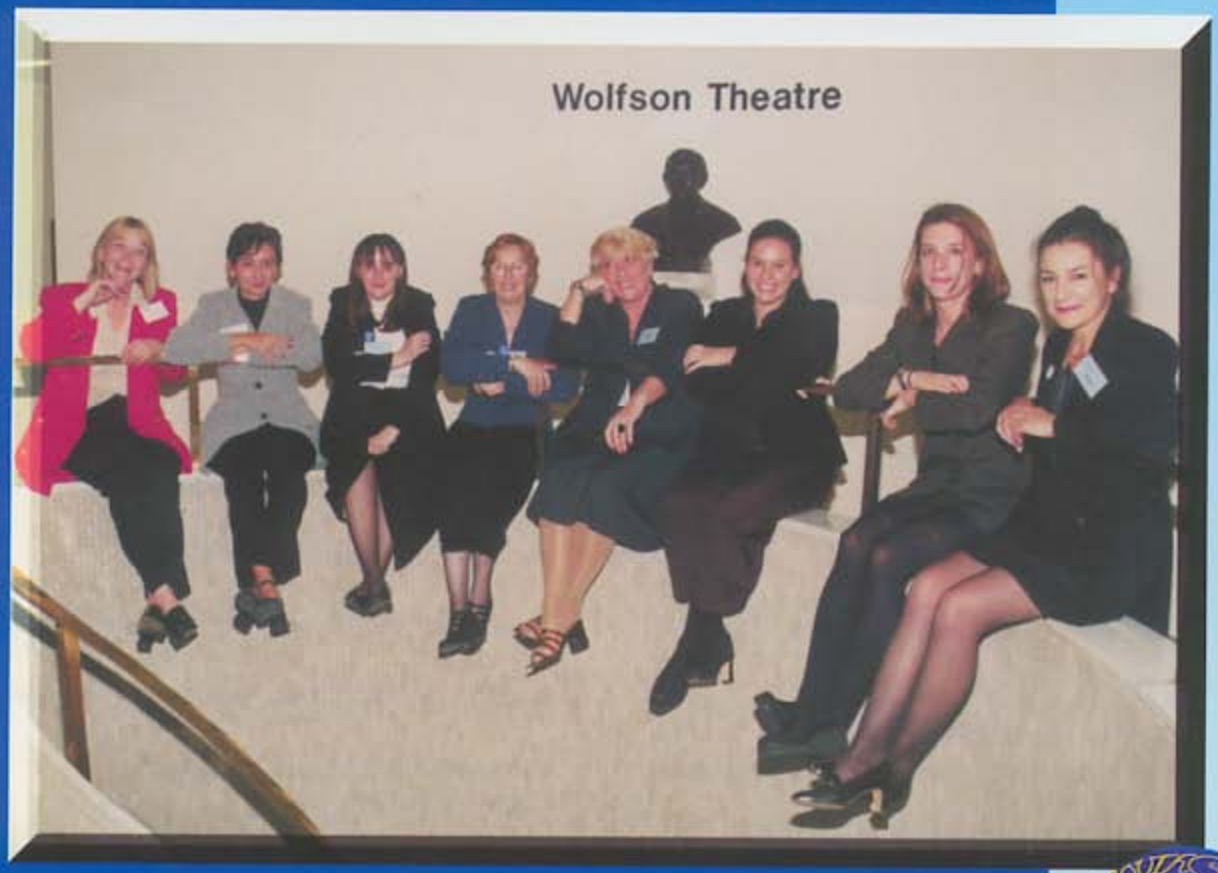
Volume 12 - No 2
Summer 99

ISSN 1363-8394

Journal of Adolescent Health and Welfare

The Journal of the Youth Support
British Society for Adolescent Health and Welfare



Incorporating the Newsletter of the International Regional Chapter of the Society for Adolescent Medicine.

Letter from the Editor -

Dear Colleagues,

So far it has proved to be a very eventful year for Youth Support. One of those years when you seem to be forever reorganising, redesigning and starting new initiatives. At Youth Support House we have been very busy and have been full of residents while a number have also moved onto The Bridge - semi independence unit. This has been a welcome addition to our services and a much needed resource for those youngsters and young parents who find it hard to cope with life on their own for the first time.

The new look Journal should be available on the website quite soon - we have had a delay caused by server problems which have plagued us at the Cyberbridge internet café for the past few months. Hopefully this is now corrected by changing server company (TWICE!!). However, you may have noticed that conference details etc are already available. We still have our main site at http://www.youthsupport.demon.co.uk but the conference details are on their own website at http://www.youthsupport.com - for full details of our websites see overleaf.

Diana Birch
Director Youth Support

CONTENTS

~ CONFERENCE ROUND UP ~

Personal Views of those attending recent conferences -

Our two conferences at the Royal College of Physicians in October 1996 and 1998 have now both been published as proceedings books which are available - see below.

We would encourage you to order the proceedings books - they are very good!!!.

Extracts will be printed in the journal.

Proceedings of our Conference 1996

Youth - Our Resource for the Future

Now available from Youth Support - £5 by mail order -
13 High Street, Penge, London SE20 7HJ
Fax: 44 181 325 8647
or Email us at
lisa@youthsupport.demon.co.uk

Proceedings of our International Conference October 1998

Youth - Conserving Our Resource for the Future

Available in April 1999
Advance orders to the above address - £8

Please send me _____ copies of Conference Proceedings 1996 @ £5

Please send me _____ copies of Conference Proceeding 1998 @ £8

I enclose cheque for £_____

Name _____

Address _____

_____

Tel No: _____ Fax No: _____

Email: _____

SAM – Society for Adolescent Medicine
Los Angeles March 1999

The first conference of the year was the SAM meeting in Los Angeles in which took place Wednesday 17th March to Sunday 21st March. The theme this year was the family and the International Chapter held a workshop entitled - "When is a family dysfunctional? - A cross cultural view." The presentations from that workshop will appear in a Journal in the near future.

Mexico March 1999

Hot on the heels of Los Angeles we had the Mexico City conference ably hosted by Anameli de Monroy. This marked the 21st anniversary of CORA the organisation founded by Anameli. The meeting was well attended and supported by PAHO Pan American Health Organisation; UNICEF in the person of Bruce Dick and several other notable speakers were Herb Friedman, John Paxman, Leo Morris ., Alberto Rizo to mention but a few. USAID, UNFPA and Pathfinder were also represented.

The proceedings are to be published in Spanish and possibly English. The presentation below 'Psychological Issues in Teenage Pregnancy' is taken from that conference.

PSICOLOGIA DEL EMBARAZO EN ADOLESCENTES

Dr Diana Birch
– Director Youth Support – London

El factor fundamental a la hora de valorar la prevencion y el impacto que supone el embarazo en la edad adolescente no se halla en el proveer a los jovenes con metodos anticonceptivos, sino en el mundo emocional de estos adolescentes y su motivacion psicologica. A continuacion consideraremos cuatro aspectos fundamentales.

1.-**Creencias sexuales de los jovenes.** El reto que supone el desarrollo de las emociones sexuales repercuten directamente en la esencia de nuestro ser. Como debemos entender este reto y las creencias sexuales del adolescente? Que influencia tienen en las relaciones sexuales y el embarazo? La tarea de crear su propia personalidad puede llegar a ser un imposible para la joven que descubre que ya no es una nina pequena, sino una mujer fertil.

2.-**Estudio de la autoestima.** Para explorar la relacion existente entre la idea que se tiene de si mismo y su sexualidad, se ha hecho un estudio sobre las diferencias existentes entre un grupo "sin problemas" de jovenes de instituto, un grupo de jovenes embarazadas de edades comprendidas entre trece y quince anos, y un tercer grupo de madres jovenes con ninos de al menos dos anos de edad. El resultado demostro

que el embarazo podia ser utilizado por ciertas jovenes con pocos recursos economicos, como una fuente de autoestima y una solucion, aunque falsa, a sus problemas.

3.-Ciclos que se repiten. Por que repiten las jovenes su experiencia con el embarazo? Un alto nivel de flexibilidad emocional y una cierta forma de resistencia, las protege, en parte, de el trauma emocional, mientras que a su vez facilita la repeticion de este proceso nocivo. Es interesante considerar esta repeticion como una forma de fracaso a la hora de tratar con estas experiencias dolorosas.

4.-El embarazo como experiencia de maduracion. Muchos de los factores hasta ahora considerados, podrian ser descritos como influencias negativas para el desarrollo y maduracion personal. Podria haber en la experiencia del parto algun aspecto positivo y beneficial para la joven madre? Para muchas jovenes, la crisis de la adolescencia, seguida de embarazo y parto, han facilitado su crecimiento psicologico.

'Psychological Issues in Teenage pregnancy'
Diana ML Birch

Psychological Issues in Teenage Pregnancy

A. Teenage sexual belief systems.

Teenage Sexual Belief Systems

That old black magic ... The challenge of developing sexual feelings and urges strikes at the core of our beliefs about the world, who we are and the meaning of our lives. How can we understand this challenge and the sexual belief systems of young people? Any assessment is inevitably influenced by our own beliefs and we must take care to retain objectivity, listening to our young patients rather than imposing our own interpretations on their situations.

Where do these belief systems stem from? Parental, cultural and religious beliefs and myths form a basis upon which the more contemporary 'up market' beliefs are built - for instance the current peer group stance or the 'dish of the day' in terms of the media 'hero'. The immediate message can be as evanescent as the foibles of the pop charts - as professionals, we need to keep abreast of what the latest 'no 1' is teaching our youth. These belief systems, however bizarre and contrary to our own personal beliefs are at least tangible. We can understand where they stem from and we can to some extent modify them with appropriate input in the style of cognitive therapy, sex education etc.

In psychotherapeutic terms we can say that they are messages from the internalised Parental ego state (Transactional analysis), in simple terms the parental 'do this' 'don't do that' voices we carry around in our heads

like a nagging conscience. Freudians would call this the superego. The intensity of these messages can be modified by educating or activating the Adult ego state (ego), the 'thinking' part of our inner selves which deals with factual knowledge. For instance group beliefs such as "You can't get pregnant the first time" or "It's OK if you do it standing up" can be confronted with factual knowledge such as '1 in 20 pregnant schoolgirls got pregnant as a result of the first time they had sex' and 'sperm can swim up hill'!

Magical Beliefs

But at a deeper level, we have beliefs that are out of reach of direct social pressures. At this deeper level are what I would describe as 'magical beliefs'. Intrinsic ideas with a high emotional content, a feeling of instinct and intuition and which may have no perceivable basis in current reality. These 'magical beliefs' acquired at an early stage of development may be ascribed to the Child ego state (TA) or perhaps the Id (Freud). They are very firmly adhered to largely out of awareness and profoundly affect the individual's sexual and reproductive practices. Failure to understand such beliefs can entirely sabotage a treatment or contraceptive programme. 'Magical beliefs' centre on fundamental concepts such as feelings about self, body and control and on the nature of life itself.

Personal Identity

The adolescent during psychological development is much preoccupied with the question "Who am I?" confusion inevitably arises when "Who am I?" becomes "Who are we?". Establishing a personal identity can be an almost impossible task for a pregnant adolescent who suddenly finds that her identity is changing beyond her control, she is no longer a 'little girl', she is a fertile woman. The role of mother is thrust upon her before she has established her own identity, hence the belief that she cannot get pregnant and the frequent denial of pregnancy.

"I knew about sex and how girls could get pregnant, but I never thought it would happen to me." Many girls deny they can become pregnant. They believe that they are too young. Belief in the impossibility of pregnancy can become almost a 'magical protection' like a lucky charm used against the evil eye 'well it won't happen to me'. These teenagers are still at the stage of concrete reasoning and cannot identify with the experiences of others. They believe fervently in the invincibility of youth. This explains why health education methods based on 'shock tactics' do not work with this age group.

Denial

"My grandad smoked and he got cancer. I've been smoking since I was thirteen but I'm OK".

"You hear about things happening to other people but you never think it will happen to you. When my friend got pregnant, I sort of thought she must have been a bit stupid but then I realised that I hadn't come on (with a period) and I realised that I had been doing the same as her."

Operating at this basic level and being unable to identify with the experiences of others means that young people (or adults who have not 'matured' psychologically) at this stage cannot learn from others mistakes, and perhaps can only learn from their own.

Control

Teenage sexuality is profoundly affected by beliefs about control. A feature of adolescent development is an internalising of the 'locus of control' ie an assumption of responsibility for one's actions and one's body. Many do not reach this stage, remain with an external locus of control and believe that they have no control over their bodies or actions. They are not in control of when they have sex and they are unable to control whether they get pregnant. They are not responsible. Pregnancy is something which 'happens' to them. It is a matter of fate. Many girls said that they hoped they would not get pregnant but never considered doing anything to prevent it. Such girls are accustomed to having little control over their circumstances. They live in poor housing, have little money, do badly at school and are unable to change their environment. When an unplanned pregnancy occurs this represents the ultimate loss of control, even their bodies are acting independently of their wishes.

Autonomous Womb

In fact, within this belief system there appears to be an element of belief in the 'autonomous womb'. It is as if the teenager believes that the body consists of three areas; the non sexual body over which one can exert some control eg running, walking; the sexual erotic areas which are under less control but can be fun to use such as the penis, breasts and vagina; and the third area over which there is no control, the womb. The belief in the autonomous womb explains why teenagers do not believe that sex will result in pregnancy. It also explains some of the denial. "Well, I knew someone was pregnant, but I didn't know it was me."

Missed periods, feeling ill and tired, putting on weight and feeling the baby move all add evidence to bring home to a girl the realisation that she is pregnant. Despite this one fifth of schoolgirls do not face up to the situation until a third person, their mothers or sisters tell them that they are pregnant. Girls seem to be spurred into taking action by missing further periods, and lull themselves into a false sense of security in the middle of the month. It is as if each expected, but missed period reminds them that they could be pregnant and should be doing something about it, whereas as this danger time passes they can deny it again with another 'magical belief'-"Well, perhaps I was only a little bit pregnant."

Poor Use of Contraception

Lack of control is at the basis of the teenagers notoriously poor use of contraception. Only 7% of London pregnant schoolgirls have ever used contraception. Young girls deny to themselves that they are having sex and convince themselves that if they do end up in bed with a boy, this is a 'once off' and not a regular happening. This denial is a protective

mechanism. They are conditioned into believing that girls who have sex or want sex are 'sluts' so they must convince themselves that they are 'not like that'. The belief is that unplanned sex is an accident. Nobody can be blamed for the occasional slip, for 'getting carried away', 'swept off her feet' ... the cliches are endless. However premeditated sex is inexcusable. "I never thought I'd be doing anything like that. I went to a party and I suppose I got a bit carried away, you know how it is."

Self Esteem

B. The Self Esteem Study

In order to explore the relationship between ideas of self and sexuality, a research model compared a control group (secondary school age girls) a group of pregnant schoolgirls (aged 13-15) and a group of schoolgirl mothers with children at least 2yrs old. The groups were investigated by - A self esteem measure, A 'deprivation score' looking at life experiences; A 'sexual' scale estimating degree of sexual experience or sexual trauma.

Girls who were more deprived, had lower self esteem but those who were pregnant were less affected by these adverse factors. Similarly those with adverse sexual experiences were generally more deprived and had lower self esteem measures. Again the pregnant girls were less affected. It would seem that pregnancy partially protects the individual from threats to self worth but the effect is temporary. By the time the child is two the harsh realities of life take their toll once more. The temporary nature of this boost to self esteem may account for repeat pregnancy, in an attempt to re-establish identity with the counter culture and redefine alternative dimensions of value. Why does it seem that pregnancy is such a potent source of self value? " ... Seen from the young girl's viewpoint, pregnancy may not be so undesirable. Certainly it brings heartache and hardship, the extent of which should not be underestimated, but for underpriviledged girls with little education and non existent job prospects, motherhood is a fulfilment. With the birth of her baby a 'failed' school drop out, an unemployable misfit, becomes an acceptable member of society with a valued role - that of a mother. She is successful and out of her loveless world she has created her own baby who will love her."

In pregnancy, a girl identifies with the ideal mother which she never had and can never be. We need to help her to identify instead with the ideal woman who has no need to be pregnant in order to achieve self value. Pregnancy can be used by some deprived girls as a source of self worth and as a false solution to their problems. That being so, an alternative solution must be offered. They must be given a different way of valuing themselves in order to ensure that, when they become pregnant, this is because they desire parenthood with all its responsibilities, hardships and joys and not merely as the only perceived escape from a catalogue of problems.

C. Repetitive Patterns –

Why do girls 'repeat' their pregnancy experiences? Girls with multiple relationships can progress from one relationship to another and repeat the experience without seeming to 'learn' from the previous situation. A high level of emotional flexibility and a kind of resilience can protect them from some of the knocks while 'enabling' further continuance of this inherently damaging pattern. The same could be said of repeating the experience of pregnancy and childbirth. If bringing up a child is hard and girls are just coping with a baby - or two, or three - why have another? Why repeat the experience? - particularly if it is not an entirely 'wanted' event. It is interesting to look at this repetition in terms of failure to 'work through' a painful experience. The girl enters into - 'falls into' - the next scenario while she is still reeling from the first. She has no time in which to 'lick her wounds', take in the experience, learn from it and so modify her future reactions. In general a traumatic event is followed by a reaction which gradually dampens with the passage of time and settles in resolution. That initial impact could be a conception, a pregnancy, childbirth, or a partner leaving.

Let us consider the stages of 'recovery' from such a 'trauma'. The initial strong reaction - the 'outcry' - is followed by a period of denial when we don't really want to deal with the situation and we would rather it 'went away'. As the denial period progresses, the 'victim' is confronted by reminders which nudge reality back into the scene ... intrusive thoughts and memories of what has really happened stop us from continuing in the denial process. Constant reminders and confrontation of denial allow a period of 'working through' to be entered into when we can come to terms with what has happened and this results in completion and acceptance of our situation. It is only by working through all these stages and arriving at understanding, accepting and fully realising our situation that we can stop it happening again.

So how is the process applicable to repetition of pregnancy? At each stage we could see how a girl could either 'work through' to the next stage or be blocked in the process. The 'blocks' can be derived from her social circumstances, by the presence of other types of emotional assaults or other traumas in her life or by the too rapid arrival of another man on the scene or another pregnancy. Basically she may not get time to deal with one stage and move on to the next before another 'trauma' raises it's head. Any of such influences will arrest the recovery process and in fact send her 'back to square one'. Each time she is sent back to 'Go' she will find it that much harder to stay on the path and will experience repeated re-experiences of the same harmful route - she is as if trapped in a mad game of 'Monopoly' never able to throw the right dice to get her 'out of jail'.

A Maturation Experience

D. Pregnancy as a Maturation Experience.

Leading on from our discussion of self worth and the manner in which young women with unfulfilling life experiences, with abusive childhoods and with poor future prospects can 'use' their pregnancies as a source of self worth .. it is worthwhile considering what else a pregnancy could contribute to the emotional changes and developments going on for that young woman in adolescence.

Inner Child

The pregnant girl can identify with the foetus and concretise her experience of the 'inner child' in her developing baby; this allows her another chance to be 'loved this time' by the 'ideal' mother. It also results in confusion between container and contained and thus confusion of the boundaries between the mother's 'self' and the baby's 'self' - preparing the ground for an overly symbiotic attachment and problems in separation and individuation. Many of the theories and factors put forward above could be said to be negative and perhaps interfering with 'normal' maturation and development- are there aspects of childbearing for young women that could be described as positive beneficial?

If in pregnancy a young woman is identifying with - and almost becoming - the 'inner baby' - will the development of this inner baby allow for the re-experiencing of the same stages of development by the young mother? Just as she can be loved and wanted again as a 'new baby' - looking at the experience from a rather psychoanalytical point of view - can she have another chance at 'getting it right' for other emotional or 'psychic' aspects of her development? " ... It is striking that despite advances in contraception and the easy availability of termination of pregnancy, a considerable number of teenage girls still become pregnant and some become mothers. For many the normal developmental crises of puberty and adolescence, followed by that of first pregnancy and motherhood, facilitated further psychic growth ...."

Psychic Growth

Certainly there are situations where pregnancy does seem to afford an opportunity for 'psychic growth' , for maturation and personal development. There are also unfortunately times where the 'traumatic nature' of the pregnancy and birth experience afford the opposite - where the experience can seem to "... revive primitive anxieties and conflicts ... which cause them to regress" (Pines 1988) and where the "... birth of a real baby may prove disastrous". That is 'real' baby as opposed to 'fantasy' baby or 'ideal' baby.

Object Relations

So what makes the difference? What turns the potentially positive experience of pregnancy and childbirth into a negative and vice versa? The key to the question lies in the girl's 'object relations' - in other words how she sees her self and the world around her - how she experienced her world and thus herself as a child. To very much oversimplify for the sake of this current discussion - Just as the young mother experiences some of her world as 'good' and some as 'bad' - she

has in childhood internalised a view of her mother as the 'good mother' or the 'bad mother' and thus also a 'good internal object' and 'bad internal object'. If we develop the premise that the foetus is the 'child within' with which the mother identifies - then that inner child can be also be seen as 'bad' or 'good' depending on the expectant woman's previous life experience. The baby is an embodiment of the girl's 'object relations' and the conception can thus be the stage upon which the early drama which defined the nature of the 'internal objects' can be replayed .. and hopefully altered for the better.

If, as is hopefully most usual, the child represents the idealised mother - the child is the 'good object' ... but if the child represents the hated mother - the child becomes the 'bad object'. In other words if the 'action replay' that we are allowed in identification with this developing 'new baby' evokes feelings of the existence of a perfect 'idealised mother' - then this experience will be positive and lead to growth and positive maturation and change.

If however the 'action replay' evokes the revival of memories of the neglectful and rejecting mother of say an abused girl - then the baby will be perceived as an unloving rejecting being who becomes unwanted, unlovable and rejected - the experience leads to regression and is more likely to lead to a need for further repetition ... another try .. another hope that it might be different .. might be better.

Being Held

The way the pregnancy / birth experience is perceived will very much depend on how the mother herself is cared for during the pregnancy. If the young mother is being 'held' and cared for and nurtured during the pregnancy , the outcome is likely to be positive - if not - if the mother is not 'held' and cared for herself - perhaps boyfriend has left and she has no support - the outcome is likely to be negative. A vulnerable or fragile personality could break down completely under the 'assault' of a pregnancy experience.

Hence the experience might be summarised thus :-

negative
+ ve - Brings identification with unspoilt self / child
→ care for neglected child
→ Love and caring for baby.

positive
- ve - Brings identification with the 'unlovable' child
→ projection of negative hostile feelings.
→ Rage and jealousy of baby.

Throughout this discussion - we must maintain the concept in our minds that the vision of 'self' as experienced by the mother is completely wound up and inextricably linked with the vision of 'the object'. In other words the 'object' which is the mother and at the same time is the child is also the 'self'.

"The special task that has to be solved by pregnancy and becoming a mother lies within the sphere of distribution and shifts between the cathexis of self representation and object representation".

Those mothers who are not 'held' during their pregnancies and who thus re-experience their childhood rejection through rejection of their pregnancies - may to some extent find that a therapy experience can put right some of those wrongs - In therapy for these girls - they need to find their 'ideal mothers' in the professional setting - in the transference - otherwise they will attempt to 'do it again' in a slightly different situation, with a different partner , with a different baby - in the hope that this will 'make them good'. Hence the 'repeaters'. Perfect mothers are hard to find!

"THE CHILD THAT ROCKS THE CRADLE"

A Fifteen Year Longitudinal Study of Schoolage Mothers and their Children.
Diana M. L. Birch

This book, although standing alone as a comprehensive account of early parenting, is also the sequel to "Are you my sister, Mummy?" and depicts the next phase along the road of parenthood. These are the same mothers, fathers and children fifteen years on. How did life turn out for them? - What kind of families did they create? - What is going on for their teenage children?

The findings of a fifteen year longitudinal study of 200 young families in which the mother gave birth under the age of 16 years has provided information which refutes many of the stereotypic views regarding young parents. It illustrates how the presence of a supportive family leads to an improved prognosis for young mothers and their children and gives insights into positive and negative predictive factors. Some unexpected outcomes and their possible aetiology are discussed.

Consideration is given to approaches which may enable professionals to confront the 'cultural trap' in which many young people are caught - in that those suffering the worst deprivation in early childhood, those raised in the 'care' system and children's homes are those young parents most likely to perpetuate the cycle of deprivation for their offspring.

ISBN: 1 870717 08 2
Youth Support Publications

Cyber Bridge

internet cafe

Tel/Fax: 0181 776 7955

Cyber Bridge

internet cafe

JUNIOR SURFERS CLUB

Welcome to the Junior Surfers Club!!
Membership fee is just £5 per year. For this you get:-

- Our Badges
- A Warm Fuzzy
- Membership Card
- Free entry to computer talks
- Use of computers during meetings
- Earn points towards 'Star Surfer'

Junior Surfers Club meets at Cyber Bridge - every Monday and Thursday at 4pm and Sunday at 11am. (Please check times as they may vary).

As a member you will be taught how to use computers, to get information from CD Roms and from the Internet and how to 'surf' the Internet. You will later also be shown how to use Email. As you learn - you will be given points towards your 'Star Surfer' award. This means that you will then be able to have discounts on things you buy at the Cyber Bridge and off the cost of time on the computers.

We may also allow Star Surfers to have their own Email addresses after they have reached a good level of understanding on the computers and have helped us with projects in the Cyber Bridge.

Tell your Schools about us! - We can arrange special sessions for schools and other organisations.

A Youth Support Project - Cyber Bridge

13 High Street Penge Tel: 0181 776 7955
Email: anyone@CyberBridge.org
Web Site: http://www.Cyberbridge.org

- International Chapter News -

News of the **International Regional Chapter (IRC)** of SAM
(Society for Adolescent Medicine)

Co Chairs -	Diana Birch	Gustavo Girard	Treasurer	Aric Schichor
	London	Buenos Aires		Connecticut
	England	Argentina		USA

Our Chapter held a workshop at the 1999 SAM meeting (Society for Adolescent Medicine) Los Angeles – entitled – **"When is a family dysfunctional? - A cross cultural view."** The planned format was as follows –

The family provides the 'stage' upon which emotional development takes place and sets the scene for future difficulties, personality problems, and patterns of low self worth, self harm and abuse. Our concept of 'family' has changed from the classical view of the nuclear family to a variety of models including extended family, single parent, adolescent parent - there is no single concept of 'family'. On a more cosmopolitan level - family structure varies cross culturally and we should perhaps also consider bands of street kids and runaways as developing their own 'family' groups.

What family structures work for the individual and why? What is a dysfunctional family? How can we and when should we intervene? By working with families we hope to break cycles of dysfunctional patterns and enable children to grow into happy effective adults and future parents themselves. This institute will explore the above issues on a cross cultural basis and attempt to draw common lessons from our joint experiences.

Proceedings of the workshop will be published in the winter 1999 issue of the Journal .

The International Special Interest Group indulging in it's 'Special Interest"

Israel 15th – 18th November 1999

International Seminar on Violence and Adolescence

A series of workshops run by international experts will examine the factors that determine the presence of violence , preventive measures to reduce its incidence and the provision of mental health care for the victims of violence. Among the speakers will be

*D Birch UK * E Chigier Israel * M Christensen, Sweden * J Cohn Norway * S Gordon USA Israel * * Y Harel Israel * J Kienhorst Netherlands * H Tolmas USA * L Verhofstadt Switzerland.*

Details from – ISAS - PO Box 574 , Jerusalem 91004, Israel -
Tel 972 2 6520574 Fax 972 2 6520558

SAM 2000 - IRC Workshop
Washington March 2000

PLEASE PREPARE IDEAS AND SEND IN CONTRIBUTIONS SUBJECT

Proposal for SAM meeting March 2000
'Institute' - International Regional Chapter (IRC) SAM

'Youth in a Violent Age – The Challenge of the new millennium?'

As we enter a new millennium, part of Europe is at war; nail bombs have exploded in London; there is news of school massacres and the number of dispossessed children and young people rises. Are we moving forward to a healthier future or to a disordered era of escalating violence?

Our modern age has brought continents and cultures closer together, air travel, the media and now the internet has bridged the gap between social groups disseminating not only knowledge and information but also spreading cultural challenges and 'unhealthy' behavioural patterns. Youth learn to mimic gangs, gun carrying school boys, and violent cultures – the peer group has become worldwide. The International community can no longer regard certain patterns of disorder as relating to 'other cultures' – we are fast becoming uniform in the problems we deal with and hence need to find common solutions.

In this institute we will examine some key areas of universal international interest focussing on issues of Youth and violence.

'Profiles'

The British Society for Adolescent Health and Welfare
(Previously the Youth Support – Forum on Adolescent Health and Welfare)
Announce their fourteenth annual meeting and the first to be held as the new 'British Society'
On Friday 15th October 1999 at 6pm
at the Royal College of Physicians, St Andrew's Place, Regent's Park , London.
Preceded by the European Chapter meeting – IAAH
Followed by the conference Dinner at 8pm
The meeting will discuss case work and outcomes of the work of Youth Support and examine prognostic signs and indicators.

Contact Conference Secretariat for further information and to secure a place.

Conference Secretariat
'The Bridge' 13 High Street
Penge, London SE20 7HJ
Tel 44 181 325 8162
Fax 44 181 325 8647

The International Chapter Hard at Work

European Meeting
'International Association for Adolescent Health' European Chapter
in conjunction with the Youth Support
'British Society for Adolescent Health and Welfare'

A combined meeting will be held on Friday 15th October and Saturday 16th October 1999 in the Seligman Lecture Theatre of the Royal College of Physicians, London.

'Profiles'

Working with adolescents we are often faced with complex situations, multiple stresses and pathologies in a combination which appear to defy solution. Here we look at profiles of our patients and their families and examine programmes and strategies for dealing with 'difficult' cases.

Sessions - Friday 15th - **Stress, Family Breakdown and the Adolescent** - Family breakdown whether it be caused by divorce, bereavement or abandonment can expose the developing young person to a confusion of roles and crises of identity. Adolescents themselves can become the focal point and the catalyst for family change whether negative or towards healing . Topics include – 'Dad I'm Gay' – sexual identity in the family setting; Disclosure of sexual abuse; Parental substance abuse – must youth follow the pattern?
Friday 6pm – **Profiles of Youth Support**- rehabilitation and prognosis.
Saturday 16th – **Creating positive Change** - free papers and case presentations
The meeting will include presentations from a number of European colleagues and will aim to provide a lively forum for discussion and interaction between professionals in the field. To this end we are keeping numbers limited to a maximum of 100 delegates, hence early registration is advised.
Abstracts and ideas for presentations are welcomed – please send to conference secretariat at address below. Abstracts should be in the form of approximately 200 words typed on A4 paper and including name, address, contact details and institution of author. Articles may also be Emailed to Lisa @ youthsupport.demon.co.uk.
The conference package includes – attendance at all sessions – lunch on both days – tea and coffees both days – dinner on Friday evening. Cost £170 per delegate. (Accompanying persons may buy added dinner tickets at £30 each)
Accommodation package – in order to provide some cheaper rooms in London we are negotiating a special rate in a top hotel near the venue. This will be on the basis of approximately £60 per night in a shared room – anyone interested in taking up this option should contact us as soon as possible and state their preference in terms of whom they wish to share with – single rooms will also be available but at a higher cost. Contact Secretariat for further information. Part payment will be required in advance.

Conference Secretariat
'The Bridge'
13 High Street, Penge
London SE20 7HJ England
Tel 44 181 325 8162
Fax 44 181 325 8647

BASPCAN

British Association for the Study and Prevention of Child Abuse and Neglect

The Millennium Congress

MEETING CHILDRENS NEEDS - THE OPPORTUNITY FOR CHANGE IN CHILD PROTECTION

17-20 September 2000
Venue: The University of York

BASPCAN's Fourth National Congress will include keynote speakers, free papers, symposia, workshops and poster presentations for a range of professionals from different disciplines involved in child welfare. Papers are invited from social work, medicine, voluntary agencies, police, the legal profession and international perspectives.

CALL FOR PAPERS*

Deadline for Submission of Abstracts	**15 January 2000**
Notification of Acceptance	**31 March 2000**

***All members will receive Abstract Forms with mailings**
***Non-members, please contact the National Office**

BASPCAN National Office, 10 Priory Street, York, YO1 6EZ, UK
Tel: +44(0)1904 613605, Fax: +44(0)1904 642239 email:- congress@baspcan.org.uk

As you all know adolescents are a special branch of people, a special species, they are young attractive and healthy. Well, at least most of them are but many of these young people are not so healthy at all. About 10 to 20% of all young people in population suffer from some sort of chronic conditions seriously affecting their daily life activities. And about 3 to 6% have serious conditions with serious consequences for daily life.

Improved Life Expectancy

As is true for cystic fibrosis and it is true for many childhood conditions that treatment improved over the last decade and life expectancy went up. Nowadays it is estimated and I quote from an American study of Bob Blum, that about 90% of all children with chronic conditions survive into young adulthood. So we should be very aware and the previous speaker already said that, that it's not only the quantity of life counted in years but also it's very important to look at the quality of life. We are talking about chronic illness and since the 70s the studies of Stein and Jessop there is a general trend in the literature that consequences of the chronic disease can be generalised to many diseases. And of course this is true, the social consequences, the risk for social isolation, the risk for problems with mood and acceptance and things like that but we should keep in mind that for the young person him or herself the social and psychological consequences of the disease are linked to that particular disease.

So a young man or a woman with a diabetes considers the consequences of daily life as a consequence of the diabetes mellitus. Chronic illness comprises a lot of different diseases from the medical point of view with difference in ideology, clinical expression and prognosis but there are difference from the psychological side. As I said for a young person himself it's that particular disease that is causing trouble, from the psychological point of view there are differences between these diseases as to the point of whether a genetic disease opposed to an acquired disease. We think that adaptation and coping with a genetic disease goes a little bit more smoothly, it's there, the disease is present from birth and it's going more quietly and smoothly as opposed to the acquired disease, for instance juvenile arthritis when a kid is 12 or 13 and is confronted with a serious and crippling disease and there has to be a period of sorrow because of the lost health and lost normal life expectancy.

Body Image

We are talking about illness and treatment on the one hand and growth and development on the other hand and of the more serious the disease manifests itself the higher the severity of illness the more chance you have for some problems, but the opposite is also true. We see a lot of young people with only mild forms of the disease for instance the juvenile arthritis with only a few joints involved where there are a lot of psychological and social problems. Probably because they compare themselves and they try to compete with normal healthy adolescents. Positive body image of course is difficult to acquire when the body feels

or is hindering you with impediments. As to autonomy we as health care workers have to teach young people that it is not shameful to need a little bit of help of your fellow people. So the development of independence in the emotional sense is quite another thing than have to be dependent in the physical sense. But that's a long story before young people and adults grow up to that point.

Education

As to education most of young people with chronic illnesses go a regular school, in our country it's up to 85%, but sometimes they are somewhat delayed in educational process and as doctors or psychologists we have to be aware that some diseases as well as some treatments, schedules go along with cognitive problems. As is true for some types of cancer treatment. And to social adjustment, integration would be a better word, the more seriously the child or the adolescent is affected the more chance that the range of social activities is restricted. Well, it's true that a lot of conferences about chronic illness in adolescence last years stressed the point of resilience and coping abilities. We should keep in mind about 85% of all adolescents with a chronic condition adjust very well. A few groups might be at risk, in the first place youngsters with invisible handicap are often inclined to keep the condition secret, this has some advantages, for instance you can avoid reaction of pity or misunderstanding, but very often the price is too high because the youngsters are permanently afraid of disclosure of other people noticing their condition. Youngsters with the unstable condition as the arthritis, youngsters with juvenile arthritis, as well as with a progressively worsening disease it's very difficult often for peers and adults to react and respond adequately. And the last point that true for cerebral palsy for instance when the brain is involved or central nervous system, you have a double handicap.

The Family

All chronically ill youngsters and this is a familiar issue should be family oriented. We have to focus on the stress of the disease as it is affecting the work or the relationship with the parents and now and then and we do that in clinical practice we should have a little talk with the siblings as well. And the literature tell you that most brothers and sisters of adolescents with chronic conditions don't have so many behavioural problems or problems with social adaptation. That maybe true but still they may suffer not so much from lack of attention of the parents but they may feel for instance a little bit guilty that they don't have the disease, for instance they may feel a little bit anxious about the genetic side of the disease and may feel anxious about their own offspring and so on and sometimes they develop psychosomatic complaints. On the other hand when you speak with these siblings you will be struck by the huge amount of solidarity and social support they give to their affected sib. Well, family even in adolescents remains very important for the social and emotional support of the adolescent, open communication within a family is very important, but the communication between the treatment and the family is very important too. And you have to enhance the coping skills of the family.

This is very important because one of the major coping skills is of course the power that allow them to stay in control because the disease goes on for many years, lifetime, there should be a balance demands of treatments dictated by the disease and the demands of the normal daily life activities. And you have to negotiate between these demands.

Social Integration

As to social integration, as the afternoon goes on we go more to the practical side and what can we do to help and support these youngsters and tomorrow in our workshop on chronic illness we'll focus more specifically on these points, there are a lot of services to support young people for this social integration, focus independently on special services, focus at education, training and employment. So what's clear is that it is a joint effort between the adolescents, family, health care workers and society. And as health care workers what we should do is educate young people about practical consequences of the disease, we do that as a rule, educate them on the emotional and social consequences, it's a little bit less the rule, but we still should do that and nowadays we focus a lot on skills training. It's not a point to assess to social difficulties for young people with chronic condition, what you should do is reverse, you should teach them skills.

In my own country unemployment rate is very low and the productivity is very high. That's good to say and that's marvellous form the economic point of view but the other side of picture that a lot of young people with physical handicap are not able to get into the labour market, so they are put on a disability allowance. What appears to happen and it's a sad story that we buy our disabled. What we should do from the society point of view is create facilities for social and economic participation otherwise it's useless to train people and support people to be young adults with a lot of facilities and abilities and then they will be stuck in their development process. We should do that so not only healthy people but also young people with physical disability can face the world proud and self-assured.

Chronic Illness and Youth

Helena Fonseca.

Working with adolescents with chronic illness is not easy but undoubtedly it is very stimulating, I have been doing this for many years. I have always felt that the effects of the chronic condition on the adolescent very often outweighs the impact of the illness itself. We have to keep this in mind when we have an adolescent with a chronic condition in front of us even if the chronic condition is not very serious, it's impact can be huge. It has been quite interesting for me thinking the impact of the chronic illness on the adolescent not only thinking about the age of onset of the condition, the nature of the condition but also trying to think about the first impact about the development of tasks of adolescents. So thinking about autonomy and identity I will go a little bit through all of these, I will try to be clear and just beginning by the age of onset I do think this is an

Age at Onset

important point just because if the chronic illness starts at birth or in early childhood what happens is that sometimes this leads to ultra parental expectations so what we see and this is really very usual we see that parents don't have the same expectations towards these kids as they have towards another one. And this is quite serious when the start is at early adolescence. At this stage what happens is that the adolescents is very concerned about his or her body and chronic illness may lead to extra concerns. Also at this stage because the adolescent has yet to separate from his family what happens is that this can lead to little struggle for independence. And you can see adolescents at this stage feel very dependent from their parents.

When the beginning is at the middle adolescence stage this age may be the most devastating time for a chronic illness to start. And the reason is because during this period the adolescent is intensely involved with parental separation with peer involvement and concerns with his or her own sexual development and so a chronic illness appears here and the adolescent will no doubt face extra difficulties in all this process. If it starts in late adolescence I do think that the main problem is that it will disrupt vocational plans, it will disrupt prospective of leaving independently and things related with this. Of course it is important to look as my colleagues said previously it is very important to look at the nature of the illness. And of course its course, the chronicity, the side effects of the medication all this is very important, the prognosis of course but I would like you to stop a little bit at this second point, the visibility.

Visibility

I have been noticing that visibility is really very important. And from our experience highly visible disease even if it is less serious may cause more disruption than a very serious one. I have some adolescents with dermatological problems and these problems which are not so serious for instance eczema but they are really disruptive. As clinicians we have to be really aware about this point.

Autonomy and Identity

So as I promised and this framework has been very important to me at least it was developed by Laurence Neinstein and I like it very much so thinking about identity and autonomy the adolescent with a chronic illness may have difficulties with his or her developing identity. And this is linked with a body image. Adolescents are highly concerned with their bodies and either because they have delayed puberty or because they are carrying some kind of malformation this can lead to a lower self-esteem, so segregation from peer and increased anxiety over sexuality and like at the end of this continuum sometimes depression and really very negative feeling. So I would say that a chronic illness at this point can severely interrupt the whole process and the whole movement towards independence. Especially if it takes place in the early or middle adolescence as we have already said this can be a problem much more than the disease in itself in my opinion.

As far as autonomy is concerned sometimes they feel tired, sometimes they feel like and this is a reality for most of the cases, they spend a lot of time in medical appointments, so they do miss school and miss activities. This may lead to fear of peer involvement and can also lead of course to social segregation. If we think about autonomy and this is the like the nice way I like to look at it if we look at autonomy as the adolescents capacity to take responsibility for their own behaviour to make decisions regarding their own lives, it is important, to maintain supportive social relationships, if we think about autonomy in these terms I do think that we can agree that the development of autonomy is perhaps the major goal for adolescents with a chronic condition.

Sexuality

Adolescents face additional difficulties especially related with sexuality. Because of delayed development, having of having too protective parents, because of feeling uncomfortable in expressing concerns about this field, they are very often seen as asexual, and I do think this is huge problem and I do think that paediatricians as me because perhaps we were trained for dealing, for working with little kids we are not sometimes aware of these problems and really need to be. Adolescent girls will have an increased health risk if becoming pregnant because of the main chronic illness but also she is an increased risk of becoming pregnant. And this because perhaps she wants to prove herself that she is able to and there might be many other reasons, we can discuss this later.

So the social and sexual aspirations of adolescents with chronic diseases are not different from the rest of the population. But this kind of adolescents are really specially sexually vulnerable. And if we think about sexual abuse all the research point to the fact that these kids are much more sexually abused than the rest of the kids of the same age. OK. So I would like now at this point to talk a little bit about the family and efforts we have developed to work together with the family especially in Minnesota where I learnt with Joan Paterson about the FAAR model I will talk a little bit about it if I have the time. I learnt that if fact that having a family with us is really very important and much more important if we are working with adolescents in early and middle adolescence. And I do think that we have a very important role in preventing something crisis that could be unnecessary if we have provided a sympathetic guidance. If at the right point we would have been able to talk about the right things, to discuss the right things to give the right help I do think that some problems would not happen.

The Family

If we look at the family as a important resource we can understand how much a successful adaptation to a chronic illness can best be promoted by focusing on the family system. If the family system will be our unit of intervention and not the adolescent individually I do think we are working better. And of course all of us are aware if the family is happy the adolescent with a chronic illness will do better.

So if we think about poor outcomes as feed back increasing demands we can also look at good outcomes as feed back to family systems that increases their repertoire of capabilities. What I mean by this is when I talk about good outcomes I am thinking about having been able individually or as a family to make the right decision at the right time or having been able to take responsibility for a particular behaviour, I do think that this gives power to the family, this makes the family feel that perhaps the nest time they will be able to do the same or even better because they have a positive previous experience.

We really need to pay attention beyond the somatic aspects to emotions. So what kind of emotions does the illness raise inside the adolescent and how is the adolescent dealing with his or her chronic illness and also how does his or her personal and family history influence all this. And at this point I do think at least for me the FAAR model, FAAR as the initials for the Family Adjustment and Adaptation Response, this model has helped me a lot for understanding the family dynamics and learn how to manage with the family. You have here the balance with the two plates and you can see that when a crisis appears what happens is that strain becomes really heavier and this upsets the balance.

Non Compliance

Sometimes we are tired about the adolescent who is not doing the medication, we are concerned about the increased risk-taking behaviours, I understand all that and I have that personal experience but the problem is that if we look at this as a healthy way, a healthy process of autonomy I do think it's a good way of thinking and of working on this. Sometimes the adolescent who copes very well with everything sometimes because she was able to reframe the situation and of course developing coping mechanisms, sometimes this is done at the expense of lots of autonomy.

Continuity of Care

Behind the physical face of the adolescent's medical condition consideration of the adolescent's psychological development and tasks is very essential. This includes informing the adolescent and the family of the nature of the illness, its course, possible limitations of the treatment. Also it is very important is to adapt our language to the kind of adolescent or family we have in front of us. We physicians often speak with very difficult words and sometimes we are not able to reach the audience. Another important point is continuity of care. We really have to think about the continuity and how to deal with it. Of course I have already talked about involving the adolescent and the family and the evaluation of the impact of the illness on the needs of the family. I would only like to say something about the multi-disciplinary team. Something actually I discussed this morning after the chronic illness presentation. I do think that nowadays we are aware that we have to involve in the team many health care professionals and I could like issue huge list but I feel at least in my country that communication sometimes is not easy among these people and this is really a point I think we need to improve. And I say this just because sometimes I do feel that this makes the difference.

CALL FOR PAPERS

Youth Support Italia

"We are shaking in our dreams"

Lisa had felt the earth move beneath her night after night as series of earthquakes had devastated her home town in Italy.

What is the psychological effect of feeling that the earth beneath our feet is not the stable bedrock which we hoped it would be? How do young people and children respond to the trauma and stress of such events?

Youth Support will be holding a conference in Italy

-28th & 29th April 2000 -

based in the medieval town of Fabriano in the Appenines.

The conference will discuss ***traumatic stress in youth*** - related principally to natural disasters and earthquakes. It will also cover other aspects and sources of stress including ***violence and abuse,*** children in war zones and ***post traumatic stress disorder.***

For further information -
please contact conference administration.

Tel: 44 20 8325 8162 Fax: 44 20 8325 8647
Email: anyone@youthsupport.demon.co.uk
Website: http://www.youthsupport.demon.co.uk
(consult 'International' section)

FABRIANO

Piazza del Comune

'The Bridge' Semi-Independence Unit.

Leaving Care
Semi-Independence
Aftercare
Half Way House

'The Bridge' provides accommodation and aftercare in our half way house, where individuals, couples or parents with children can be offered a semi-independent lifestyle. They are able to move on to their 'own flat' with staff available for support. The ethos is generally that of an extended family - like having an aunt to call on for support and advice. Clients also have access to the services of therapy, counselling and occupational opportunities run by the charity both in Beckenham and in Penge.

Accommodation is arranged in four self contained units and a fifth staff area accessible from the same common hall way. Units have their own gas and electric key meters to aid budgeting and there is a common pay phone.

Each unit consists of a 'bedsit' room, second bedroom, kitchen and bathroom. They are suitable for single occupancy / double occupancy / a couple with or without children / mother with baby or child / parent with baby and child.

"Finding your own place to live can be hard - and with a baby to look after too - I sometimes felt desperate..."

Enquiries to -

The Manager
'The Bridge'
13 High Street
Penge SE20 7HJ

Tel - 0181 650 6296
Fax - 0181 659 3309

"I have never lived on my own and I was so scared. I needed to be able to call the staff at night... Now I have a nice flat and I can cope with my daughter - we're happy!"

Youth Support Forum Comes of Age!!!

Forum Comes of Age!!

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.

First in the Field

The forum was the first national body to draw together professionals in the field of Adolescent Health and Welfare and now with thirteen annual meetings and two major International conferences to our credit - the Forum can well and truly be described as highly important if not the leading force in this difficult area. We have achieved our goal - that of putting Adolescent Health and Adolescent needs on the map!

Conference Success

The feedback from our last conference has been overwhelming in it's praise and encouragement and many delegates expressed the wish for -

- a regular commitment to future conferences;
- the Forum to become more visible as an advocate for Youth;
- wider recognition of the work and successes achieved thus far.

In response to delegates suggestions the 'Forum' has been renamed -

'The British Society for Adolescent Health and Welfare'

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 in the front line in high risk areas such as teenage pregnancy, teenage sexuality, young people and HIV, sexual abuse, drugs and violence.
- Feeling that you do not have the support of your professional peer group.

Membership

Membership - Now is the time to join our Society -
Send us your name, address and professional designation. Articles for our Journal and requests for meeting topics always welcome.
Regular Membership - £20 per year - Journal and some meeting privileges.
Full Membership - £50 per year - Journal meetings and seminar concessions - half price conference attendance if payment made by direct debit or covenant. One copy Youth Support Books per member free.
Ten Year Membership - £350 one off payment - all of above plus free conference attendance for a maximum of ten years or until dissolution of the organisation.
Life Membership - £500 one off payment - all of above plus free conference attendance for 'life' or until dissolution of the organisation.

The British Society for Adolescent Health and Welfare

(Previously The Youth Support Forum on Adolescent Health and Welfare)

Announce the Fifteenth annual meeting and Third Youth Support Conference

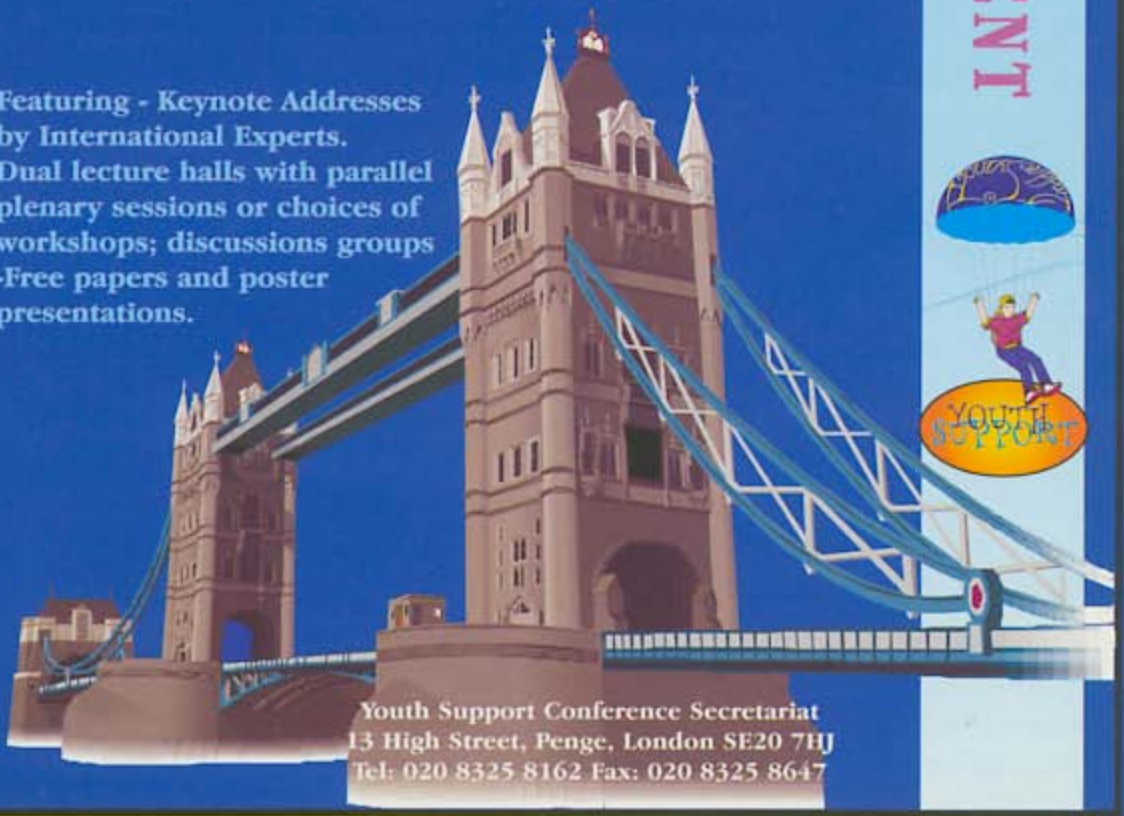
International Conference on Adolescent Health

Youth and The Promise of a New Millennium?

FIRST ANNOUNCEMENT

Dates - Thursday 19th / Friday 20th October 2000
Venue - The Royal College of Physicians
St Andrew's Place, Regent's Park
London, England

Featuring - Keynote Addresses by International Experts. Dual lecture halls with parallel plenary sessions or choices of workshops; discussions groups -Free papers and poster presentations.



Youth Support Conference Secretariat
13 High Street, Penge, London SE20 7HJ
Tel: 020 8325 8162 Fax: 020 8325 8647

Youth Support
Publications Department

13 High Street
Penge, London
SE20 7HJ
Tel: 020 8325 8162
Fax: 020 8325 8647

The Journal of Adolescent Health and Welfare
is published by
Youth Support
Charity No. 296080