking it.

- *Nonprescription medications* such as acetaminophen or ibuprofen to reduce aches and pains may be of some help.
- *Calcium* (1200 mg per day) and *magnesium* (200 mg per day) supplements have both been shown to reduce symptoms of PMS (especially physical discomforts) by 40 to 50 percent. Improvements may not be noticed, however, until two or three cycles have passed while taking the supplements.
- *Vitamin E* supplements (usually at 400 IU per day, but no more than that) have shown mixed results in research studies on PMS.
- *Vitamin B_6*, which has long been advocated as a remedy for PMS symptoms, has performed poorly in controlled studies and probably has limited usefulness at best. If numbness or tingling of the hands or feet occur while taking this vitamin, it should be discontinued.
- A number of *herbal preparations* have been advocated for

one or more symptoms of PMS, but research studies investigating such claims have yielded mixed results. Evening primrose oil and ginkgo biloba, for example, have not been shown to be effective. Dry extracts of agnus castus fruit (also called chasteberry) improved symptoms in one study.[1] If you are considering an herbal remedy for your adolescent, keep in mind that the Food and Drug Administration (FDA) does not certify herbal preparations for safety or effectiveness.

- *Prescription medications* most widely used for PMS fall into three basic categories: diuretics, antidepressants, and hormonal manipulators. Obviously, the use of any of these will require evaluation and follow-up by a physician.
  - *Diuretics*. For many women, much of the discomfort from PMS arises from bloating and fluid retention, so the use of a mild diuretic (or "water pill") to maintain normal fluid levels during the second half of each cycle can be effective.
  - *Antidepressants*. Many PMS symptoms, and certainly those of PMDD, duplicate those seen in depression. Some women with severe PMS fight milder forms of the same emotional symptoms throughout the month. It now appears that the fundamental physiological problem in PMS involves changes in the levels of biological messengers in the brain known as *neurotransmitters*.

    New research has shown significant reduction in PMS symptoms with a specific family of antidepressants called *selective serotonin reuptake inhibitors (SSRIs)*, such as fluoxetine (Prozac or Sarafem), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), and others. Often, doses lower than those needed to treat depression are effective in reducing PMS/PMDD symptoms, and many women obtain satisfactory results by taking one of these

medications on an intermittent basis, typically seven to ten days each month. Though these drugs are safe and well tolerated for the vast majority who use them, and definitely *not* habit-forming, individual responses and side effects can vary considerably—especially in teens.

Before your daughter starts a prescription (or takes samples from her doctor), it is essential to have a careful discussion with her health-care provider about the potential benefits and problems associated with SSRIs. It is particularly important to report any *increase* in irritability or agitation in a teenager who is taking this type of medication. (For more information, see chapter 6.)

- *Hormonal manipulation* has been utilized with variable success, though this is not commonly prescribed for teens with PMS. Women who take supplemental progesterone during the second half of the menstrual cycle may report marked improvement, a worsening of symptoms (especially depression), or no effect at all. Though supplemental progesterone is heavily promoted on the Internet and radio infomercials as a treatment for PMS, most research studies have shown it to be no more effective than a placebo.[2] (A substance that provides no greater relief than a placebo is generally considered ineffective.) Hormonal preparations should be utilized in teens only after thoughtful consideration of the pros and cons by patient, parent, and physician.

Which is best for my daughter: pad or tampon?

From the very first to the final reproductive cycle, either tampons or external pads may be used to absorb menstrual flow. Each has its specific advantages and disadvantages. Deodorant pads and tampons and feminine hygiene sprays may irritate delicate tissue, and douching is unnecessary and should be avoided. Any

persistent drainage that is discolored, itchy, painful, or foul-smelling should be evaluated by a physician.

External pads may be more comfortable for a young adolescent who feels uneasy about inserting a foreign object into her vagina. However, pads may cause heat and moisture to be retained around the external genital area (especially in hot or humid climates) and increase the likelihood of local irritation or infection.

Tampons allow more freedom of activity (especially for vigorous exercise or swimming) and less chance of contributing to external irritation. Some parents may worry about tampons causing damage inside or at the opening of the vagina; however, inserting a tampon does not tear the hymen (the ring of soft tissue just inside the labia at the entrance to the vagina), although difficulty inserting tampons may be the first indication of an abnormality of this structure. Very rarely, small vaginal ulcerations may result from improper tampon insertion.

Of more concern is the association of tampon use with toxic shock syndrome (TSS), a condition caused by a toxin produced by *Staphylococcus aureus* bacteria. A number of cases occurred in the 1980s in connection with a particular type of tampon that appeared to foster the growth of *S. aureus* in the vagina and irritate the vaginal lining. This tampon was taken off the market, but subsequent evidence has indicated that the primary risk factors for the development of TSS are the amount of time a tampon is left in place near the opening of the vagina, and the size and absorbency of the tampon.

Most symptoms of this problem are nonspecific: fever, chills, headache, muscle aches, vomiting, diarrhea, and faintness (caused by a drop in blood pressure). A more specific sign is a sunburn-like rash on the palms and soles. When severe, toxic shock syndrome is treated in the hospital with large doses of antibiotics as well as fluids given intravenously to maintain blood pressure. The development of flu-like symptoms and light-headedness—feeling faint

or actually passing out, especially associated with standing up or other changes in position—may be very significant if they occur during a menstrual period. These symptoms should be evaluated by a physician *as soon as possible*.

Fortunately, TSS is rare. (Some *S. aureus* or *Streptococcus* bacterial infections may provoke TSS in situations that do not involve tampon use, and thus may occur in either males or females.) Most physicians believe that tampons are safe for both teens and older women, although fifteen- to nineteen-year-olds have the highest risk for developing toxic shock syndrome from tampon use. Simple precautions can markedly reduce this risk.

First, and most important, don't leave a tampon in place for more than six hours. Follow the manufacturer's instructions closely. Insert (and remove) tampons carefully. Store tampons in a clean, dry place. Wash hands before inserting or removing tampons. Use tampons with the least absorbency necessary to control the flow. Tampons are now graded for absorbency as follows: light, regular, super, super plus, and ultra. (Super plus and ultra are not recommended for use by teens.)

Less absorbent tampons are smaller and less likely to irritate the lining of the vagina. If a tampon is difficult to remove, shreds, doesn't need to be changed for several hours, or is associated with vaginal dryness, a smaller size should be used.

Consider alternating tampons and pads during the same menstrual period. (For example, use tampons during the day—changing them every few hours—and pads at night.)

What tests are usually done in a routine physical exam?

During the next few years, your teenager will probably need medical input on a number of occasions, including screening exams for sports, camp, and general health assessment. Injuries arising from sports or other vigorous activities may need attention. Problems related to menstruation may require medical evaluation

and intervention. In addition, a variety of symptoms and emotional concerns may arise during these years.

Adolescent health-care guidelines recommend yearly visits to the doctor for assessment, screening, and guidance, even if there have been other evaluations during the year for specific medical problems. Quick exams for camp or sports, especially those done assembly-line style on large groups of teens, are no substitute for a more comprehensive physical exam by your regular health-care provider. If there are special health problems, more frequent exams may be necessary.

Most doctors will talk with parent and teen together during the visit, but part of the time will be spent without the parent present. This is usually done to increase the likelihood that the doctor is receiving accurate information, with the assumption that many teenagers may feel uncomfortable answering sensitive questions in front of their parents. It is customary during this time alone for a physician to assure the young patient of the confidentiality of their conversation. (When abuse is suspected, however, the health-care provider must notify the appropriate local social-service agency. Also, if there appears to be an imminent threat of suicide, referral to a qualified counselor, psychiatrist, or mental-health facility will be necessary.) *It is therefore extremely important that you consider carefully who is going to provide health care for your adolescent.*

Ideally, your teenager's health-care provider will not only be medically competent, but also someone whom your teenager trusts and can talk with comfortably; whom *you* trust; who knows you and your family; and who shares your basic values.

The last qualification is particularly significant because of the near certainty that your teenager will eventually be in a one-on-one situation with the physician. Your son or daughter may feel more comfortable discussing sensitive topics with a doctor than with you, even if you have an extremely close and honest relationship. You will want to be certain that the advice and counsel given behind

closed doors, especially regarding sexual behavior, will not contradict or undermine principles you have been teaching at home. During these critical years, everyone needs to be on the same team.

Although teens usually have an interest in discussing a variety of topics with their doctors, they may feel embarrassed to broach certain subjects. The physician should have the interest (and time) to ask some probing questions and then offer sound input based on the response. (There is no guarantee, of course, that a teenager will tell "the whole truth and nothing but," even when confidentiality is assured.) Along with questions about past history and any current symptoms, specific topics that are usually on the physician's agenda (if not on the patient's) include the following:

- Growth and development. Younger teens are particularly concerned about whether they are normal, especially if pubertal changes are taking place earlier or later than in their peers.
- Physical safety, including the use of seat belts, bicycle or motorcycle helmets, and appropriate sports equipment.
- Current dietary practices. Are they healthy, erratic, or extreme in any way?
- Immunization history and updates.
- Exercise and sleep. Is there enough of each?
- Tobacco use.
- Alcohol and drug use.
- Sexual activity.
- Relationships at home and school.
- The emotional climate. Are there any signs of depression?
- Sexual or other physical abuse. A physician who is attentive to an adolescent's physical well-being and demeanor may be the first to detect signs of abuse. By law, physicians are required to report any concerns about abuse to the appropriate local social-service or law-enforcement agency.

In addition to the usual elements of a medical exam (ears, throat, neck, chest, heart, abdomen), a few other areas are also important:

- Blood pressure. Though hypertension (elevated blood pressure) is not common in teens, if detected it must be evaluated further.
- The spine. Special attention is given to scoliosis, a sideways curvature of the spine. There are specific guidelines regarding the degree of curvature that help determine whether treatment is needed, and if so, what methods might be appropriate.
- The groin area should be checked for hernias (primarily in boys).
- The testes should be checked for appropriate development and for any abnormal masses. Testicular cancer is unique for its prevalence among young men, and teenagers should get in the habit of a brief monthly self-check for unusual growths in this area.
- The breasts in both sexes.

Some additional tests may be done during a basic physical exam. These could include the following:

- Vision and hearing screening
- Urinalysis
- Blood tests, such as a blood count to check for anemia (especially in girls), or screening for cholesterol and other circulating fat molecules (called lipids) if there is a history of elevated cholesterol or heart attack before age fifty-five in one or more family members
- A screening test for tuberculosis (TB) may be put on the

arm if there is a risk of prior exposure to this infection, or if required for school or college entrance.

What about immunizations?

A number of immunization updates are usually given during the adolescent years.

A vaccine called Tdap, which provides booster immunization against *tetanus*, *diphtheria*, and *whooping cough* (pertussis), may be given as early as age ten, but no later than ten years after the previous tetanus booster (which was probably given at age four or five as DTaP, the combination given to infants and children up to six years of age). Thereafter, tetanus immunizations are normally repeated every ten years throughout one's life. A booster may be given after five years if one sustains a wound from a puncture, crush injury, burn, or frostbite, or a wound contaminated with dirt, feces, or saliva. Some physicians recommend a tetanus booster if five years have elapsed since the previous one and the adolescent is going on a wilderness expedition or to a foreign country where the vaccine might not be available.

Meningococcus vaccine should be given if it was not included during an earlier immunization visit (at age eleven or twelve).

Measles/mumps/rubella (MMR) vaccine should be given if your adolescent had only one such injection during infancy or childhood. (Normally one dose is given between one year and fifteen months, and a second between four and six years of age.) If your teenager has never received this vaccine, two doses should be given, separated by a minimum of four weeks.

Hepatitis A and/or *hepatitis B* vaccines should be given if one (or both) series has not already been completed. Most teens have received a hepatitis B series during infancy or prior to admission to kindergarten. Routine vaccination against hepatitis A is a more recent recommendation, but it is particularly important for teens to complete a series of two doses if they are planning to travel

extensively, especially to rural or impoverished areas of foreign countries.

If your adolescent has never had *chicken pox* (*varicella*) and has not been immunized against it, vaccination against this virus is advisable, especially because infections in teenagers and adults tend to be more severe than in younger children. Two doses of varicella vaccine are recommended, separated by at least four weeks for a teenager (thirteen years and older) or by at least three months for a child seven to twelve years of age. If your child previously had one dose of vaccine, now is the time for a booster. Varicella vaccine may be given at the same time as an MMR and/or Tdap injection. However, if varicella and MMR are not given simultaneously, an interval of at least a month should separate the two.

The *influenza* virus makes an annual appearance in most communities during the winter, provoking fever, aches, and coughing that are often more intense than a garden-variety upper-respiratory infection. Though most teens recover from influenza after a few days of rest, fluids, and acetaminophen for their aches and pains, this illness can derail a teen's activities for several days. Furthermore, those with significant medical problems such as heart disease, diabetes, or chronic respiratory disturbances (especially asthma) may suffer severe complications. The CDC now recommends that everyone over six months of age (including healthy teenagers) receive a flu vaccine every year. Because new strains of this virus appear annually, a new vaccine must be prepared each year and is typically given during the fall.

You should check with your doctor if you have any questions about the advisability of these immunizations. This is particularly important if your adolescent has a significant medical issue, especially one that affects the function of the immune system (for example, leukemia, symptomatic HIV disease, pregnancy, or a cancer under treatment with chemotherapy). Be sure to inquire

about precautions or potential side effects of any vaccine your teenager might be given.

What about the human papillomavirus (HPV) vaccine?

HPV is the most common sexually transmitted infection in the United States, with approximately twenty million Americans infected.[3] There are approximately one hundred types of HPV, of which about thirty are sexually transmitted.[4] Most people who are infected with the virus have no symptoms and the infection clears up without intervention. Other people, however, can develop genital warts and precancerous changes in cells in the cervix, vulva, anus, or penis. Still other infections progress to cancer in these and other areas. HPV is the primary cause of more than 99 percent of cervical cancers,[5] and is implicated as a cause of 30 to 50 percent of cancers of the mouth and throat.[6] The American Cancer Society estimated that in 2011 more than 12,000 women would be diagnosed with cervical cancer and nearly 4,300 women would die from the disease.[7] In addition, it was projected that about 34,000 new cases of mouth and throat cancer would be diagnosed in 2011, and nearly 7,000 would die from this disease. (This form of cancer occurs about twice as often in men as in women.)[8]

Two vaccines now available can prevent infection with the subtypes of HPV most commonly associated with cervical cancer. Cervarix targets two types of the virus and has been approved only for females. Gardasil provides immunity for four types of HPV and has been approved for use in both males and females. Gardasil also protects females against most genital warts, as well as anal, vaginal, and vulvar cancers. Furthermore, it protects males against genital warts and most anal cancers. HPV vaccination is now recommended for girls and boys at age eleven or twelve, though it may be given as early as age nine and as late as age twenty-six. It is given in a three-dose series, with the second dose given one to two months after the first, and the third dose six months after the first.

While the thought of giving your school-age child a vaccine to protect against a sexually transmitted virus might be unsettling, there are a number of good reasons to consider doing so:

- The immune response is more robust when the vaccine is given at a younger age.
- Girls and boys in this age group are not likely to have been exposed to HPV infection.
- Even if an adolescent makes and keeps a commitment to sexual abstinence until marriage, there is no guarantee that the person he or she marries will have done so, nor is it possible to determine whether the other person is carrying (and could transmit) one of the high-risk HPV viruses. Furthermore, if your child were to become the victim of a sexual assault, the attacker could be carrying one or more of the high-risk viruses.
- The HPV immunization process presents an opportunity for parents and children to have candid, ongoing conversations about sexuality before the onset of adolescence. A girl or boy receiving the vaccine should understand that it does not protect against all strains of HPV, nor against other sexually transmitted organisms, and that reserving sexual activity for marriage is the healthiest decision she or he can make—physically, emotionally, and spiritually. For further guidance regarding teenage sexuality, see chapter 4.

When should a girl receive her first pelvic exam?

Most medical authorities recommend a pelvic exam for a girl or young woman

- within three years of the onset of sexual activity;
- if she has symptoms or concerns about disease—such as

vaginal discharge, pelvic pain, or other pelvic symptoms, which normally cannot be diagnosed by history alone;
- if she is going to be married in the near future;
- if she is going to start on birth control pills for any reason;
- by the age of twenty-one, even if she is not sexually active or has no specific concerns.

No adolescent girl (or any older woman, for that matter) is excited about having a pelvic exam, especially if there is already discomfort in this area. It is important that the practitioner explain the process step-by-step and then talk the patient through the procedure while it is being done. Reassure your daughter that it is normal to feel nervous and awkward, and make sure she knows that though the exam is not particularly comfortable, it should not be extremely painful either. Both you and your daughter should understand that a pelvic exam does not compromise her virginity. Sexual morality is not violated by a medical procedure whose purpose is to assess, diagnose, and treat potential physical problems.

Your daughter should feel free to tell her physician when and where it hurts and know that the exam will be modified if she is having a lot of pain. Many teenagers feel more comfortable if the exam is done by a physician they know and trust, regardless of gender, while others prefer that it be done by a female health-care provider. In either case, the examiner should be accompanied by a female attendant.

Normally during a pelvic exam, the external genitals are briefly inspected, and then a speculum (the "duckbill" instrument) is gently inserted. A narrow speculum should be available for younger patients, and this should pass through the hymen (the ring of soft tissue just inside the labia at the entrance to the vagina) without tearing it. The vaginal walls will be checked, and a Pap test (smear) is normally done.

This painless test collects cells from the cervix (the opening

of the uterus) to check for abnormalities that might indicate an increased risk for developing cancer in this area (or, in rare cases among teenagers, the actual presence of cancer). Using a wooden or plastic spatula, the outer surface of the cervix is scraped, and a swab or thin brush is used to collect cells for testing. These specimens may be spread on microscope slides or placed in a liquid preparation before being placed on a slide. The latter approach, called a "thin prep" Pap, is more likely to remove extraneous debris from the specimen and spread the cells more evenly.

However it is prepared, the slide will be read by a specially trained technologist or pathologist—a physician who, among other things, is an expert at identifying abnormalities in cells.

Test results typically fall into one of three categories: normal, abnormal but not yet cancerous, or highly likely to be cancerous. Thin-prep Pap tests can also identify specific types of the human papillomavirus (HPV) associated with cancer of the cervix, and even diagnose two other sexually transmitted infections: gonorrhea and chlamydia. Action taken in response to an abnormal Pap test will depend on several factors, including the severity of the changes observed.

After taking the Pap test specimen, the examiner will insert one or two fingers into the vagina while the other hand gently presses on the lower abdomen. Much information can be obtained from this simple maneuver, including the size of the uterus and ovaries and the location and intensity of any tenderness. A rectal examination may also be done at this time.

What should I do if my teenager has recurring vague physical symptoms?

You may at times become frustrated by ongoing vague physical complaints ("I don't feel well . . ."), especially those that sound very compelling in the morning yet seem to evaporate by midafternoon. How do you know whether to offer TLC and bed rest or send your

teenager off to school? The answer isn't always easy. More than once you may struggle with guilt after discovering your child really *was* sick but you had overruled his protests and made him attend classes. On other occasions, you may be compassionate in the morning and then feel as if you've been taken advantage of when your teenager makes a "miraculous recovery" at the end of the school day.

If symptoms are frequent, ask your health-care provider to help sort things out. To get the most out of this consultation, spend time before the visit talking over the problem with your teenager, listing the problems (fatigue, headaches) and their characteristics (how often, how long, what helps, what makes it worse).

While you're at it, try to get a feel for the social climate at school, in the neighborhood, or at church. Questions with no obvious right or wrong answer ("Who do you like to hang around with?" or "What's your least favorite class?") may open the window to some current events and possibly tip you off about pressures that might be contributing to the symptoms.

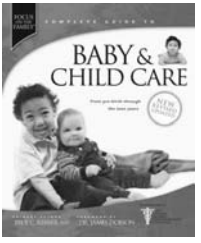
Ultimately, your teen's doctor will need to ask some specific questions, perhaps including a little gentle probing into the issues of the patient's daily life. If the medical evaluation uncovers a specific diagnosis, be sure that both you and your adolescent understand what should be done about it—including the parameters for going to school versus staying home. If the problem doesn't appear to be an ongoing physical illness, develop a game plan for dealing with mornings when your teenager doesn't feel well and agree on the ground rules for school attendance.

If you uncover personal issues that are contributing to physical symptoms, don't shy away from working toward solutions. Whether it's a hard-nosed teacher, a hallway bully, an acute absence of friendships, or some other emotion-jarring problem, your teenager needs to feel your support and know you will help to find an answer. Making progress in one or more of these areas will typically go a long way toward shortening the list of symptoms.

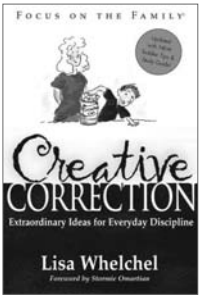
About the Author

Dr. Paul Reisser is a family physician in Southern California. He has been a member of Focus on the Family's Physicians Resource Council since 1991, and he served as the primary author of Focus on the Family's *Complete Guide to Baby and Child Care*. He married Teri, a marriage and family therapist, in 1975 and is still very happy about that decision. They have two grown children, three wonderful grandchildren, and one lovable but spoiled dog.

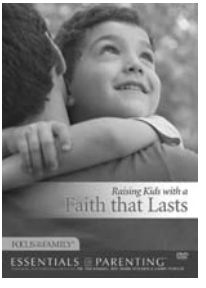
Look for these additional parenting resources wherever fine books are sold:

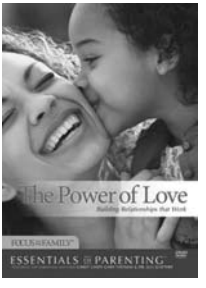


Complete Guide to Baby & Child Care is a comprehensive guidebook to parenting from before birth through the end of the teen years. It takes a balanced, commonsense approach to raising children to be healthy emotionally, physically, mentally, and spiritually. This indispensable guide delivers practical and critical information parents need to know, including 25 Special Concerns sections that cover topics such as fever in small children, effective discipline, ADHD, cyberspace safety, and much more!



Creative Correction
Drawing from her own family's experiences and from interaction with other parents, Lisa Whelchel offers creative solutions for parents who are out of ideas and desperate for new, proven approaches to discipline. In addition to advice on topics such as sibling conflict and lying, Whelchel offers a biblical perspective and down-to-earth encouragement for parents who are feeling overwhelmed.





Essentials of Parenting
Becoming a parent is one of God's greatest gifts in life. Children don't, however, come with an instruction manual, so where can parents turn to get the answers they need? Essentials of Parenting™ DVD series brings top childrearing experts into your home or church—with practical wisdom, honest confessions, and decades of experience.

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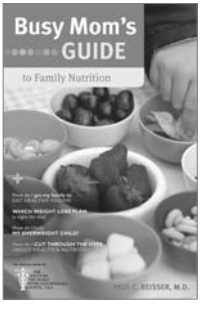
Busy Mom's Guide to Parenting Young Children
Using a question-and-answer format, *Busy Mom's Guide to Parenting Young Children* takes you from birth through age 4 with tips on sleep patterns, potty training, developmental milestones, and more. Tired already? Get energized and equipped for the journey with this quick reference guide, and look forward to the joy of growing with your child.
(Some content previously published in the *Complete Guide to Baby & Child Care*.)

Busy Mom's Guide to Parenting Teens
Using a question-and-answer format, *Busy Mom's Guide to Parenting Teens* gives you tips and solid advice as your child heads into the teen years and develops independence. Driving, cell phones, social networking, physical and emotional changes—your teen is being bombarded with new experiences! Don't just survive your child's leap into adolescence, take the journey together and learn to thrive. Your road map is inside this book—enjoy the ride!
(Some content previously published in the *Complete Guide to Baby & Child Care*.)



Busy Mom's Guide to Family Nutrition
Using a question-and-answer format, *Busy Mom's Guide to Family Nutrition* provides bite-size pieces of information, including nutritional basics, the skinny on fats, interpreting food labels, exploring popular diet plans, and much more. Improve your family's health quotient with this quick reference guide, and enjoy your healthy family!
(Some content previously published in the *Complete Guide to Family Health, Nutrition & Fitness*.)

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