Journal of Adolescent Health & Welfare

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Incorporating the Autumn Newsletter of the International Regional Chapter of the Society of Adolescent Medicine (IRC.SAM)

Letter from the Editor -

Dear Colleagues,

Welcome to our joint Youth Support / International Regional Chapter SAM publication. Most of the International members probably know of Youth Support and some of you have had our Journal in the past - I do hope that you will keep contact with us and exchange information. All our publications are available by mail order. You are very welcome to attend any of our meetings - and if you do come to England the chances are that we could extend our hospitality and find you somewhere to stay with colleagues.

International members are also invited to consider a stay with us as a sabbatical - we have had students and professors from a number of countries, including the USA and Russia!

Similarly if any of our local UK forum members want more information about the International side - please write in. The Society for Adolescent Medicine - SAM - holds annual meetings in a different city each year - 1993 was Chicago and 1994 will be in Los Angeles. The International Regional Chapter (IRC) of SAM meets at the time of the SAM convention and holds an annual dinner and scientific workshop style meeting.

The next workshop will be on the theme of Adolescents and the media and contributions would be welcome.

Best wishes,

Diana Birch
Director Youth Support

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Youth and The Media

International Workshop

The International Regional Chapter (IRC) of the Society of Adolescent Medicine (SAM) will present a

full day workshop

on the use of media with young people on

Wednesday March 16th 1994

as part of the annual SAM meeting to be held in Los Angeles (March 16-20 1994) . If you have experience with the use of radio, television, video newspapers or brochures as a way of reaching adolescents and would like to present your experience at the workshop please get in touch with -

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- Daughter of Persia - A Review -

"Human beings are like parts of a body,
Created from the same essence.
When one part is hurt and in pain,
The others cannot remain in peace and be quiet.
If the misery of others leaves you indifferent
And with no feelings of sorrow,
You cannot be called a human being."

Sa'adi thirteenth century Persian poet.

From time to time we have included in our journal material relating to the coming of age of adolescents and particularly women. It seemed appropriate that in this, the 75th anniversary year of the Suffragette movement we should review the autobiography of Sattareh Farman Farmian who made a transition from the life of her father's Harem to that of a modern day social worker in the west.

Sattareh spent her early years within the walls of her family compound and her childhood playing in their enclosed garden or 'pairidaeza' - though the origin of our word Paradise, this world was somewhat less than idyllic for the older women of the family.

"I was the fifteenth of his thirty six children and the third child of my mother who was the third of his (eight) wives .. they were married when my father was in his middle fifties ... naturally my mother, who had been raised in the strictest traditions of Shiite Moslem womanhood, assented without a murmur when she was told that she was to be the next (3rd) wife of (her father's) employer and whom she had never seen. Nevertheless .. it had been very hard for her. She had been only twelve years old..."

Sattareh's 12 year old mother, newly married quickly became pregnant. "She knew nothing about this condition and had not a single competent adult woman to advise her.... Her own mother died in a cholera epidemic and her father had brought his eldest daughter her six and nine year old sisters for her to raise."

"..Being very devout she parted her thick waist length black hair straight down the middle winding it tightly in a plain heavy bun at her neck and never set foot in public without her chador. Her existence was one of unremitting toil .... Like nearly every other Iranian woman of childbearing age, when she was not nursing one child, she was usually pregnant with another and by the time I was sixteen and she was about thirty-nine there were nine of us in all."

One of Sattareh's accomplishments was to introduce family planning to her country. Iran's birthrate was one of the highest on earth.. fathers and mothers made desperate by the arrival of babies they couldn't afford would send their children out onto the streets to beg or shift for themselves or abandon them..

In the early sixties she founded the 'Family planning association of Iran' - helped by the US based Pathfinder fund. Despite their hardships, many of the older women clung to traditional values and

distrusted the new ideas of family planning and contraception - provoking conversations such as the following - .

..." You are saying you do not want women to get close to their husbands"
.. "She's saying that now, with this little white pill, they can get close better, because they won't have to worry ."
"... He always told us that having lots of babies made women more radiant .. That was just like him - he didn't have to have them himself! So maybe the pill too is part of God's plan."

The family planning pioneers found themselves supported by Al Azhar University in Cairo which issued a ruling on birth control. They found that the principles of contraceptive practice were in accordance with Islamic law because the planning and spacing of children promoted the health of women and the financial well being of the entire family.

Eventually Sattareh found herself caught up in the Islamic revolution and her work came to an end as she and colleagues fled to the USA. This biography provides a fascinating account of a family living through turbulent times but is also an example of how politics can manipulate religious principles and sociological ideas to it's own end. Whatever country we work in we need to ensure that good health care provision is not dependant on political decision.

Daughter of Persia - A woman's journey from her father's harem through the Islamic revolution.
Sattareh Farman Farmaian - Bantam Press 1992 - Corgi edition 1993

Family Values - Are we letting young people down?

A recent issue of the VOICE - London's main Black newspaper - carries an article by Tony Sewell - 'Bring the Family Back'. Tony makes the point that the black community is open to criticism that the notion of the black family has become extinct. In the UK, fifty percent of black families are run by single mothers.
"..There was once criticism of black men who irresponsibly roamed the inner cities leaving babies in their wake .." now times have changed and it seems that women are encouraging the idea of the maraundering male by wanting man just for his procreative possibilities.
" .. The new independant Black woman will not hang around for her man to get responsible - she'll take the baby and run.
...Increasingly , Black men are becoming walking sperm banks - not only for the naive, wide eyed teenagers, but for those high flyers who are watching their biological clocks..."
It would appear that committment and loyalty is something that few people are prepared to invest in a relationship - Tony concludes that black men and women have forgotten how to love each other. - Maybe so, but looking around our inner cities, it is self evident that it is not just the Black community which is suffering the affliction of the absence of family.

The late Arthur Ashe said "I believe in abstinence from extramarital affairs. I think such activity is morally wrong, as

well as contractually wrong in the context of the vow one takes in marriage. I absolutely believe in the need to refrain from promiscuity. This is a term almost always applied to women and almost never applied to men, but in writing of promiscuity I am thinking above all of men and the double standard by which we have lived for centuries. Nowadays it is true, some women measure their freedom in the same way, the ability to be sexually promiscuous. I think this is not freedom but one of the fantasies of freedom. Both men and women should realise that promiscuity is as often as not a condition of violence against our own individual best interests'

International Dinner

Wilfred M. Lee (213) 556 3388

JADE WEST

ABC Entertainment Center Century City

2040 Avenue Of The Stars Los Angeles, California 90067

The International Regional Chapter SAM will be holding our annual special interest group dinner on
- Thursday 17th March 1994 - 7pm-
This year we will be having a Chinese Banquet at the Jade West - Century Plaza which is within easy walking distance of the SAM conference Hotel. Cost of dinner will be $30 per head and an alternative vegetarian menu is available. Please let Diana Birch or Aric Schichor know if you wish to book a place or sign up at the wednesday workshop. It's going to be a great night out!

Third European Forum for Adolescent Health

Youth and Society: Barriers and Opportunities

July 4th and 5th 1994

at the University Hospital for Children and Youth
Utrecht - Netherlands

Many young people find barriers on their way into society. These barriers may, for instance be linked to a disability, handicap, an immigrant status or unemployment. The conference will focus on intervention programs to remove these barriers and to enhance opportunities for a succesful integration into society.

For Information contact - **Gerben Sinnema** - University Hospital for Children and Youth
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"Working with the family that is not there"

- The Philosphy of Youth Support House -

Youth Support House is run as a therapeutic community. All our transactions with residents, patients and clients are based on psychotherapeutic principles. This means that not only are residents involved in formal therapy 'sessions', but that everyday living experiences and conversations are used as opportunities for informal therapy.

The type of client who we often see at Youth Support and particularly our teenage residents, do not always respond well to formal therapy such as sitting in a room with a therapist for an hour of individual work - they are not able to keep up regular appointments and their attention span is often short. Interpretations are not always acceptable. They often do not understand therapy.'Active' therapies are useful - art therapy and dance/ movement therapy are obvious examples - but just as an activity can be used therapeuticaly in such disciplines, so everyday activities can be a focus of therapy in a unit such as Youth Support.

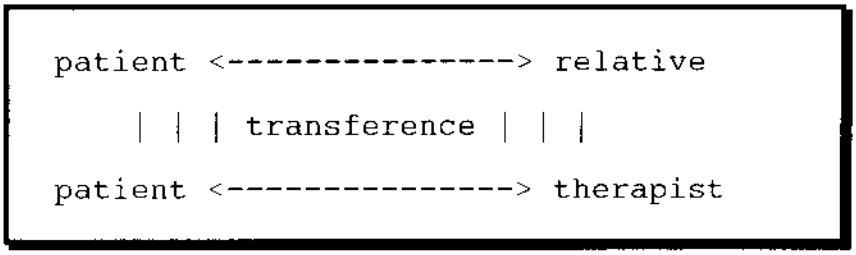
The following paper provides a guideline as to the philosophy of therapy and care within the unit taken from the direction of working on the family background. It was presented as part of the International Chapter Workshop on Youth and Families which coincided with the Denver SAM meeting of March 1991.

Working with Families?

When working with disturbed teenagers our motto should be **Ignore the family at your peril!**. Should we however aim to work with the family or in spite of the family?
Traditionally the family therapist works by assembling the whole family in a room and observing and perhaps conducting their interactions. There obviously needs to be a considerable degree of cooperation in this process and it must be said that a fairly high proportion of family therapy is conducted in the private sector where motivation to comply with therapy is high.
What can we do when families have no wish to 'interact' in a goldfish bowl or when family tensions and perhaps violence are so strong that the therapeutic situation cannot hold them? I would suggest that the alternative is to work **'through the family'.**

In working with young people from very disturbed family backgrounds or in situations where they have been removed from their family of origin we can work through the family by observing transference issues.

Freud was the first to formulate the concept that emotional illness developed **in relation** to others. Thus arose the idea that it was possible to heal or modify the relationship by creating a 'therapeutic' relationship with a therapist from which parallels could be drawn to help the patient. This **'transference'** process involves two aspects - the therapists **interpretations** and the patient's learning how to cope with situations by **inference.**



In working with **the family that 'isn't there',** transference ideas can be applied to the 'group' both in the formal sense of the therapeutic groups within the unit and informally looking at interactions in the 'living space' of a residential setting.
This works both ways. By observing emotional reactions and interchanges the family norms and beliefs can be postulated. While at the same time knowledge of the family background can help us to understand disturbed patterns of behaviour. Looking at this in one direction only ie listening to only one half of the story can lead to pitfalls in interpretation.

Example 1. Ann was placed in our residential unit after a long history of abuse of both herself and other family members by several male relatives. She had a child by her stepfather and the father of her other three children, whom she had married, was accused of sexually abusing her younger sister at age 14.

In the unit Ann was unable to ever express her opinion on things, she would never take sides. If there was a dispute between residents or someone was accused of breaking a rule her reaction was always 'Well, if they say that has happened, then that must be so, Maybe someone has done something wrong but it's none of my business really, maybe I would have done the same'. She always spent time with other girls who were distressed and generally acted as peacemaker. Ann's behaviour in the unit parallelled her position in the family - she had been frequently pressed into taking sides - either with mother who tried to maintain a facade of caring, despite having exposed her children to repeated abuse; or with stepfather who had abused her; or with her husband against her sister ... She was caught up in the double bind of feeling guilty at having been abused and feeling sorry and responsible for the abusers. Thus she was condemned by her social worker for not having denounced her husband when he raped her sister and similarly condemned when she looked after her uncle after he had been found guilty of incest. In a family where there was no security and no idea of whom to trust, Ann could not know which side to take in order to survive.

Therapy thus centered on correcting Ann's functioning within her 'replacement family' - the unit - by encouraging her to trust that she would not be abused, feel safe in expressing herself without criticism, and to be able to develop self confidence - and subsequently to enable her to use this new role in the 'real world'.

Example 2 - In Tracey's case - knowing half the story resulted in a partially erroneous interpretation. Tracey had been in care all her life while still maintining some contact with family. She was a very needy, immature young lady. Her story was that her mother had abandoned her and run off with several young men. At times there had been reconciliations but swiftly followed by another affair and the children being abandoned again. Tracey described her mother as a 'slag' (promiscuous slut) who had even gone to bed with her social worker.

Tracey's behaviour in the unit deteriorated suddenly after she had been discovered with a boy in her room and simultaneously seemed to have been 'ditched' by the father of her baby. She attacked her care worker and accused her of sneaking men into the house and sleeping around. On several nights she kept everyone awake by hammering on the staff doors shouting 'slag, slag'.

The initial interpretation, based on what Tracey had disclosed in therapy, was that she was torn between being different from her mother, being a good mother to her own baby, and ending up like her mother -she was afraid of becoming a 'slag' , felt an inevitable pull to follow that path and seemed to be accusing others of the very thing she was afraid of becoming.

The other side of the tale emerged after contact was made with the social worker who had supposedly slept with Tracey's mother. It appeared that the family were under the strong influence of a bullying father who continually berated his ex wife and had built up a family

myth of the abandoning, sluttish mother. In fact he had been the one to abandon the children and had also abused them. The family pattern was to avoid getting close to 'mother' and when closeness was threatened, to break up the relationship with accusations against the carer and disruptive behaviour aimed at fostering rejection and break up of the 'family' unit. Tracey had repeated this pattern in other homes and foster situations when she had caused breakdown of all her placements.
Understanding this mechanism enabled us to show **solidarity** within the unit thus confounding her wish to break us up, continue to show **caring and consistent** reactions to her, thus not being manipulated into rejecting her and **confronting** her false allegations with statements of fact.

Solidarity <----------> Break up

Caring <----------> Rejection

Truth <---confrontation---> Falsehood

In assessing the family functioning and teenagers roles within the family we have various levels to consider. -
Our patients are often teenage mothers hence we begin on the level of the
' immediate family' - ie girl - baby ....boyfriend
these are influenced by the
'family of origin' girl - parents ..siblings
and on a deeper level by
Transgenerational issues
and are mirrored in the
'transplanted family' - girl - adoptive parents
girl - residential staff

It is possible to view many of the concepts of family therapy in the context of the 'transplanted family'. Let us consider some of the issues which are prominent in the type of family seen at the Youth Support unit.
Boundary issues. Many of the abusing families, such as Anna's have almost non existant boundaries. THere is poor differentiation between individuals with a tendency for personalities to fuse - the situation has been described as an 'undifferentiated family ego mass' (Murray Bowen 1978).

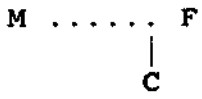
Boundary issues operate on
intergenerational level - invisible loyalties and indebtedness - (cf Anna letting Uncle stay)
personal space -intrusions and invasions (incest)
emotional space no room for own feelings
Information space -live by others opinions - mother answers questions

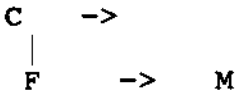
If there is *too much enmeshment* -there is a *loss of autonomy* - if the individuals are *too disengaged* - there is *loss of intimacy*. In a disturbed family the teenager

can oscillate emotionally between these two extremes thus avoiding any real commitment to a relationship. Both extremes are equally painful.
THe boundary issue is seen to operate very qraphically in the interplay between teenage mother and baby. Tracey showed an almost complete symbiosis with her baby, who was almost used as a coat hanger - something to hang her feelings on - something to wear her watch, to look pretty for her, to put on more weight than the other babies, to laugh or be sick when Tracey wanted to attract attention or disrupt a conversation.

In the residential setting, *interpersonal boundaries must be scrupulously adhered to* and echoed by consistent handling in terms of house rules and 'professional' caring.

Triangulations and Collusions





In many of our families 'straight' communication betweeen family members has been difficult. The young person has often been used as a pawn in communication issues. Patterns may involve triangulations whereby parents avoid direct transactions by relating through the child or collusions when the child is made to side with one parent - often the abuser - against the other. Thus Tracey sided with Father against her mother.

These patterns, if repeated in the residential unit can be extremely destructive. Our clients are masters of **manipulation** and will consciously and subconsciously be continually attempting to triangulate and collude - setting up one staff member against another. We need to be constantly aware of these mechanisms and avoid being enmeshed while maintaining close communication on an open 'honest' level.
It cannot be overestimated how powerful the pull to follow disturbed patterns of behaviour can be and how much energy our patients use in trying to ensnare us - trying to make us behave like the family of origin.

Our **staff support** group often dwells on this issue alone and is vital in maintaining care workers morale - it is the easy path to allow girls to **recreate their family of origin** - it is a tough order to maintain the integrity of **'our family'.**

The technique of **cross confrontation** is of value in family therapy - ie showing family A who is unable to express feeling how family B is able to do so and is not destroyed by the process. The residential Unit can function on this level by demonstrating how this 'transplanted or substitute family' can cope with emotions, can handle family secrets and can accept the young person as a valued individual no matter what his or her background might be - can do this without being destroyed by the process - and moreover can emerge still caring for and accepting of the young person in its care.

Family of origin
Family A - afraid of emotions
- destroyed by emotions
- release of family secrets = destruction
- rejecting if above taboos broken

cross confrontation

Substitute family – unit
Family B - encouraging show of emotions
- surviving emotional outbursts
- not destroyed by discosure of secrets
- not rejecting

Hence the residential unit can operate as a **therapeutic community** in which by applying the principles of family therapy and transference issues teenagers can be helped to work through the emotional scars of disturbance in their family of origin even in the absence of the family members.

International Chapter Editorial

Roger Tonkin

I have just returned from Seattle and the fall meeting of NWSAM. Six of the two dozen attendees were from BC. It was a light enjoyable evening dinner meeting with Chapter colleagues. It featured an after the meal address from Richard MacKenzie . The combination of the thrust of his talk, current hapenings within SAM, and the fact that I will be stepping down as Chapter President and Newsletter editor this coming March prompt my present musings.

Let me begin with a few reflections on Richard's talk. It's theme was "Adolescent Medicine Past, Present and Future" and he offered us a sense of the rich history and early struggles of SAM and of Adolescent Medicine within the USA. For example did you know that early leaders in the field eg Roswell Galagher, MacKenzie were internists? The earliest meetings of SAM were convened in bars and it wasn't until the mid seventies that a formal scientific program with research presentations began. One definitely got the sense of an evolving group and the important role that early leaders such as Richard M, Michael Cohen must have played. SAM's evolution from a small group of professionals on the fringe into the present mainstream organisation with over 1000 members was , in Richard's mind, clearly linked with the development of the knowledge base of Adolescent Medicine and the clinical committment to adolescents. Promotion of academic and research activities was seen as important but I think that Richard sees the development of non-traditional models of adolescent health care such as 'The Door' as the base upon which contemporary Adolescent Medicine is built. - But what of the future?

Richard saw the immediate future of SAM as being linked to happenings in the USA. For example, the new subspeciality certification and 3 year fellowship process, SAM's new role as advocates for Youth , and last but certainly not least, Health Care Reform. He also suggested that the future will depend on the ability of our programs and professionals in Adolescent Medicine to respond effectively in the present situation. In essence, Richard's view is, if I understand it correctly, that SAM and it's membership will get a brief opportunity to respond to contemporary challenges in health care reform and how we respond to this challenge will shape our collective future.

From my vantage point the future is differently shaped. Certainly the factors which mold it should be different. What began as a collection of interested USA-based physicians has become a world class academic organisation that focuses upon medicine for adolescents. The model that we now see is of academic programs not of non-traditional or outreach activities. The annual showcase meeting, while excellent, is dominated by academic paediatricians and research presentations on a narrow range of topics. These present features of the 'SAM Model' are impossible to replicate outside the USA. If Adolescent Health Care is to flourish as a discipline we, in the international community, must learn to adapt the USA model to our needs and priorities.

Advocacy and responding to the politics of health care reform or even the creation of a sub-specialty in Adolescent Medicine may preoccupy the bulk of SAM's energy and resources in the months to come. The longer term challenge for SAM will be how best to draw upon the broader, interested and committed multidisciplinary community of Adolescent health professionals within and without North America. It is my belief that in the interim, we in the international community must continue to prompt and challenge SAM's leadership to remain multidisciplinary and to retain an international perspective. As we turn our attention to the adolescent health needs of our own countries we will continue to draw upon the expertise of our colleagues in SAM. AT the same time , SAM's leadership, as it faces the immediate challenges of health care reform, should be encouraged to draw upon the collective experience and perspective of it's international colleagues. In this way the future of adolescent health care around the globe will leap into the future and acheive a plane that Richard MacKenzie and the early pioneers in our field have not yet envisioned

International Chapter News

Roger Tonkin

It has been a quiet few months on the chapter front Diana Birch and Aric Schichor have been working on plans for a full day workshop in LA next March 1994. I am really grateful that they have assumed the reins for this endeavour. More details elsewhere in the newsletter

The society is taking a close look at it's chapters and their role within SAM. Diana Birch attended a full day workshop on this subject last March and will continue to maintain a watching brief in this regard. Suzanne Riggs reported to the executive board of SAM (fall 1993) - An excerpt from her report reads -

. As a result of the March 1993 Regional Chapter meeting a regional chapter steering committee was formed to work on the issues of structure and function of regional chapters in relation to SAM. The Committee consists of Drs Barbara Cromer, Rich Brookman, Jim Farrow and Regional Chapter members Drs Maurice Schneider, Terry Gilbert, Rob Lehman, Chuck Wibblesman plus myself. The steering committee has had several conference calls this summer and have prioritised the various issues discussed in March. As a first project the steering committee is seeking to foster increased organisation and standardisation in the function of Regional chapters. In this vein we have developed and circulated a 'bioler plate' constitution with th erecommendation that all chapters would adopt a constitution which would have some similarity and some standardisation in terms of officers, times of elections and a reporting mechanism to central SAm for financial data as well as the details involving a chapters organisation and activities The regional chapter steering committee would very much like the executive board of SAM to consider whether a suggested constitution and organisation for regional chapters should be part of the by laws of SAM wit h regard to Reional chapters. (There is a specification that a president of a regional chapter needs to be a member of national SAM and there are specifications as to how many members of national SAM have to sign a petition to form a new chapter). ....'

A 'bioler plate' constitution, requirements for financial reporting and standardization of chapter election of officers seems to be in the works. The question for our chapter is whether these actions should be applied to the non USA chapters. It would seem questionable, indeed three of the five international chapters have, since last March, ceased to exist (Western Pacific, Eastern Pacific, Eastern Canada, Western Canada) The two remaining chapters with non USA membership are IRC and NWSAM. Hopefully, we will have more news and a lively debate in Los Angeles next March.

This newsletter is moving towards becoming a shared activity. Diana Birch and her Youth Support publication and John Court and the IAAH newsletter will each share responsibiliyt for a joint issue. The chapter will also produce a fall issue (this one) as a way of letting the membership know about the spring SAM meeting activities. Contributions from the membership are always welcome. Of late, they have been sparse or we have been too late in printing them.

International Chapter News

Roger Tonkin

LA Meeting - March 16-20 1994 Century Plaza Hotel

The Official program for the spring annual meeting should be out before the Christmas break - It will contain the usual mix of Institutes, Workshops, Special Interest Groups, Professional Interest Dinners; General Events and presentations.Special for this year's meeting is a media focus including an exciting range of what are classified as "Media Luncheons" Look for more details in the program booklet

Once again there will be a number of international activities. These include our own day workshop (now called an Institute) entitled "International Perspectives on Adolescents and the media" an off site Professional Interest dinner and our Chapter's breakfast meeting.

Resources display - the LA meeting will include a special display of educational pamphlets and other health education materials. If interested send one copy of each pamphlet along with name and adress of publisher and cost to Paula Braverman.

SAM and Change -

For some years now the Board and Executive of SAM have been going through a process of self examination, priority setting and change The society continues to support and encourage it's International membership but it is clear that as a consequence of the broader organisational shifts, the role of the non-USA based members within SAM will change We need to make sure that our input is heard.

SAM sees itself as becoming a North AMerican organisation with an International membership. This move will have important implications for the development of IAAH as the international body in the field. However it remains important that SAM retain a provision for non-USA based clinicians to participate at all levels of the society Many of us wish to continue our links with SAM and to be able to enjoy it's many benefits (collegiality, resources, Journal, annual meeting etc)

SAM is examining it's management approach and giving serious consideration to relocating to Washington DC. These are not easy changes for the society to make. Some of the decisions will be controversial and are likely to generate a heated debate within the organisation. It is critical that the society take steps to avoid divisiveness and to preserve the personal touch which has characterised it over the years As international colleagues we have a stake in this debate and should not hesitate to learn more and to make our views known.

SAM sees it's regional chapters as cornerstones in it's development as a multidisciplinary society advocating on behalf of Youth in America The priority being given to advocacy and the changes that it will require of the organisation will, in my view, preclude or at least greatly reduce the international membership's voice in many aspects of the society's future activities. How then should we encourage SAM to proceed? Do we maintain a single international chapter and redefine it's constitution, procedures etc. Do we simply disband IRC/SAM and become absorbed into the general membership of the Society (not all of whom belong to a regional chapter)? Do we lobby the board to create an administrative section within the membership and charge the central office with dealing with any special issues that the international section identifies?

International Section of SAM?

In the preceding pages I have outlined a number of current themes within SAM. It is my belief that the international membership of SAM is valued by the society but at risk of being

International Chapter News

Roger Tonkin

disenfranchised by the current developments within and without SAM. As a board member I have encouraged and supported our American colleagues as they have made decisions and set priorities. I would like to promote a discussion on the creation of an administrative section within SAM that would replace IRC/SAM and better serve our needs. Such a section might have a different fee structure; might be eligible for direct financial support for it's activities; would not be dependant on the goodwill or generosity of any single individual; might become the vehicle through which certain SAM benefits might be chanelled to the international members; and could create a special forum for input to the SAM board.

This is not the first time that I have floated this proposal. So far it has not received much discussion. However the time for needed change is imminent and we must at least explore our options. Your input is encouraged. Write to Diana Birch or I (or key individuals within SAM such as Lonnie Zeltzer, Suzanne Riggs).

Youth Health Assembly - Vancouver 1995

Planning for this exciting event is moving swiftly forward. It will be held at the Vancouver Trade and Convention centre from Monday March 20th to Saturday March 25th 1995. The Assembly will feature three overlapping events: A Youth for Youth Health conferencefeaturing 200-300 delegates from around the world; the 6th International Congress on Adolescent Health featuring the multidisciplinary scientific Adolescent Health professional community from IAAH and the traditional annual (27th) scientific meeting of SAM.

The theme of the Assembly is Youth Empowerment in the context of health care reform. There has been active collaboration between SAM and IAAH in planning committees. There will be a common registration fee, all programs will be open to participants from each event and there will be a common set of program announcement brochures. A special feature will be an extensive International exhibitors area with an emphasis on programs that work for youth health.

This promises to be a unique, must be there, event. It will be another important milestone in the annals of adolescent halth care. The venue is superb, the program will have a distinctively international dimension and the pre/post Assembly options will be attractive to those wishing to take advantage of being in Vancouver at blossom time. For more details look for the preliminary brochure in your january mail or stop by our display at the LA meeting.

"Uncle" SAM  Needs You!

And so does his newsletter!

It has been four years since the rebirth of the SAM Newsletter. Happily the reviews have been kind: the criticisms constructive. After the next issue (Vol 4, Number 3) our current editor willbe stepping down as he and his wife anticipate the arrival of their first child in early March. - This is where you come in! We here atthe newsletter are confident that one or more of our readers are ready to steup to the plate and keep the rally going" (Please forgive seasonal baseball references.) Waste no time in contacting Sam LeBaron - Director of Publications SAM 19401 East 40 Highway, Suite 120,Independence Missouri 64055

NB:Newsletters need contributions - from YOU! This applies also to the Chapter Newsletter and Youth Support Journal contact Roger Tonkin and Diana Birch respectively.

IRC Workshop - Chicago 1993
- School Health Education - An International Review -

The following formed the basis for our discussions at the International Regional Chapter SAM meeting in Chicago March 1993.

Health education programmes and practices vary across international boundaries, but considerable variations may also exist between different schools in the same area. There is still dispute about 'who does what' - the outside expert vs general teacher debate continues, and the content of programmes is not standard.

Many models have been put forward by educators and health workers usually in response to a particular public concern eg anti-smoking campaigns, HIV epidemic etc but it would appear that most models do not fulfil our specifications.

Why are we failing to communicate the desired message to youth? Often what seems to be a fantastic, hard hitting campaign misses it's target **- good advertising does not equate with good teaching.** A clever catch phrase may be remembered as just that rather than the underlying message it is meant to convey. Associating a message with a topical subject or a media figure can convey the opposite message from the desired one. Associating rock stars with HIV campaigns can be interpreted as - let's all live in the fast lane - who want's to live to be thirty? We can be **aiding the creation of an alternative value system.**

How receptive is our audience and what influences that receptiveness?

We might consider - a) **General factors** - 'learning ability' and societal variables which influence the ability of groups of teenagers to receive or benefit from an educational message.

Children attending schools in poor areas or young people from deprived families have the greatest need of good health education -however they are also those least likely to respond to school lessons and have higher rates of special educational need.

b) **Personal factors** - Emotional and psychological factors are of prime importance in considering the way that young people receive a message. Identity and nature of the 'self' - are we talking to the calculating, thinking 'adult' in our patients - or the feeling, intuitive 'inner child'. Self worth determines whether we 'deserve' good health, influences our ability to choose lifestyles. In our English study deprived girls 'used' pregnancy to boost self esteem and hence were unable to hear the contraception message. An external locus of control precludes taking responsibility for our actions

INTEREST
IDENTIFICATION
IMMEDIACY

Programmes - What are the basic precepts of a successful programme? Consider- arousing the young person's **INTEREST;** encouraging **IDENTIFICATION;** and **IMMEDIACY** of the message.

Avenues and Approaches - Multidimensional - using several channels to target different groups of teenagers. A good example provided by the Swiss.

Interactive /involving youth.
Youth Empowerment.
Utilising and enhancing **resilience** of youth - Australian approach.
Message to be absorbed and actively **practised** - not just taught. An example being the British Columbia **"Learning for living"** curriculum - an analysis of the whole school - healthy school projects.

An example of a sex education programme - the following factors should be considered - **Personal / Emotional**
Factual / Information
Relationships / Interpersonal
All themes recur at different levels of understanding

Early stage (approx 5-10 years)	
Personal	Trusting people Protecting ourselves People we don't like Choosing what we want to do / saying no
Factual	Simple 'Where do babies come from?' Answers to posed questions
Relationships	Friendships - 'my best friend' Respect for others/Sharing, playing together Brothers and sisters - Families Looking after others (early parenting) Babies need mothers and fathers.

Middle stage (approx 10-12 years)	
Personal	Being in control of lives Self worth
Factual	Basic 'facts of life' / Biology Menstrual cycle / childbirth
Relationships	Loving and being in love Parenting

Later stage (approx 12-16 years)	
Personal	Choices / how far / who where does it lead
Factual	Pregnancy + control Contraception /Abortion/Infertility Sexual physiology / responses Sexually transmitted diseases
Relationships	Sexual relationships Protection within relationships Sexual abuse and exploitation Types of sexual relationships

Relationships
Getting close to people <----> deciding how close. **Which people? <----> How do we choose?** **Protection <----> dangers + advantages**

New Home for BCCH Youth Clinic In Burnaby's Overlynn Mansion

On October 1, BC's Children's Hospital's Eating Disorders program headed by Dr Roger Tonkin, made a long-awaited move from Sunny Hill Health Centre for children to a new and larger location : Burnaby's Overlynn Mansion. "It's been a long time coming, but we are delighted with our new home" says Dr Tonkin " The house provides a warm informal ,family-oriented environment, which is the perfect setting for a program like ours" It's beauty as a heritage site, coupled with it's central location, has long made Overlynne the preffered site for expansion of teh eating disorders program. But plans had to be put on hold when inspections last year revealed that the site did not meet building codes for the city of Burnaby. The move was delayed until the Children's identified a funding source for necessary renovations. Earlier this year th eVariety club of British Columbia generously contributed funds to bring the building up to code. This work is now completed and Dr Tonkin and his staff have been at Overlynne for a month. "Since most of our patients come from the Fraser area, Overlynne allows us to bring care closer to our patient's homes " he explains, "In addition we now have enough space to substantially expand our group programs. We also have enough space that we can finally develop an extensive patient family and professional resource library specializing in Youth issues" For the future, Dr Tonkin says Overlynn provides many unique features that may allow for the program to expand to provide residential services. "We are working on a kitchen now, we are currently seeking funding to begin a residential program in the next few years. This will greatly improve access to our services for adolescents who live in teh more remote parts of the province as well as providing a more appropriate and less costly alternative to hospitalization" Joining the program shortly is Dr Sandy Whitehouse, a paediatrician with a special interest in Adolescent medicine. Dr Whitehouse is from London Ontario and her new role will include expanding the scope of the youth care program and increasing the hospital's outreach capacity. Overlyyn will also provide work space for researchers specialising in youth health issues from both BC and the McCreary Centre Society.

Change of Address

Children's Hospital 's
Eating Disorders Clinic
Overlynn Mansion
401 North Esmond
Burnaby BC
V5C 1S4
Tel 291 6786

- Suicidal Adolescents : Lessons to be learned from early intervention -

Patrick Alvin MD - Hospital Bicetre-Peds; 78 Ave du General Leclerc; 94275 Le Kremlin; Bicetre Cedex; France

The following is an excerpt from a paper in press in the Journal of Paediatric Child Health.

Suicide is a highly sensitive controversial stigmatising issue. Whether carried out, attempted or merely considered, suicide is not a disease like pneumonia or cancer, nor is it listed in DSMIII The problem of suicide is enigmatic in many ways. Contrary to a still common belief. it is not dependent on a specific illness or mental state and it cuts across all diagnostic categories.The problem is even more complex with Adolescents. because suicidal behaviour at that age cannot bc separated from the unique and challenging developmental processes of adolescence itself, and their tight connections with family dynamics and social context Furthermore research data on adolescent suicide attempters may vary widely depending on whether the subjects come from emergency rooms, pediatric floors psychiatric hospitals or psychiatric out patient clinics.

On the whole we as professionals have not been well prepared for the subject.Many of us , even among psychiatrists, shjare with laymen simple misconceptions about suicide. In fact, we may feel so uneasy wit ht hematter that we choose to deny , ignore or avoid confrontation with it The violence and apparent irrationality of suicidal behaviours contribute to many of teh observed individual or institutional defensive attitudes. Also, the lack of specificity and poor predictive value of risk factors may be discouraging in clinical practice The same is true for warning clues, such as recent drop in school performance, acting out behaviour or social ostracism. But adolescents suicide attempts are highly meaningful and are often dedicated symptoms of intense suffering. These acts appear to be critical responses to a usually long-standing series of inresolved , overt or covert difficulties. Suicidal adolescents are definitely relevant to adolescent medicine atthe outset. In our experience as well as in others, only a few require transfer to an inpatient psychiatric facility

*** LOS ANGELES 1994 ***

The **International Chapter** of SAM
Will be holding a **WORKSHOP** on Wednesday 16th March
Theme - **Adolescents and the Media**

Ideas and Contributions Please
Further details to follow - Keep the Friday evening free for our (Very) Informal **International Dinner**

Enquiries to Diana Birch or Aric Schichor
Fax Nos - 081 659 3309 : 203 548 5439

- Thoughts after SAM 1993 - I suppose if there was one message that I took away with me from Chicago - it must be "Jordan is God!". My son and I had three aims to fulfill in Chicago (apart from my attending the scientific meetings of course). Aim one - to see the locations of our favourite film - "The Blues Brothers" - my office wall is actually decorated with a five foot poster proclaiming the famous words - "We're 120 miles from Chicago, we've got a half a tank of gas, it's dark and we're wearing sunglasses - let's hit it!" - Aim two - to visit Buddy Guy's, arguably the world's best Blues Guitarist - Aim three - to see Michael Jordan play with the Bulls .. we made two out of three but we could not get an audience with God - the tickets are sold out forever and a day! However I found the pro-sport attitude of the young people heartening. Certainly Jordan seems able to portray a positive role model - even if he does advertise MacDonalds Jordanburgers! It's refreshing to get away from the basketball/ AIDS connection - incidentally Magic's book on safe sex did a big belly flop with the youth of London - some people found his excessive promiscuity a 'turn off'- Contrast Arthur Ashe's comments overleaf. It was with the sport's image in mind that I included the following article in this issue.

- 'Martial arts' -
The role of the Sports Doctor.

Many young people involve themselves at some time or other in practise of the Martial arts. Fashions change depending on role models and current films and very frequently the choice of discipline is arbitrary.

In previous articles we have discussed the stresses of training for young people, particularly the psychological aspects. These certainly apply in the martial arts where children and youth can be exploited or led on to think that they can become Bruce

Lees or weedy adolescents picture themselves as the avenging hero of 'Karate Kid'.

As in any training, the most important factor in protecting participants and turning a potentially dangerous situation into an enjoyable and enriching experience, is a competent coach - someone who can bring the individual along at their own pace and within their personal limitations, bringing out their attributes and training to peak without undue risk of injury.

Any sport can become dangerous under the wrong 'teacher' but there are differences in emphasis and risk between the various Martial arts. It is perhaps part of the role of the sports doctor to advise youth of the comparative risks and to be aware of new trends and practices.

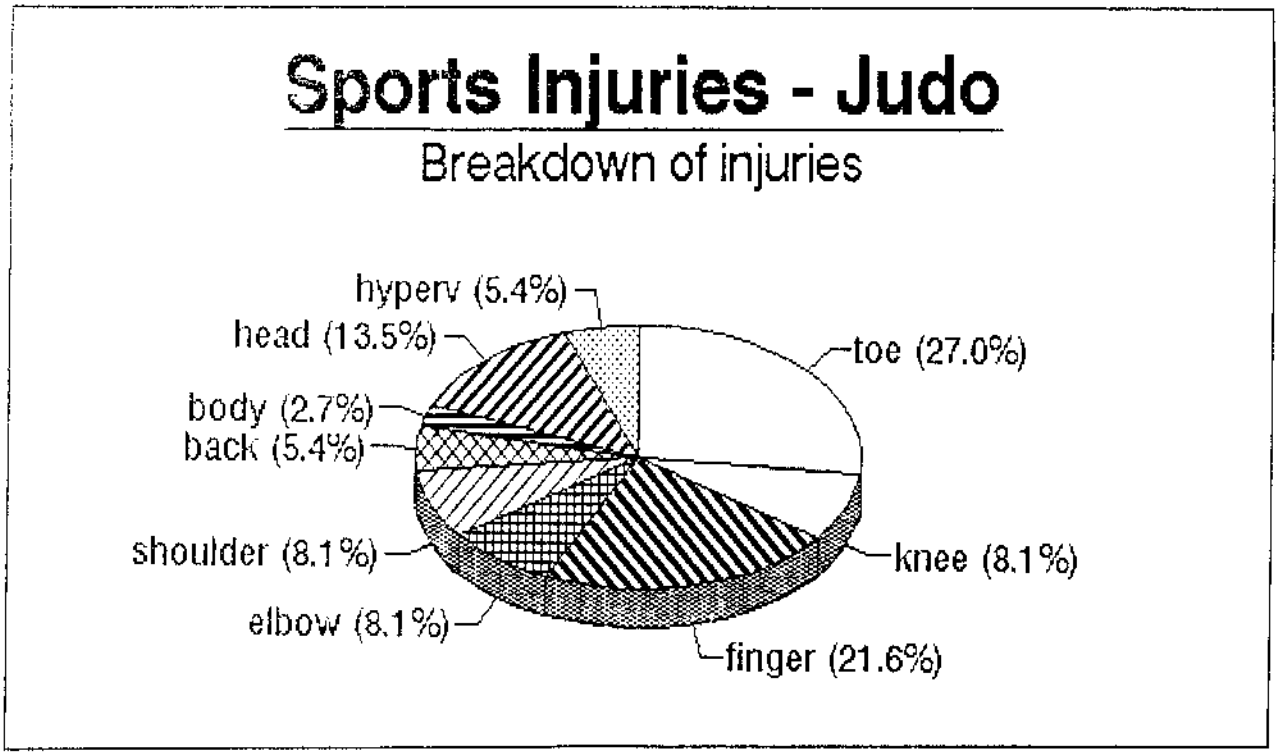
In the UK for a number of years the major Martial arts were Judo and Karate. Many young people did not know the difference between Judo - the so-called gentle way -and JuJitsu - which is similar but involves a higher degree of danger with emphasis on certain joint locks banned in Judo and direct blows. The Chinese and Korean sports of Kung-Fu and Taekwondo have now become more popular and we have also seen the influence of Thailand in kick-boxing.
Kick boxing,practised within a system of rules isa legitimate martial art - but there have been cases of youngsters (mainly girls) being more or less set against one another like pit bull terriers.There are other examples of 'fly by night' Sensei setting up so called Martial arts which can have serious physical and psychological dangers for their acolytes 'Kateda' was a recent example.

The lowest injury rates are in the 'Kata' forms of practise or 'patterns' which form part of the discipline of many of the arts. Tai-chi is actually a healing form derived from a self-defence discipline and can be safely practised by anyone whatever age. Aikido (in the original Ueshida non combatitive style) is a very safe martial art.

A breakdown of the type of injury prevalent in a Martial art (fig 1,2,3) gives an idea of the level of medical input required and an indication of possible preventive measures.

In Judo (Fig 1) players can exert a great deal of force upon each other and in a badly executed fall, the weight of the opponent can come down on a major joint causing fracture or dislocation - the shoulder joint is especialy vulnerable as are the knees where the rotation of a throw can put additional shearing stresses on the major ligaments. The

Fig 1



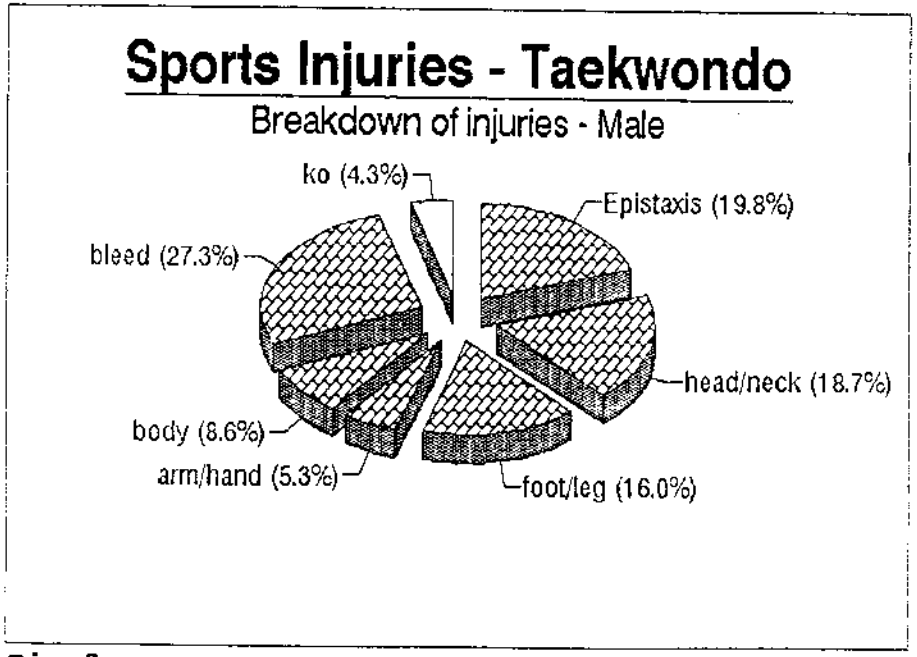


Fig 2

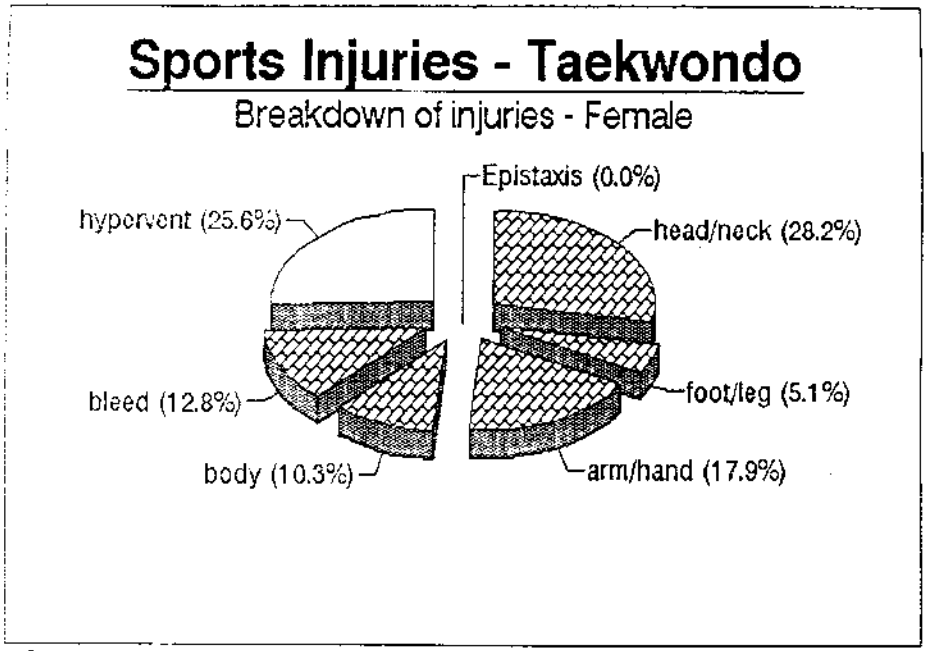


Fig 3

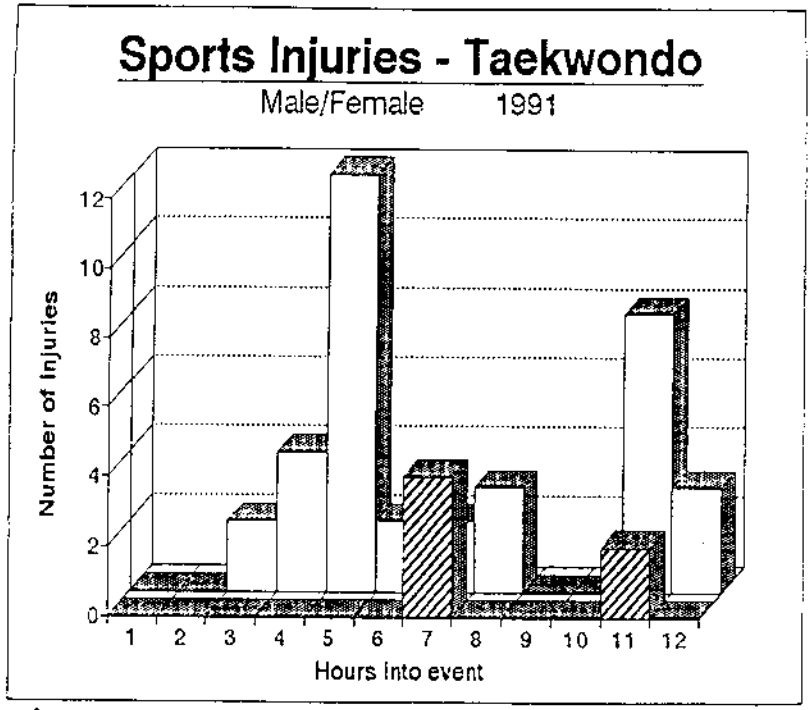


Fig 4

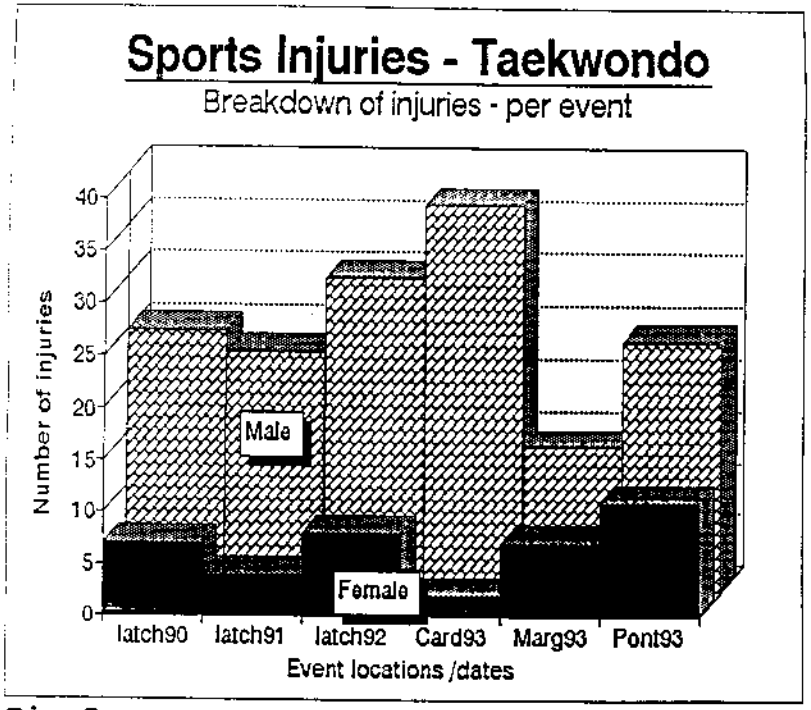


Fig 5

elbow joint can be damaged in falling or strained in a badly 'snapped' joint lock. The pie chart shows the high frequency of finger and toe injury - the extremities can catch in clothing during groundwork, toes can be stubbed on the mats and fingers are also prone to dislocations and arthritic changes in response to the pulling action exerted on the thick jackets. This is not a sport to recommend to music students who need to keep their fingers!

The head injuries in Judo involve eyes and ears gouged during ground work - cauliflower ears and haematoma of the pinna are common - unlike in Taekwondo where the compulsory use of headgear has eliminated such injury. The neck is more commonly injured in Judo where torsion can occur during groundwork or a faulty landing can strain the neck. In contrast, injuries in Taekwondo are usually due to direct blows - hence the common nosebleeds, broken noses and knock outs.

There are marked sex differences (Figs 2,3) in injury rates - knock outs are not usually seen in females and hyperventilation is a distinct feature of young female competitors and is not seen in club practice - young women can become extremely distressed, overheat from the contest, become stressed and hyperventilate. Lying them down in a calm cool room, away from their parents and friends restores them to perfect health - in this case, as in other psychosomatic 'injuries' the best cure is to win the round!

In Taekwondo most of the injuries to limbs occur during the breaking exercises whereas head and body injuries occur during sparring. A very high proportion of injury involves loss of blood - almost 20% are nosebleeds and a further 27% of injuries involve some bleeding - hence this is a potential risk area for the transmission of hepatitis B and possible HIV. Measures have recently been instituted to reduce risk of cross contamination with swabbing of spilt blood with bleach solution, changing soiled clothing and stopping a contest where repeat epistaxis has occurred.

The infection control aspect of the sports doctor's role is often forgotten - but clubs would do well to heed advice - often simple measures can drastically reduce infection. In American college wrestling herpes simplex was frequently passed from one competitor to another in head to head contact - in the UK we have seen this type of transmission in Rugby scrums - but the Judo mat is another important and often unwashed fomite for infection control.

When is a doctor needed in a competition? The simplest answer would be not JUST in the competition - adequate medical cover means following the sport and the needs of participants between events - advising on health measures and training stresses - however within a competition there are peaks when medical intervention is more critical. A chart of injury against time in a Taekwondo event (fig 4) shows how few injuries occur in the first few hours - during the 'patterns' and junior events. There is then a peak as the finals of the lower grades are reached and finally another peak as the senior sparring takes place. Late injuries occur in the breaking contest. The female injuries show two peaks - coinciding with the sparring finals and the breaking.

The injury rate varies greatly from one event to another (Fig 5) note the low rate in the Margate event an example of good organisation. The main way to avoid injury in competition, whatever the sport, is to have good training, good organisation and competitors who enjoy their sport. The lowest injury rates I have seen so far have been in the veteran events - sad that one has to wait to that stage to enjoy a Martial art - what can we do to 'take the heat' out of sport and encourage Youth to enjoy physical exercise?

Stronger Children - Stronger Families

1994 Year of the Family - Invitational Conference

on the UN Convention of The Rights Of the Child

June 18-23 1994

Conference Objectives -

To Build on earlier UN International Years concerning women Children Youth Persons with disabilities and Aboriginal persons, highlighting the interdependance of health of children and families in all areas

To promote the meaningful participation of youth, practitioners, policy makers, NGOs, researchers and government.

To showcase positive examples of national and international child and family programs and projects through a diverse range of media, workshops and events.

To promote international linkages among government and non governmental organisations, children, youth and families

To create a forum which will provide opportunities to develop strategies, identify roles and identify how Canada's report can be used as a catalyst for positive change.

Further details from - University of Victoria - British Columbia

Goings on at Youth Support

Youth Support House

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How does a child feel growing up with a mother only twelve or thirteen years older than himself?

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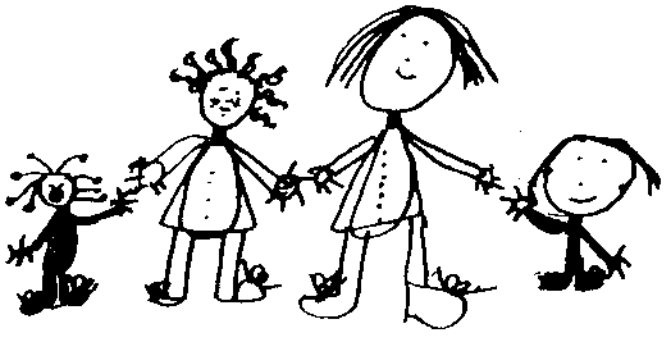

Youth Support -- Charity No. 296080

FORUM ON ADOLESCENT HEALTH AND WELFARE

The **Youth Support Forum on Adolescent Health and Welfare** was founded in 1986 as a support network and professional body linking together all those interested in working with teenagers.

Teenage welfare and Adolescent health have been neglected by statutory services and there has been no career structure in the UK for those working in what is often a very stressful but very rewarding field.

If you would like to be involved in:–

– **promoting the health and welfare** of young people.
– being part of a rapidly expanding **professional network**

Or if you are:–

– working at the 'front line' in **'high risk' areas** such as schoolgirl pregnancy; teenage sexuality; young people and AIDS; sexual abuse; drugs and violence.
– feeling that you do not have the **support** of your professional peer group.

Now is the time to **Join our Forum –**

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Annual subscription £20
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and journal)

Articles for our Journal and requests for meeting topics always welcome.

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Youth Support Professional Training
- Publications and reprints -

Journal - Back copies Journal of Adolescent Health and Welfare Back copies - (1988-1993) £ 4.00 each

Books

"Are you my sister, Mummy?" Study of school age pregnancy. 2nd edition 1992 £10.00

"Retracing the Echoes" Children of the Russian revolution - Emotional aspects of growing up. £ 3.95

"Inner Worlds and Outer Challenges" Development of the personality and assaults of emotional environment £5.

"Mother or Child?" Tape slide presentation

Reports, Articles and Reprints - £3.50 each.

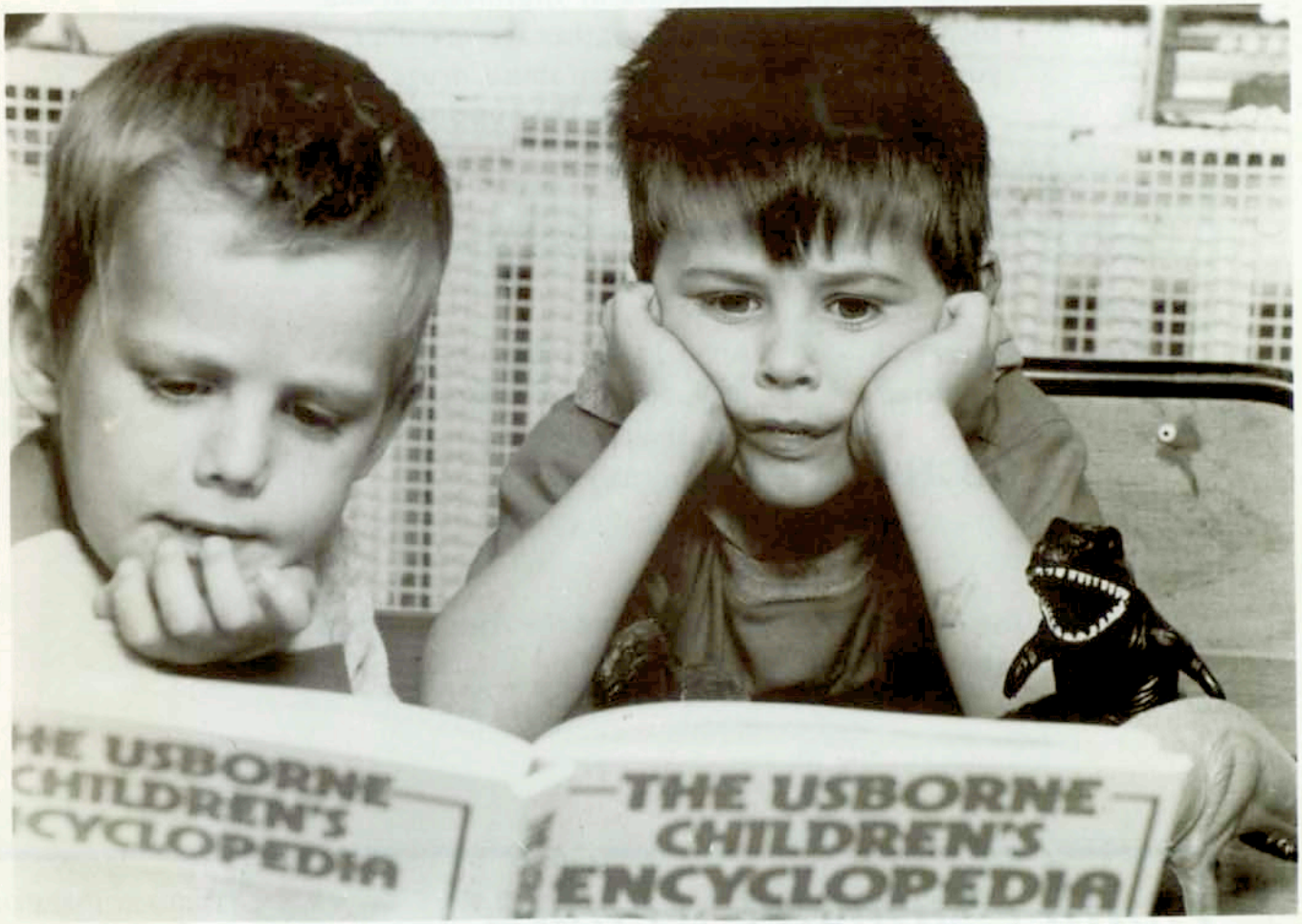
1.1 "Schoolgirl Pregnancy" overview and medical aspects.
1.2 "Teenage sexuality and the Media"
1.3 "Schoolgirl pregnancy - a culture of poverty"
1.4 "That old Black Magic? - Sexual belief systems.
1.5 "Schoolage Pregnancy, the International scene"
1.6 "Sex Education - Does Mother Know Best?"
1.7 "Teenage Pregnancy - A problem for the nineties?"
1.8 "Self Esteem in early pregnancy"
2.1 "The search for the True self in adolescence - the dilemma of childhood handicap"
2.2 Sports Medicine - "The Training stresses for children and Young People" "Diet and Preparing for the Marathon"
2.3 "Healing abuse - Working with family that is not there".
2.4 "HIV infection - AIDS and the Young" conf report.
2.5 "Providing staff support in child abuse procedures".
2.6 "Emotional Abuse - The hidden scars"
2.7 "Working with families - how not to perpetuate the abuse"
2.8 "Reflections-Emotional development,origin of personality"
2.9 "The invisible woman - the hysterical personality"
2.10 "Fear is the key - the depressed adolescent"
2.12 "One Track Minds - obsessive part of our personalities"
2.11 "Divided loyalties - the schizoid teenager".

Theses

These are avilable in limited supply and usually require two weeks delivery time.

'Schoolgirl pregnancy in Camberwell' - A population study of schoolgirl pregnancy, motherhood and two year follow up. London University MD thesis, January 1986 - soft copies £50 - loan £15 for one month.

"A Study of Self Esteem measurement in Schoolgirl Pregnancy" soft copies £15 - loan £5 for one month.



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