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

Letter from the Editor -

Dear Colleagues,

Welcome to Volume seven. This year we will be having our ninth annual scientific meeting at the Royal Society of Medicine and next year (1995) will be our tenth year of operation - time flies!

In this, the United Nations "International Year of the Family", we have seen an enormous growth in the family work carried out at Youth Support House. Most of this centres on child protection. So far as Adolescents are concerned, we are seeing both ends of the spectrum - teenage parents of both sexes referred regarding the relationship between themselves and their young children - and teenage 'children' referred with problems with their own parents.

In all our work, and particularly in child protection, we do need to remember that the young person is part of their peer group, part of our society and part of some kind of a family (even if for children in care and in children's homes this exists in fantasy only). Young people cannot be treated in isolation. The content of this journal echoes this concept.

The 1989 Children's Act which has been in operation since October 1991, is very specific in emphasising the need to work with families. Since the passing of the children's act a very high proportion of our referrals have come to us via the legal system for assessment or rehabilitation. Hence our 1994 meeting will focus on Child protection, child abuse work and the legal issues involved. As usual we are inviting contributions for the journal and are canvassing participation for the annual meeting.

Next year we hope to have a larger meeting with an International input to celebrate our Tenth Anniversary - format is yet to be decided but it will include a dinner after the meeting. I am hoping that we will be able to invite back some of the excellent speakers who have contributed over the years and that the meeting will cover a résumé of the most important topics in Adolescent Health and Welfare. Please contact us early if you wish to be included in any way. Presentations, suggestions for subject matter etc. will be welcome.

Best wishes,

Diana Birch
Director Youth Support

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Youth Support Forum on Adolescent Health and Welfare

Ninth Annual Meeting 1994

"Child Protection and the Family"

At the Royal Society of Medicine
1, Wimpole Street London WC1

On Wednesday 19th October 1994 6-9pm

Refreshments and displays at 6pm
Opening address 6.45pm

The meeting is multidisciplinary and will include contributions from professionals who are expert in the field including Child Psychiatry / Legal system / Social Work. Ample time will be available for discussion and questions to our 'panel' of experts.

.....

I would like to attend the Ninth Annual Meeting of the Youth Support Forum on Adolescent Health and Welfare at the Royal Society of Medicine on Wednesday 19th October.....

I will bring ..... guests.
I am a Forum member ..... (attendance free + guests free)
I would like to join the forum and enclose £20 annual fee.
I am not a member and enclose fee of £5 per person for attendance - total .....

Name ..... Designation .....

Address ..... Tel no .....
..... (Admission free to students and
..... young people under 21)

Youth Support - Family Resource Centre

In the United Nations **International Year of the Family** we are proud to announce the further development of our **family Work.** A facility which was first developed to work with very young mothers is now accepting referrals of families of all ages - we have even worked with three generations - a true example of 'breaking the cycle'. We have full facilities for both residential and day assessment of families and for longer term rehabilitation including outreach work. Thanks to the efforts of our fund raising committee we have also acquired full video facilities for recording of sessions, disclosure, video feedback in therapy and 'ear bug' tuition of parenting skills.

For further information contact :-
Youth Support House
13 Crescent Road
London BR3 2NF
Tel : 081 650 6296
Fax: 081 659 3309

"When I told my manager that I wanted to send a family of six right across the country for an assessment - he thought I was mad! ..... But the amount of information we acquired from a residential assessment was more than we could have ever put together in a year of intensive social work. We were able to reach concrete conclusions and make decisions to safeguard the welfare of the children - well worth the expense!"

"Child Protection and the Family"
Dr Diana Birch

So much of the work which we are involved in as professionals in the 'child protection' scene involves crisis intervention and short term protection goals. What more can we do to help the abused child, the vulnerable adolescent and their families to confront the barriers which they meet in attempting to lead 'normal' lives. How can we help 'heal the pain'? How do we ensure that our interventions are not in themselves harmful?

This new title in the Youth Support Publications range will be available in the autumn - Advance orders are being processed now. £5 inc P&P.

Rehabilitation and the Family - "What do we hope to achieve?"

The following article appeared in shortened form in the newsletter of SAM -(Society for Adolescent Medicine).

This year I have been reeling from one intense court case to another - Should this mother be allowed a chance to have her child back? - Should a child be brought up by her natural parent? Can you achieve good bonding after prolonged separation? Is a child more harmed by failed rehabilitation than no rehabilitation? Should a teenage mother be encouraged to bond with her child? What is the aftermath of parental loss? Clichéd questions coming up time after time. Nevertheless hard to answer in the harsh glare of the court scenario when respected colleagues argue against each other - quoting contrasting literature and research findings with equal zeal. 'Zeal' is I feel, the right word for it - there are few areas where passion, and subjective fervour are more apt to cloud objective judgement than in that of child protection and separation of parent and child.

Certainly there is a difference in perspective - social workers do not want a dead baby on their case load and know the media will point the finger of blame in their direction; paediatricians may see neglected children gaining weight in hospital away from their families; child psychiatrists look at the disorganised family structure and find it hard to see a child being able to overcome parental patterns.

I wonder sometimes quite what we are hoping to achieve when we take the other view? What are we doing in our rehabilitation programme? With success rates running at perhaps 50% - if you're lucky and how do you measure success anyway? Varying criteria for selection for rehabilitation and no consensus on long term goals. Helping disturbed mothers parent disturbed children can seem a thankless task.

Unless you work with adolescents. That is when you begin to see the point. What do we see as the child reaches adolescence? And what happens when that child becomes a parent? Removal from the family is sadly not a panacea - we see young people whose self esteem is in their boots - crying out to know why their families did not want them, why they failed their parents so badly - and often recreating their own family disturbance and imagined parental traumas in an attempt to understand and identify with their absent parents.

Mark was placed in care at the age of four, lived in children's homes, then a 'good' foster family. He did well at school and college, gained professional qualifications and then 'blew it all', lost his job, on the verge of divorce and with seething rage directed at his four year old daughter. He remembers nothing of his early life but his fantasy is that his behaviour was so bad that his parents had to send him away. He needs to somehow prove that his parents were good and he was bad by recreating the scene in this generation.

A teenage mother may well prove, with help, to be an excellent parent, able to meet her child's needs in a way that cannot be faulted. On the other hand she may be too much a child herself, needing love, care and attention which her child cannot supply. The same

situation could apply to a mother who is for other reasons unable to meet her child's needs - by virtue of mental or physical illness or deprived circumstances. It is important that such mothers (and fathers) be given the chance to explore their own potential - to be supported and encouraged and to be allowed to share in the decision whether to parent their own children or give them over to the care of another.

I know how grateful fourteen year old Kim was when I asked her if she would like me to find a foster mother for her child. She had wanted so much to please us all by being a good mother - but the depression and loss of herself showed through. At the court hearing they called her an unfit parent and brought up all her past delinquency - several months work on self worth destroyed in a day. But her little son will know, when he reaches his adolescence that he was a valued child, that his mother tried her best, and then gave him up in love.

I am constantly being told by my paediatric colleagues that good bonding between parent and child is essential for future mental health and that this can only occur in the first year of life.Many authors have disputed this time limitation and even Bowlby has revised his views. But even if this were so surely the chance of establishing a rapport with your own mother - at whatever age is preferable to whatever bond may be established with a stranger?

Winnicott once wrote a paper titled "Delinquency as a sign of hope". Rebelling, pushing out against the injustices that you have suffered in childhood - that is indeed a sign of hope - a sign that the spirit is not broken, that there is an individual in there shouting out "Hey! What about ME!" The beginnings of change, of a sense of one's own needs, of self worth.

Adolescence is regarded traditionally as a time of 'delinquency' and rebellion, a time of change and energy - both can be channelled in the healing process and that is often what makes working with young people so exciting. However the 'adolescent process' can be seen in many phases of change. An abused 'victim' who begins to assert himself, a 'battered wife' who gains the courage to leave her husband, a drug addict or alcoholic who decides to opt for a different lifestyle - all enter a new way of being - all experience the honeymoon elation of starting on a fresh beginning - they all in their own ways feel the exhilarating freedom of an 'Adolescence'.

Thus , just as for the adolescent, we can make use of this energy for change in the rehabilitation process for our damaged families. And , just as in adolescence, we must appreciate the stages of this process and work through them with our patients - understanding and support is the cornerstone - coercion and ultimata have no place in rehabilitation.

The damaged parent of whatever age,needs to go through a stage of being allowed to be the 'needy child' - for that indeed is what he or she is.Years of deprivation and abuse have taken their toll in terms of the individual's needs never having been met. A young parent often becomes a young parent partially to find a way to fill this unmet need.It is a mistake to either disregard this need entirely, or to somehow expect it to be dismissed at will. How often have we heard the expression that a parent is "Unable to place the child's needs above her (his) own".As

if this were a conscious decision.OF COURSE they can't!.

The answer lies not in condemning this need, or pushing it to one side - but in fulfilling it. A needy parent is like an empty vessel , without caring or 'mothering' to fill the void - they have no resources - nothing to give their children. So our first task is to accept the needs of the patient's inner child, to allow them to be child like and to parent them - often for the first time in their lives. Here 'dependence' is healthy and a required stage in the treatment process - however, like all good parents, we need to set boundaries and be consistent in our caring during this childlike dependency stage.

As the patient grows in trust and confidence, we also, as good parents, relinquish some control and responsibility so that our 'children' can grow up. Having had some of their own needs met, they can now look to their own children's needs - but gradually at first. We take them through Bowlby's 'exploring from a safe base' , we ARE that safe base. They go through an adolescence with us 'holding' and 'containing' their anxieties and gradually emerge as competent adults.

Let us not forget that all parents need a measure of 'parenting' themselves.Not just as a model, a way of building up the 'inner parent'by example as described above. But also when giving birth, at the time of becoming a parent, we also need to be cared for - to be 'mothered' or cared for by a loving partner. Those who often need this most - our deprived or damaged patients, are those least likely to get it. To make matters worse, they have far greater traumas to bear during the early months of parenthood - single parenthood, domestic violence,poverty, poor housing, inexperience.They will also suffer greater stresses and assaults to their self worth and parenting -criticism, children failing to thrive, childhood illness, professional intervention (usually perceived as unhelpful and critical),case conferences, child protection procedure and possibly court action or assessment.

It is too easy for assessment and observation to become negative,destructive and almost a sneer from the sidelines rather than a productive process. There is no value in watching a sinking man drown.If you see he can't swim,you throw him a life raft.So there is no value in purely observational assessment.Seeing a faltering parent damage herself and her child holds no joy for observer or observed. Such an observer deserves to bear the shame of such failure and is a perpetrator of abuse to child and parent alike.

Assessment means 'working together' to see what can be achieved and what cannot. It is only in this way that a fair evaluation can be made of the situation and one that has a chance of being accepted by the family. So I suppose that I have answered my initial question "What do we hope to achieve?"- We hope to achieve a realistic appraisal of families strengths and weaknesses;a forward plan which will best serve the needs of each individual within that family as well as the needs of the whole;and an appreciation of the dynamics of the situation which is not based on blame, fault or failure,but rather on understanding, empathy and regard.

"Working with Families - How not to perpetuate the abuse".

Dr Diana Birch
Director Youth Support

Introduction -

The way in which we handle families and individuals within those families, have far reaching effects on the way that family will function afterwards.

However much we may disapprove of or be at odds with a family's structure and functioning, we must realise that the child has been brought up within that structure and will have to survive within it after the 'professional' intervention is over.

In addition since this family structure is the only one the child has known; the way that child perceives his world is based on this blueprint - all the child's 'survival tactics' are based on this reality.

We cannot destroy the child's environment without replacing it with something else and without realising and appreciating the 'dynamics' of the situation.

Altering the structure or dynamics can leave members 'exposed' and unearth other conflicts.

this can be desired -> used in therapy
or undesired -> recreating the conflict from a different base. (false cure).

Family structure

A family is structured around it's own ethos - it may be an emotionally distanced grouping of individuals who constitute a 'family' in name only and where the individual feels no support or bonding with his fellows.

Alternatively, as is more common in many of the families coming under professional scrutiny, it may be an enmeshed body which takes on an existence of it's own and where individual personalities are lost in a common boundaryless ego.

So called 'normal' families fall somewhere between the two extremes but are still prone to power struggles between the members - who is in charge, who is the spokesperson, who is the scapegoat? Family members assume or are pushed into a role and interactions between family members are influenced by these roles and by the interplay between them - striking up allegiances, involving one another in power triangulations and using one another in indirect communication.

How often have we heard a child used in something like - "Tell your father if he wants his dinner he had better come home on time".
or a parent implicated in indirect communication as in -

"Wait till your father gets home" or "What will your mother say when .."

Families frequently take sides - with one child siding with mother and another with father, or all 'ganging up' on the weakest member. In 'abusive' families a child frequently appears to side with the abusing parent against the other - since this is the safest thing to do.

It is worth while taking a little time to consider some examples of this - think of the last two families you worked with and how they functioned - consider also your own family of origin - what part did you play? This topic can form the basis of an excellent role play with colleagues in a workshop situation.

The family is a microcosm of the outside world and of the wider environment. The way in which we learn to function within our families, provides the 'blueprint' for how we function in society at large.

We carry our family 'role' with us from our family of origin to school, to our workplace , to relationships and social settings and to our eventual roles in the family we create.

The stability of maintenance of a role and 'place' within the world, of being secure in the knowledge that things turn out or people behave in the way we expect them to do - this is the most important factor in family life.

Stability and predictability are more important than the quality of that condition. In other words the secure knowledge that mother loves you is certainly conducive to mental health and well being - but so, in a perverse way, is the secure knowledge that father will hit you every time he comes home - as opposed to the insecurity of not knowing whether he will or not.

There is nothing so destructive as the insecurity and unpredictability of not knowing whether for instance dad will be drunk or sober when he comes home and thus whether he will hit you (perhaps when you have been good) or hug you and give you a present (maybe when you have not had such a good day).

If your behaviour has no predictive consequence - then it has no importance. And if your behaviour has no importance, then perhaps you do not either. The child's self worth is destroyed because nobody cares what he does or how he acts. It is as if he does not exist.

This is no less the case for those unfortunate children who are raised in families where abuse - physical, sexual or emotional has taken place.

Sarah had been sexually abused by her grandfather since the age of 4 or 5. In common with many victims of sexual abuse, she was unable to 'disclose' what was happening. She at the same time could not believe that people - her mother, her aunt and her grandmother could not 'see' her distress and acted as if they did not know.

She began to act out the anger and frustration she felt in delinquent activity - smashing windows on her estate and minor acts of vandalism. This did not get her into trouble, people did not seem to notice.

There was no consequence to her behaviour - just as there appeared to be no consequence to her grandfather's behaviour.

Later, as an adolescent, Sarah's rages became more intense. She walked a long distance with a knife in her hands , wanting to kill her grandfather. When she arrived she saw her grandmother and could not commit the deed. She thus went home, smashed the family home and was committed to a mental institution. She calmed down and was released. Another example of missed communication.

In adult life during therapy she went into an 'uncontrollable rage' one night and smashed windows in the treatment unit. The following day she doggedly refuted that there was any possible consequence to her behaviour. A breakthrough in therapy occurred when she was faced with possible consequences and a code of 'acceptable behaviour' was laid down. It was as if at last 'it mattered' what she did and therefore 'she mattered'.

Problems of the 'meddlesome ' worker

When working in child protection - there is an intense desire to 'do something' - it is thus very easy to take action just so that this need can be fulfilled and the professional can be 'seen to be doing something'. Under such pressure however there is a very real danger that the 'something' can be of no use whatsoever to the child needing protection or to his or her family - and can at best be useless and at worst harmful and dangerous.

Some of the aftermath of 'meddlesome activity' in child protection is not immediately apparent due to the flawed manner in which much child protection work is conducted - i.e. that of crisis intervention based mainly on protection from harm without follow up or any treatment process to 'heal the wounds' . Hence the total gamut of the inflicted harm is not fully appreciated nor the contribution within that wounding process which can be laid at the door of professional error or misjudgement.

Hence , when we feel urged to 'do something' - it is imperative that we consider for whose sake we do that i.e. are we being helpful to the client or 'helpful' to ourselves?.

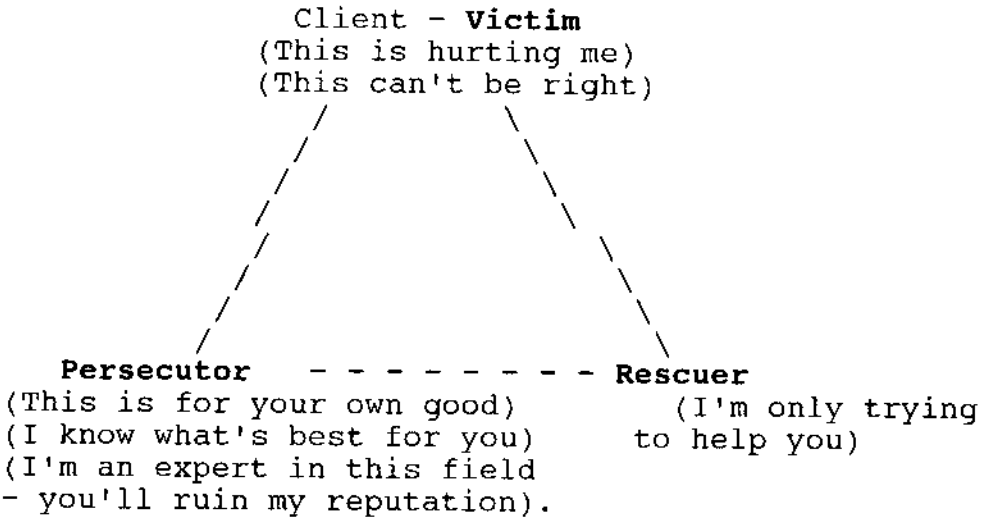
In looking at this dilemma , it is useful to consider a concept borrowed from Transactional Analysis (TA) - that of Karpmann's drama triangle. The 'Drama Triangle' can be used to look at roles in any situation where a psychological 'Game; is being played ; in other words, where two people are not being straight with each other, not saying what they really mean. In such 'Game play' the roles of Victim, Rescuer and Persecutor are played and switched by the participants in a manner that can leave both feeling uncomfortable.

A classic 'family view' of the triangle in action is provided by the alcoholic family. A common scenario might be - drunken husband (Persecutor) comes in late and berates wife (Victim) for not having dinner

ready; she (now Persecutor) then turns on him (Now Victim) for being drunk again ; he then throws up and complains how ill he feels so she 'Rescues' him by sympathy and cleaning up after him and probably rings his boss in the morning to tell him her husband has the flu'.. thus enabling him to continue in his behaviour pattern and Persecute her all over again.

In our scenario of the 'meddlesome worker' one might play the game with the professional as Rescuer turning Persecutor. In such a situation the term 'Rescuer' is not complimentary. Such a person 'Rescues' for their own personal ends. Their actions are generally harmful to their clients even though they might superficially fool some of the people some of the time. The Rescuer begins by making the inappropriate intervention in the vein of the dentist telling the patient that 'It won't hurt' or the old fashioned school teacher caning the pupil with a 'This is for your own good and it hurts me more than it hurts you' attitude.

When the client, hardly surprisingly, fails to respond to such treatment; the Rescuer becomes Persecutor,blaming the client for lack of response rather than seeing that his methods might be flawed. This is akin to the Doctor blaming his patient for failing to get better rather than stopping to consider that the 'cure' might have been the wrong one.



Case Histories -

The following case histories illustrate a number of difficulties faced by workers and the contrasting possible end points which could be brought about by insensitive or inappropriate action. The cases are based on true facts although one end point actually happened , and the other was fabricated. Sadly , the end point which I would have liked to see happen is the fabricated one.

Unfortunately we work in an age when the very words 'child abuse' can engender such subjective response from professionals that interventions are often less than ideal and once the hot potato of

abuse has started rolling, albeit in the wrong direction, it can acquire a momentum of it's own and be impossible to stop or to shift onto a more appropriate course.

Hence ill thought out actions, however well meaning can have devastating results for the child who has been the victim of abuse and for it's family. It is thus that our interventions can be in themselves abusive. As they say "The path to hell is paved with good intentions".

Please read through the case histories and evaluate how you would have acted. Discuss the two possible endpoints.

Case History 1 - Margaret, Harry and Tom.

Margaret had her first baby when she was in her late thirties. Her husband Tom was a business man who spent a lot of time away from home on business trips.

In the weeks after the birth, Margaret was tired, lonely and depressed. She had not expected to have a child at this stage in her marriage and had not imagined that her life could be so changed.

One night,baby Harry seemed to cry incessantly. She did not know how to pacify him. Margaret eventually managed to get him to sleep and , just as she was dropping off herself - he started to cry again. She picked him up roughly and shook him, crying, "Please, please stop it" - she pushed him back down into his cot, ran crying into the next room and shut the door on him.

The next morning, Margaret found that Harry had two tiny bruises on his cheeks - she must have handled him more roughly than she thought. She wrapped him up and rushed round to her GPs surgery.

A. The GP examined the child, found light finger tip bruising on the cheeks, and no other signs of abuse. Harry was well nourished and developmentally up to date. He did seem to be a 'windy' baby however and so advice was given about feeding regimes to try and reduce his indigestion and night time colic.

The GP also diagnosed post natal depression, which was contributing to Margaret's low threshold of tolerance and which, combined with her excessive tiredness, was diminishing her supply of breast milk, thus contributing to Harry's fractiousness.

It was arranged that the health visitor call regularly on Margaret to help her build confidence in handling her baby. He knew that this was a long awaited child and felt Margaret may be feeling a sense of anti-climax ad failure in not being able to be the perfect mother.He asked Tom to take some time off work to allow Margaret to rest.

B. The GP found bruising on the baby's cheeks and questioned Margaret about it. She was distraught, confessed that she had handled the child roughly and shaken him.

The doctor had recently moved into the practice and did not know the family, he was very concerned about Harry and

decided that since he was born late to a professional career oriented couple, he was probably an unplanned and possibly unwanted child.

The child was sent to hospital for X ray studies and Margaret was cross examined by the Casualty officer, followed by the paediatric houseman, registrar, senior registrar and consultant. The hospital social worker came and asked if she understood about the child abuse procedure in their district.

The social worker telephoned Margaret's husband, Tom who was embarrassed to be summoned out of an important meeting because a protection order was being taken on his son.

When Tom arrived at the hospital, he was not able to speak to his wife immediately or see his child, first he was cross questioned about his wife's character, her history and whether he thought she was capable of injuring her baby. Tom was devastated. Margaret confessed, she felt like a criminal.

It was several days before they had Harry back. They were told he was on the 'at risk register'. Margaret's depression got worse, she could not cope. One night she took an overdose, Tom came home to find Harry crying alone and his wife semi comatose. What danger Harry was in!

Margaret saw a psychiatrist who gave her tablets which made her more sleepy and less able to cope. Tom thought it best that Harry go and stay with his parents, who knew how to look after children.

The marriage did not last long after that. Margaret was branded as 'unsafe' with children. Tom had to change his job and is now less well paid.

- What of Harry?

Case History 2 Ann and Zoe

Ann had been in care for most of her life. She did not know what family life was like, it had been one children's home after another.

When she fell pregnant at 17, she desperately wanted to make a go of her life, to bring up her child herself and to learn how to be a better mother than her own mother had been.

Pregnancy was unplanned but baby wanted. Boyfriend Dave was supportive though jobless so unable to help much.

Ann had been abused as a young child and had been on the social services, child abuse register. When her child was born, her social worker thought that her child was therefore at risk of being abused - abused children become abusing parents.

A. Baby Zoe was placed with a foster mother; Ann fought to have her back. She was given the task of 'proving' herself. Could she be a good mother, did she know how to handle a baby?

So every weekend Ann was allowed to 'handle' Zoe under the supervision of a social worker. She picked up the unfamiliar bundle and did not know what to do - criticism followed criticism - she was set up to fail.

B. Ann and Zoe were placed in a residential unit together. Ann was given support in caring for her daughter and was gently allowed to assume responsibility for her care as her confidence grew.

Zoe was on the 'child protection' register but six months later, the authorities were happy that Ann could cope with her child and plans were made for return to a flat in the community.

Thus what might initially appear to be merely a subtle difference of emphasis in dealing with a case can have far reaching and devastating consequences for the child who we are aiming to protect and the family who we can either support and 'nurse' to psycho social health or who we can very easily destroy.

Sexual Abuse

Consider the case of a sexually abused child who 'discloses' to a professional.

How do we stop him or her from being further abused by the consequences?

What are the further possibilities for abuse?

1 - **GUILT** at having been the victim - it must have been my fault somehow.

2. Being seen as **accuser** - accusing 'family' and mother or carer of not protecting her enough.

3. Breaker of family - perpetrator - father possibly - being removed from family - **break up** of family his or her fault.

4. Made to testify - **witness** of fathers or family's guilt.

5. **Physical** abuse - the examination itself can be 'abusing'.

6. Circumstances of examination and disclosure can be an **abusing ordeal.**

7. **Court** appearance and evidence giving can be traumatic.

8. Abuse in **not being believed** or not taken seriously.

9. Having to **'confront'** perpetrator or argue what did or did not happen.

10. possible further abuse in terms of what happens if child placed **back in contact** with abuser - revenge, blackmail, etc.

11. Professionals involved giving **covert messages** - e.g. why don't you retract and make life easier for everyone - perhaps you exaggerated?

12 Or **covert disgust** at circumstances being 'misread' as disgust for victim?

13 What of the 'stigma' of being an abuse victim?

There are a number of further possibilities which might arise in discussion. It is worthwhile pausing to consider - what could have been abusive in the last case you were involved in? Could this have been circumvented in some way?

Conclusion

All intervention both effective and ineffective is going to produce change - either in the individual or in the family. Change is painful - it is often easier to stay with the status quo than to risk the uncertainty of change and 'moving on' even if we are moving to a healthier position.
The arguments put forward here are not intended to deter the professional from making interventions - many of which are essential to safeguard the welfare, and sometimes the lives of children.

It is hoped however that the measures we take are positive and helpful to the families we work with and that if we have to cause a measure of harm and distress in our interventions; that we are at least aware of such injury and can act appropriately to minimise it's long term effect.

- International Chapter News -

We had planned to include the International News in the next issue of the Journal - However, since there have been a number of developments, it was thought best to include a section in this issue also.

What is the IRC SAM?
The International Regional Chapter of SAM.

1995 will see the staging of rather an unusual spring meeting - as you know the IAAH (International Association for Adolescent Health) will be holding it's International Congress in Vancouver in tandem with the SAM (Society for Adolescent Medicine) annual meeting. This will mean that there will be the usual format of SAM activities plus a large and varied programme laid on by the International membership of IAAH. With such a big emphasis on the larger International scene via IAAH - it seems appropriate to define and explain the position of the smaller IRC SAM group within the whole.

The IRC is a chapter of SAM which has been in existence since 1987 to provide a forum for both non USA members and US members with an interest in International affairs. In common with other chapters, not all participants are full SAM members but we encourage colleagues to join SAM wherever possible.

Our principal objectives are to :-

* *Encourage International participation in SAM and at SAM meetings.*
* *Increase awareness in International issues among SAM members.*
* *Provide a forum via our newsletters and annual workshop for interchange of ideas and for professional 'networking'.*

The IRC has to date been the only chapter of SAM to run a workshop at the annual SAM meeting. This activity has been a successful focus for the chapter. We intend to hold our usual workshop (or institute) at the 1995 meeting. In accordance with the above definition of our chapter - this should be seen as a SAM activity as distinct from an IAAH event.

There is naturally some overlap in membership of IRC SAM and IAAH - but this constitutes a very small proportion of individuals and the ethos and structure of the organisations are quite distinct.

- Report Of The 1994 Meeting - Los Angeles -

Message from Roger Tonkin -

The members of the Chapter present in Los Angeles held a highly successful Workshop and a well attended Breakfast meeting. Many thanks are due to Aric Schichor and Diana Birch as well as to the presenters for what was clearly one of the best workshops we have held in recent years.
As in the past years we also had a lively dinner meeting outside the hotel. It produced exciting notions about what to arrange for our next get together in Vancouver in March '95 (keep tuned to your newsletter for further information). Once again our thanks to Diana for setting up a Chinese feast for us within walking distance of the meeting hotel.
The Los Angeles meeting included continuing discussions on the future of the chapters within SAM. Unfortunately there didn't seem to be much in the way of a definitive outcome as SAM as an organisation seems to be preoccupied with planning a fall retreat and is putting off decisions till then. I suggest that chapter members make their views known by direct letters to Richard Brookman (copy to Birch / Girard) soon. {See below for response}.
My impression of the direction that SAM is taking is to reorganise it's chapters and require more accountability of them. I see this as a good thing but there are obvious complications for us as international members. My recommendations include creation of an International Section within SAM and dissolution of all non USA chapters. Such a section would continue to enjoy the JAH, receive all SAM publications, be eligible for lower membership fees, be supported by central office services e.g. for the collection of dues, maintenance of membership lists etc. With the help of SAMs office the section would publish a newsletter, sponsor an annual workshop and be generally supportive to our International colleagues.
The section would be a formal entity within SAM and have an appointed Executive (by SAMs board). The section members need not be full members of SAM but those who are would also enjoy full rights including voting of SAM membership. In the meantime the present situation wherein the cost of running the chapter mailings, collection of dues, organising an annual event, printing a newsletter which are absorbed by my office, Aric's hospital or Diana's Youth Support could end and be replaced by a simpler device for supporting our activities that is created and paid for by SAM. We lose some autonomy but gain a smoother less erratic method of keeping a vibrant international presence within SAM. A situation that SAM both understands and appreciates.

From Vaughan Rickert - Workshop Co-ordinator - SAM

With regard to the formal ratings that were completed for the workshop "An International Perspective on Adolescents and the Media" - Co directed by Diana Birch and Aric Schichor - almost all respondents rated the workshop in the good to excellent category across the various dimensions. The written comments were also positive.
This is a very encouraging result - many thanks to all the presenters. It is particularly encouraging when we consider that we are getting more USA based participants attending the workshops - this means that we can act as a showcase for the International group. Hopefully we can keep up the standard for the next IRC workshop in Vancouver. A suggested title is "International Perspectives in Sexual abuse of teenagers" - I am waiting to hear from SAM as to the timing of the workshops for 1995 - I have asked for a half day only since there are obviously a number of other International initiatives in the 1995 meeting- we will not know definitely until the autumn - however in the meantime I would love to hear from anybody who would like to present something at the workshop.

An International Perspective on Adolescents and the Media

The 1994 International Regional Chapter Workshop was held at the 26th Annual meeting of the Society for Adolescent Medicine - Los Angeles on 16th March.

Introduction - Youth and The Media - The scope of Media influence - an overview by Diana Birch - Youth Support - England.

How does 'The Media' and Youth Interact? We live in a 'high tech' age - we live and breathe media. Youth are more 'Media wise' than their parent's generation.

Differing Vehicles for media impact

- Written word
- Audio messages - music - radio - tapes
- Telephone, chat lines, recorded messages
- TV, Video, Cable, Satellite
- Cinema
- Theatre
- Computer Games
- Computer Electronic mail, porn lines etc.

What Aspects Should We Consider?

- Effect of media on youth - good and bad - desired and undesired.
- Effect of Youth on Media - Young trends and Youth purchasing power affects advertising and productions.
- Consider Media as part of a whole - pattern of society - it serves our needs - it does not arise spontaneously.
- Consider hypochrisy of some of the outcry against the media - we enjoy horror, fear, violence in films - they produce what the public wants.
- Seed and soil - Removing all media violence would not produce a peaceful world.
- Difference between real and fictitious - drama/doc.

Youth In Media

How does appearing on Tv - being a child star - being used by the media - or being part of the illusion affect youth?

Workshop format was divided into three sections -

- **The Impact of images**
- **The message in the Media**
- **Making Media Work**

Teens Take Note: Ask PCs Everything You Always Wanted to Know About Sex

Younger and younger teens are having sex—15 is the average age for first experiences—but they're poorly informed about birth control and parenting.

To get information into teenage hands, adolescent-medicine specialist David Paperny disguised computer programs as games and developed two software packages that provide no-nonsense advice about sex.

The first package, Romance, explains the responsibilities of sex and prompts teenagers to think about whether they're ready for sexual intimacy. It also offers advice on contraceptive methods. The Baby Game explains the financial and emotional costs associated with parenting.

Getting the facts onto a personal computer was the key to the programs' success, according to Paperny. Teenagers view adults as judgmental and approving, but they take computers seriously. "Kids want to see what computer has to say about them and their responses," says Paperny.

Sex education goes high tech

By Walter T. Middlebrook
USA TODAY

Computer games are making it easier for teens to talk about sex.

Reason: Computers don't blush and they don't judge.

be spent after the baby arrives and details the cost of having a baby and raising a child.

▶ **The Romance Game.** Examines sexual attitudes and provides information on abstinence vs. birth control.

It poses 60 dating situations, asking the player to chose a birth control method — and examines possible consequences of each. Then, it looks at the chances of having a baby with each method.

▶ **Teen Health Advisor.** Evaluates overall health and offers personal advice. Typical questions: Have you ever had intercourse? Has anyone ever forced you to have sex? Have you ever used drugs?

Hawaii's high schools and more than 300 health and social service institutions nationwide are using the programs.

- The Impact of Images -

A youth in Belfast throws a petrol bomb, Palestinian children hurl stones, Freddie Kreuger's mother performs unspeakable acts of cruelty, human remains are carried out in a dustbin from the mulitple murder scene in Gloucester, Beavis and Butt Head stock pile weapons, some faceless men are burned alive in a porn cinema in Smithfield, 'Yogi ' hits a target over Bosnia, a doll crushes a dustman in a refuse lorry ..... somewhere in the middle we lose track of the fact that a boatload of Sri Lankans have drowned .. and Schwarzenegger tells us he'll be back....

Interactive Video Resposes -

The first part of our workshop involved an interactive video presentation eliciting responses to a variety of images which might commonly be presented to Youth.
The purpose of this was two fold - Firstly the video compilation provided a tool by which responses of groups of youth and professionals could be gauged - the responses which had been elicited at Youth Support in London were discussed - and secondly the material provided a 'warm up' exercise for the workshop - in that rather than discussing media responses 'cold' - the audience experienced differing reactions to varying degrees of violence and thus had an immediate personal experience to tap while discussing research data presented by later speakers.

The clips - each lasting from 15 seconds to a couple of minutes wre randomly mixed examples of screen violence - taken from popular films - 'Witness' ' Freddie's Dead' 'Child's Play Three' 'Terminator' - plus news footage of violence - plus violent 'humour' sucha s in the Blues Brothers or Robin Hood or Crocodile Dundee.
It was noted that some levels of reporting news produced more impact - the same story on BBC or CNN was very different - impact varied depending on visual imagery rather than talking heads - scenes depicting emotion.
Use of familiar objects in horrific guises produced reaction - dolls and toys out of context. The War Games clips which had actually been taken off CNN news of a plane shot down over Bosnia - looked like a computer game and the impact of death and the horror of war was lost.
The older members of audience (both in London and in LA) were most upset by real news items than by films - the older generation also found the film clips more disturbing than the ?somewhat conditioned youth.

"The Effects of Violence in the Media" Lilli Friedland - President of media psychology division of the American Psychological Association.

The American Psychological Association published an important document - "Big World Small Screen" which deals with the issues we are discussing today. We are all concerned because the institutions which help civilise people and who help individuals to become functioning healthy parts of society are all in a terrible state. The family the church or synagogue and the school and at least in this country they all need a massive amount of support. Typically in other generations , in other millennium if there was a problem with one, the other two balanced it out - to the best of my knowledge this is the first time that all three basic institutions are all so weak that they can't compensate for the weakness in another and therefore all the cultural messages all the values are passed on not by the traditional story telling and sharing of values from the church family and school - but we have the media. And that is why we are here today because we need the media's help and to

see why it is so particularly influential today and why we see the kind of violence that we are shown - in our generation or in our parents generation - it might not have had the same effect.

What we have now is an increasingly vulnerable generation of adolescents that need even more structure , more guidance and more healthy values and alternatives to be shown. Carried to an extreme - we know how to make even health people unhealthy - we know how to make a pretty normal kid growing up in a pretty normal home into somebody who operates from the dark side.

There is a wonderful movie out which was put out by a Greek Junta some time ago "My Neighbour's Son" - it is available through Amnesty International. They pan in on typical adolescent in a family in Greece and show how he was introduced to terrorism and became part of the terrorist scene. How they broke down his defences systematically - how at first he was appalled by i t and then how he became part of it and the importance of that is that even under the best of conditions - and the assumption of course is that this was a normal kid with normal values etc. - could be incredibly affected by massive influences coming at him and now we are talking about those who are more vulnerable feeling the effects of such influences.

I will not go into a lot of statistics - suffice it to say that the average child witnesses 8,000 murders and more than 100,000 acts of violence before he graduates from elementary school. Children spend more time watching TV than they do going to school by the time they are in high school in this country. Thus there is a tremendous effect of the media which we have to look at. The psychological association had a task force on Television - There is no clear cut view - Roger Kline of Pittsburgh University came out with information that women are differentially affected by violence in the news than men - older people are more disturbed by violence in the news - many concentrate on violence in films but there is a growing body of interest in the effect of the news.

The average Us child watches at least 3 hours TV per day - pre-school child watches 57 hours per week that means it has more influence than anything else that the child comes into contact with. The elderly watch more TV than any other group and the low income groups watch more, the Afro-American watch more than whites but well educated black youth watch the most boys watch more than girls but women watch more than men. We also need to look at the changes in society with more people working from home, spending more time at home and the whole concept of cocooning.
Most ethnic minorities are mainly portrayed negatively. Men are shown more as protagonists of violence. Exposure to highly stereotyped images increase adolescent sexual stereotype beliefs. Pro social interaction and non stereotypic portrayals can lead to co-operation, reduction in prejudice and promote traditional sex role images and promote good citizenship. So though we can point out the negative affects - violence aggression etc. we can also point out the positive . In the field of emotion and behaviour - TV can increase or decrease emotional arousal which can lead to desensitisation. Watching violence in a sexual context can lead to acceptance of rape and other forms of sexual assault. The rate of violence in prime time TV is 5 to 6 incidents per hour but Children's Saturday morning programmes have 20-25 incidents per hour. Children expect to have things going on all the time - if not its boring. What does that boredom mean and the constant need for hype and arousal and what it does to them psychologically as well as physically.

Two important meta analysis studies Addison in 1977 and Herald in 1986 combined a number of studies 67 and 230 with 100,000 subjects and 300,000 subjects respectively - showing that a positive association between televised violence exposure and aggressive

behaviour over a wide range of ages - also it lowers the prosocial behaviour. Effects on viewer 1. Increase in violence towards other people - Aggressor effect
2. Victim effect - increases fearfulness - older people and women more
3. Bystander effect - increased callousness towards other people.
4. Self socialisation effect - increased self directed behaviour which exposes one to further risk of violence. The opposite happens is there is a showing of pro social behaviour - i.e. decrease in violence towards others.

Effects through the different mediums - Music video men who have listened to only 17 min. of heavy metal music express greater endorsement of sexual stereotypes than those listening to easy listening music. The addition of sexual images in a rock video increased the college viewers appreciation of the music but violent images did not. Deleting violence from the rock video did not affect the appreciation - they thought it just as good. So violence does not increase sales. Those who watch violence against women in the rock videos seem to have an easier time being desensitised and feel that women 'ask for rape' rape is a women caused phenomena.

Cartoons - the pre-school children were just as likely to imitate violence with a real model as a filmed model and cartoons also imitated the aggressive behaviour - animated characters influence as much - show no consequences for behaviours in children's programmes so they do not think there is a consequence - children walking in front of cars - they don't come back to life - they assume you go on living - they perceive this from media. Violence from video games - also effective. lot of school have video games as rewards - these could have bad effect. Children less prosocial behaviour if play video games with violence. Young minds incorporate this as important influence.

In TV 90% of aggressive facts in prime time are shown as justifiable acts - many did not have expression of remorse or regret - hence difficult for adolescents to learn behaviour model. 88% of aggressive behaviour is rewarded. Paying attention to the negative aggressive behaviour is thus harmful. Again decreasing violence does not decrease popularity of programme.

The association between aggression and violence is more important for watching home video and television and part of that difference is that in cable industry and how video aggression and violence is more explicit and more connected. The importance in connecting sex and violence and the importance it has in degrading the viewers image of women and seeming to promote rape and aggression against women.

So what do we do and what can we do? Critical viewing in schools - Canada does this. Rating systems - various types. Help care givers to be better guides.
Tools and blockers to help parents screen out certain programmes - but parents who bother with that are those most involved with their children anyway - something is needed for the others. We need the help of the industry and everyone working wit adolescents in order to counteract this effect - but looking at the future it is even more scary - we are starting to get involved in trying to assess the effects of various types of interactive mediums on adolescents children and adults. The University of Kansas is doing some work on this - educational hardware and software as experiential learning is working well - you use more than one sense - auditory, visual and tactile to promote learning - so as an educational tool this is important. However there is concern because the two directions with most influence in interactive medium comes from pornography and aggressive games and that means an even larger problem for all of us.

Virtual reality is also a very powerful field - exciting and scary - you come out of it not knowing what is real and what is imaginary - if we are talking about the scope for desensitising human beings - that is the most profound area I know - because if you can't determine which is your experience - where did you learn that?

Cocooning - living by yourself - this has an important influence . Of course there is a lot of positive in working at home but the negative influences come from this. What we learn about the world is based on our interactions with other people and by judging the reactions of other people - that constructive input and feedback - both in the family and positive relationships or in the workplace where we need feedback - the opportunity for this is going to be reduced. So our feelings about ourselves - our grandiosity is going to be less challenged - you are not going to have to compromise - What we find is that those people who are not going to their extended families or meeting friends are using networks such as internet and groups that they find through the computer systems as ways of connecting. Partly that could be great - for some people this could be easier - less self revealing - young people do that a lot. There are real problems - but there are difficulties with reality - you can make up fictitious names and fantasy creatures can fill your time instead of real people. More and more are cocooning - using computers to create fantasy friends. These have consequences on a societal as well as an individual basis..

The Message in the media

Using media to convey a message. The contribution of soaps, storylines which have a moral or covert message - Examples of a number of British TV programmes and child oriented soaps were provided in video form by British TV companies.

Manny Chigier - Youth Aliyah Israel - presented a fascinating idea **"The use of good movies in sexual health education in pre-adults"** So often the content of movies is criticised for giving negative stereotypes and portraying unacceptable behaviour patterns particularly with regard to sexuality. Dr Chigier demonstrated how by chosing the right material one could also find plenty of positive messages in the film repertoire which can be used as a useful instrument in working with young people. Films can also be discussed with youth and their content used to bring out undestanding of love and relationships - classics such as Bonnie and Clyde - or 'The Fabulous Baker Boys' looking at the dynamics of the relationship and the 'death' of a love relationship between them.
Exercises such as How would you make a sequel?

Making Media Work

A number of presentations followed this theme -
Dr Roger Tonkin - took us through a progression of newspaper articles which started out by condemning a youth health survey in British Columbia and then gradually turned round to support the project - a wonderful example of how professionals can canvass the help of the press in combatting prejudice against issues such as sex education. It was seen to be important to cultivate a relationship with the media rather than work in opposition.
George Creatsas - Greece - and **Gustavo Girard - Argentina** described the practices in their respective countries.

Nancy Okinow - Minneapolis - From the centre for Youth and Disabilities - described collaborative projects and PR work with disabled youth. Their newsletter is a beautifully produced piece of PR work which is circulated widely to all IRC members.

Aric Schichor - Connecticut - Described the use of Video skits - short PR messages produced by his young patients. These items of 'peer advocacy' were short, pithy and to the point - Public access TV is an effective way of reaching Youth with these short public service announcements and video clips which will provide scope for increased work.

Ueli Buhlmann - Switzerland - Also showed us videos made by patients and for patients - in this case to illustrate physical illness and practical procedures - gastrostomy patients, diabetics etc. The video education programme is short and compact and can be shown over and over again hence increasing the degree of knowledge gained from it - Animated cartoons were also discussed as a means of putting across a clear message in a clear but inoffensive way and in the 'international language ' of animation.

Interactive Media - David Paperny - Honolulu - Described his computer games - "Ask PCs everything you wanted to know about Sex" .... Computers don't blush and they don't judge!

An Open Letter to The President of SAM

Dear Dr Brookman,

Re The International Regional Chapter (IRC) of SAM

At the last SAM meeting we were nominated as co-chairs of the IRC. It seemed appropriate therefore to outline the role and aims of our chapter. Out of the total 1,170 SAM members, 86(7.20%) live outside the USA - only a few of them usually attend the annual SAM meetings and thus for most of them the principal link with the society is the Journal of Adolescent Health.

Our Chapter would wish to redress this in terms of :-

* Encouraging members from outside the US to attend the annual SAM meeting
* Presenting ideas to the SAM board with a view to strengthening participation by members from outside the US.
* Strengthening participation in the IRC SAM.
* Encouraging the growth of the international membership of SAM.

This could be accomplished by :-

* Continuing to hold a chapter workshop at the annual SAM meetings as a forum where members from outside the USA can exchange views and experiences.
* Expanding the coverage of the chapter newsletter.
* Organising a special presentation of the IRC SAM at the International Congress in Vancouver.
* Encouraging IRC members to be more visible within SAM in presenting papers or posters at SAM meetings.

We are aware that there has been a lot of discussion within SAM with regard to the position of SAM in the International scene and the question of whether SAM is a US or North American or world-wide organisation - It would appear that if SAM were to consider it's wider role and develop an International section - the IRC should provide a focus and impetus for this transition.

Dr Diana Birch
Director Youth Support
London England

Dr Gustavo Girard
Buenos Aires
Argentina

What is Planned for The SAM 1995 meeting in Vancouver?

{There are a number of International Initiatives at the 1995 SAM meeting - These are in addition to the IAAH events which Roger Tonkin has outlined in the Youth Health Assembly programme. To Clarify - IAAH meets 20/21/22 March : SAM meets 23/24/25 March.}

1. The International Dinner - This annual dinner meeting is an informal opportunity for International members of SAM to socialise and compare notes on matters of mutual interest. Those who do not belong to International Regional Chapter SAM are welcome to join us. Reflecting the cultural diversity of our membership we vary our choice of restaurant - Washington Tex/Mex - L.A. a Chinese Banquet - In Vancouver Native American?

2. International Lunches - I understand that there are to be a number of 'Meet the professor lunches' involving pairs of USA SAM members and International members.

3. Multicultural Forum - This has been suggested under various guises - I understand that now the suggestion is that SAM, the IAAH and the multicultural special interest group and the Canadian Association for Adolescent Health are to jointly hold a 2.5 hour meeting which will be organised by The Canadian organisation - Dr J. Frappier.

4. The IRC SAM -(International Regional Chapter)- Workshop Our chapter traditionally hold a workshop each year at SAM - Gustavo Girard and I would wish to hold a workshop again in Vancouver meeting - a half day A suggested topic is "International perspectives in sexual abuse of teenagers".

Nancy Okinow

Presented an account of the production of this newspaper by Youth with various disabilities - a great success!!

Working to Voice Concerns, Hopes of 8 Disabled Kids

For two days in October, a group of eight students and eight journalists from the **Star Tribune** met and worked together to produce a package of stories and photographs that appear in the November 30 Variety section of the newspaper.

This workshop was unique because each of the students has a physical disability. The National Center for Youth with Disabilities, located at the University of Minnesota, and the **Star Tribune** designed this workshop to give youths with disabilities a place to voice their opinions, concerns, interests and hopes.

A group of young people in wheelchairs went shopping in downtown Minneapolis and wrote of the difficulties they experienced getting around, and also of the understanding people they met. A young woman wrote about what it means to be deaf. Another student tells what it's like to have a pacemaker.

The Youth Health Assembly - 1995

Please refer to Roger Tonkin's Conference Programme for details of all the events - so far as Youth Support members are concerned - we hope to put on a workshop in the IAAH sector of the programme (first three days) - details as follows - please note that this is a preliminary notice only and the event has not been confirmed. Please note that this is distinct from the SAM part of the programme (last three days) detailed above. If at this stage any Youth Support members wish to involve themselves in the Vancouver meeting please contact Youth Support House as soon as possible.

"Using Drama in the healing process"

Lack of effective communication poses one of the most important barriers in the use of conventional therapy with young people. We have to 'break the silence" surrounding family secrets and find common ground for empathy and understanding.
Adolescents may "communicate" their pain by acting out or somatisation of emotions - by using 'active therapies' such as Drama we can explore an alternative medium for expression and externalisation of their hurt.
This workshop will cover basic theory and demonstrate the use of Dramatic techniques through use of video recording and case histories. There will also be an interactive component introducing role play, scene setting and family work.
Young people will be welcome to join this session.

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 & 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.

NEW - **"Child Protection and The Family"** - NEW
ORDER NOW - AVAILABLE SHORTLY

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