Journal of Adolescent Health & Welfare

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Letter from the editor -

Dear Colleagues,

Welcome to our **New Look** Journal which is now into it's sixth year. You will be pleased to see that the journal is looking a bit fatter now after having gone through a very slim phase! The recession has hit all charities very hard and we have suffered considerably from lack of financial support for publications, training courses and workshops. It seems that employers are now entirely blocking study leave and course fees for their staff, which is most regrettable particularly in these times of new acts, changing procedures. The Children's act, the Charities Act and changes in the education structure have all had to be taken on board. Most important is the need to keep up with changes in incidence and recognition of patterns of disturbance in the community.

We are seeing more street youth, more homeless people with mental health problems, higher levels of reporting of sexual abuse, less residential care. Young people are increasingly stressed by unemployment, financial problems and media / peer pressure encouraging early sexual encounters, consumerism and substance abuse. Now more than ever, there is a crying need for our services and it is imperative to maintain a good training structure.

In response to these needs, we have increased our subsidy of all our training courses and publications to enable professionals and workers to fund themselves. We have continued to be 'self supporting' in terms of basing all our enterprises on fees for 'services rendered' to health authorities and social services. So far we are surviving on this level but life has been very difficult and we live from day to day on a shoestring. We are maintaining our principle of keeping a well trained professional staff and regard our unit at Crescent Road as a 'centre of excellence' - we are indeed unique, although I often wonder how we get through each month! The worst problem is exacting payment from agencies - boroughs are so often late in paying bills that we have to continuously suffer the extra expense of court orders and solicitors fees to get invoices paid! We continue to operate on a 'Robin Hood' basis subsidising one service with another when clients are unable to pay. The day nursery is a particularly heavy 'loss leader' since parents could never afford the level of fees necessary to meet the cost of local authority requirements.

I would encourage colleagues to join our Forum. Regular membership is well worth while securing free entry to the Royal Society of Medicine meetings, journal and discounts on courses.

We welcome articles and comments for the journal and suggestions for meeting topics. During the past year we have had a number of meetings at request of groups in different parts of the country and I hope you have seen us on TV and heard us on radio.

I look forward to meeting members at future meetings and we are always pleased to receive visitors at Youth Support House.

Best wishes,

Dr Diana Birch
Director Youth Support

Contents

Youth Support House
Residential Unit

1992 began with a **major readjustment** and overhaul of our services. The residential unit was entirely redecorated and some of the rooms had their usage changed.
The Children's act had brought a number of difficulties in it's wake for child protection services, leaving care, and for residential units. We were no exception. The first day of the children's act in October 1991 had provoked our first major disturbance in the residential unit when irresponsible reporting of the act had led many young people to believe that their social workers no longer had control over them. Somehow the issue of protection had been forgotten in the quest for 'rights'.

One year on, there are still major concerns regarding the act which has widely been reported as being unworkable, under funded and a vehicle for hindrance and chastisement of those working with children and young people, rather than an enlightenment of procedures.

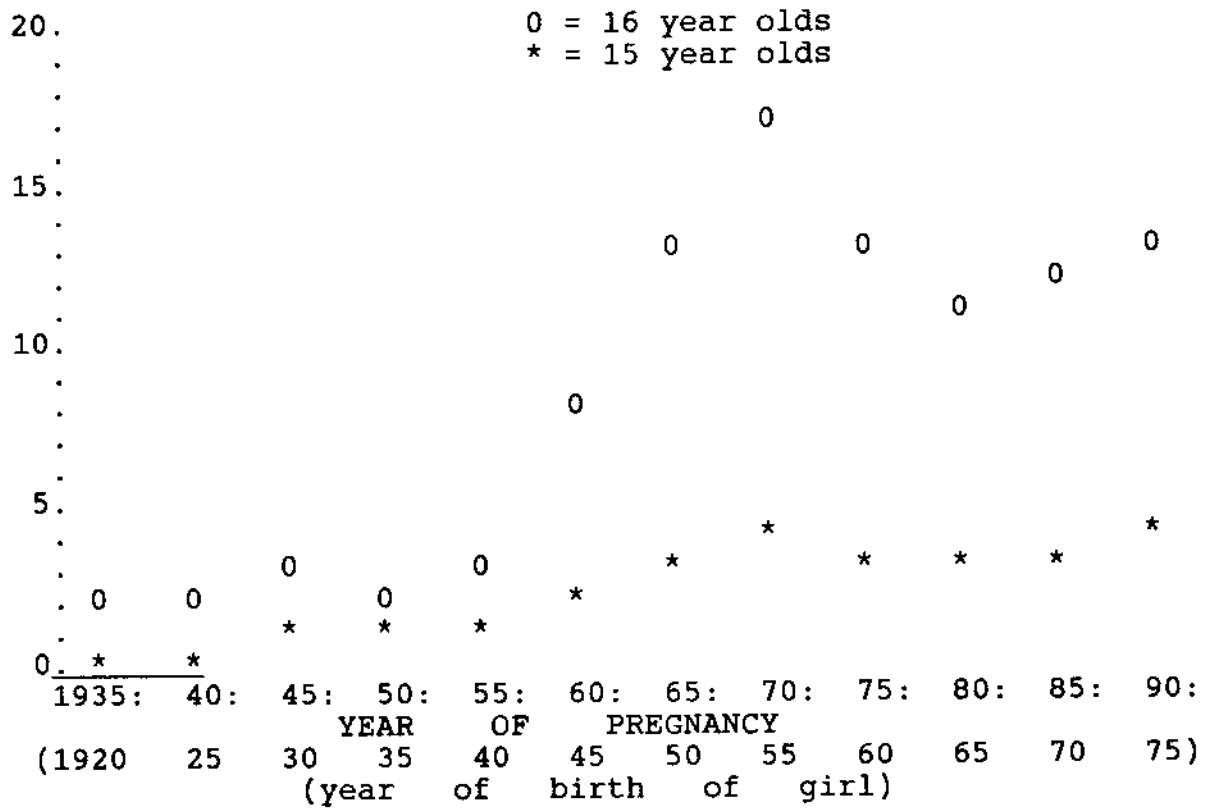
On the positive side, the act encourages working with families and emphasises rehabilitation. These aspects we have taken fully on board by developing our family work. We have designated a part of the residential unit as a **family resource centre** and have been involved with family assessment, treatment and rehabilitation.
The children's act also requires authorities to provide a **leaving care and 'befriending service'.** We have offered to provide this facility for social services but have so far had little response even though boroughs adjacent to Youth Support House have not developed their own. Our leaving care project is held on one evening a week with a social club, advice and counselling provided on a drop in basis.

The emphasis of referrals has changed over the past years. Initially the unit at Crescent Road was opened to provide a service for young pregnant girls - with the premise that the under 14s often had a history of abuse, truancy and rejection - they needed care, therapy and education.

The numbers of **schoolgirl pregnancies** has increased over the past few years, but most importantly - the shift has been to a higher proportion of the under 14s.
The graph below illustrates the trend towards higher pregnancy and abortion rates in the late eighties and early nineties. What the graph does not show however, is a very worrying aspect which can easily be missed. As the total numbers of fertile young women have fallen, total numbers of births will seem to go down. However conception rates have increased disproportionately for younger teenagers so that the youngest girls now constitute a higher proportion of the number of school age births.

Fertility Rates - Age specific - (Births per 1,000)
trends 1935 - 1990

England and Wales OPCS 1992



Conception rates for girls fourteen and under rose by 27% between 1978 and 1988. The very young, most vulnerable girls needing most support and specialised services are being failed by preventive and educational programmes.

CHANGES IN CONCEPTION RATES 1978/88

14 and under	+ 27%	
15	+ 17%	
16	+ 12%	(-6% from '74)
17	+ 10%	(-8% from '74)

Despite this referrals have dropped in this age group - this is entirely a financial decision - social work agencies do not have funding to give these girls the care that they need and hence less satisfactory placements are used as a stop gap. The sad result is seen in the **increase in admissions of girls in their twenties** with toddlers who have been abused, where families have broken down and cases where we are given 'three month's funding' for rehabilitation of a problem which took several years to create.

Child Protection services

Child protection has been a major concern of the residential unit and we have also been involved in a number of 'outpatient' assessments. In line with the children act we have worked with families and mothers with children looking at their coping skills, viability as a family unit and safety of the children within the family. This has generated a high number of court appearances which have caused a significant increase in work load for the charity without bringing an equivalent increase in income.
We have continued to hold **training sessions** in the field of **abuse, protection** and diagnosis and these have been well attended by GPs, hospital doctors, teachers, nursing staff and social work staff. Further work is required in this field. It is encouraging that a multidisciplinary group attend these sessions but there are still areas, such as **disclosure of sexual abuse** where the standard of professional involvement and expertise is sadly lacking. It is also a pity that members of the medical profession do not sign up for the 'emotional abuse' seminars and leave that session to their colleagues in social work and education.

The abuse of the **mentally** handicapped or **disabled** person is another field which has caused immense difficulties. Despite increased awareness on the part of professionals, this is an area where one can feel that the law is unable or unwilling to give people the help and protection which they deserve.

Psychotherapy Services

'Insight' at Youth Support

All residents at Youth Support House are provided with a tailor made package of education, care and therapy. This may involve one to one therapy, group work, art, drama or dance therapy.
We have now expanded the therapy programme to include a number of 'outpatient' sessions and a series of 'on going' groups which are attended by both residents and visitors.
A full treatment programme is available for substance abuse - including alcoholism and we have sessions for family and friends of such patients. These are based on 'Minnesota' model and the AA/Alanon programmes. Similarly a programme is available for eating disorders.
Other regular groups are - 'Self esteem group' 'Anxiety control group' 'Social skills' 'Expressive therapy' 'Step group' and an evening 'Open group'.

Case Histories - Example treatment programmes

The Carter family had been separated. Both parents were **alcoholic** and had **marital problems**. The twelve year old son was depressed and not coping at school. The baby had been removed to a children's home for **failing to thrive.** Their residential care involved an intensive alcohol treatment programme, individual **therapy** for the adults and older child, couples sessions to work on the marriage and family sessions to work on family roles and relationships. Remedial **education** and assessment was provided for the son and the baby's

developmental progress monitored. With the family working together in a stable nurturing environment, the child's development scales improved dramatically:-

The Lang Family - A sad young family where mother and father married at 16 and had two children very soon afterwards. She had an **eating disorder** and was very **depressed.** Admission followed an incident of near infanticide. The family were rehabilitated in a very structured and supportive programme. Parents were helped to understand family stresses and bulimia for which a specific behavioural programme was drawn up.

Sandra Quinn - had problems coping with a toddler and young baby. She had ambivalent feelings towards their father and a very low opinion of herself. When depressed, she harmed herself. She had been sexually abused by her deceased father. Treatment centred on her own unresolved feelings and abuse while supporting and rebuilding the family structure.

INSIGHT AT YOUTH SUPPORT

What kinds of therapy can we offer?

- Individual psychodynamic psychotherapy
- Relaxation and stress management
- Focused group work - tranquilliser withdrawal and substance abuse, stop smoking, weight problems.
- On going group psychotherapy
- Family and couples oriented work
- Work related stresses and staff support
- Psychodrama and drama therapy
- Art and movement therapy

Residential Treatment Programme

Our residential programme deals with emotional problems, eating disorders or substance abuse.

A special residential treatment programme is offered for young people or mothers with children.

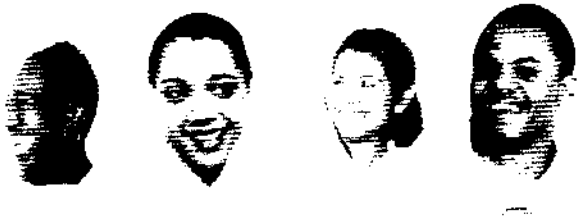
For out patient, residential treatment, or self referral - Enquiries to

Youth Support House

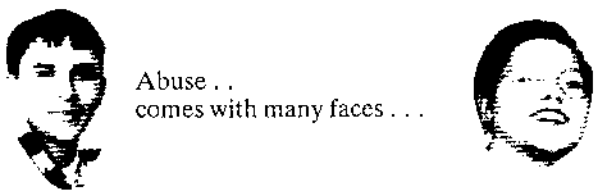
13 Crescent Road
Beckenham
Kent BR3 2NF
Telephone: 081 650 6296

FAMILY RESOURCE UNIT

Children need families . . there is no adequate substitute for the love of your own mother and your own father. Sometimes families run into problems. Young parents can lack the expertise and knowledge to meet their children's needs, especially if they did not have that all important love and attention when they were growing up. Unemployment, poverty and poor housing can put stresses on a family. **Family breakdown** might follow child **abuse** or **domestic violence** which may have been preventable. **Drinking, gambling** or emotional and mental **illness** can make it impossible for a family to cope without help. We provide that help to families in **crisis** families which have broken down and to parents and children whose lives are falling apart.



CHILD PROTECTION



AIDS/HIV

The most rapidly developing area with regards to sexually transmitted disease has undoubtedly been the advent of HIV infection.

At Youth Support, we have been involved two years running in the production of a Television documentary for world aids day (1st Dec) - "Aids, What do we tell our children" Dec 1991 and "Dangerous liaisons" 1992. We also helped in the revision of Magic Johnson's book.

There is increasing awareness that a high proportion of AIDS sufferers contracted their HIV infection during their teens. HIV has a long incubation, there may be as much as five or more years between infection and any sign of illness. It is thus very difficult for young people to identify with the risk of contracting HIV - it is 'unseen', there are no immediate effects, youth feel invincible, unable to be 'contaminated'. The same sort of denial mechanism that we see operating at the level of 'well, I never thought I could get pregnant' and 'I never thought it could happen to me' operates even more strongly with the concept of HIV infection.

All the reasons why young people don't use condoms for contraception apply also to not using condoms for 'safe sex'. Plus other feelings such as - 'How can I doubt him/ her by asking for safe sex', 'I'm almost accusing him of being unfaithful and sleeping around'.

Young people are missing the message about AIDS, they don't think it applies to them. Media publicity linking it to special groups, 'at risk' groups, pop stars alienates them further. As one teenage mother said to me 'I'm not bloody coming to an AIDS talk, what sort of a person do you think I am?'.

Too much shroud waving and emphasis on death as in the early health education material merely 'blanks off' the teenager, while too much emphasis on the infected pop star or celebrity and publicity messages linked to rock concerts merely engenders a sort of 'counter culture' feeling of 'life in the fast lane' the Janis Joplin, Billy Halliday, Hendrix mentality 'so what if we're dead when we're thirty - who wants to be alive then anyway!'

It would be more helpful if we regarded HIV and AIDS as what it really is - an infectious disease with several modes of transmission, one of which is sexual. Removing the mystique and taboos would help educate and protect young people.

Youth Support House has been the venue for teachers **seminars and support to teachers** involved in health education, **sex education** including issues regarding HIV/AIDS which can be very difficult matters for unsupported staff to handle in schools.

The Day Nursery

Our day nursery at Youth Support House has been re-registered under the new law although the amount of paper work and the additional requirements of the local authority have cause difficulties. We have had a number of new members of staff and the nursery classroom is now running efficiently.
A new development has been the introduction of regular swimming, dance and drama sessions which are also open to outside children and to children of residents.

Publications
Youth Support Publications have been selling well and "Are you my sister, Mummy?" has now gone into a second edition. Our latest publication "Inner Worlds and Outer Challenges" will be available in Feb 1993.
We have extended our series of monographs and reprints to cover most of our workshop titles. The following publications are now available:-

Journal and Back copies
Journal of Adolescent Health and Welfare Back copies £4.00 each

Books
"Are you my sister, Mummy?" Study of schoolage pregnancy. 2nd edition 1992 £10.00
"Retracing the Echoes" Children of the Russian revolution - Emotional aspects of growing up echoed in our 'inner child'£ 3.95
"Inner Worlds and Outer Challenges" Development of the personality and the assaults of the emotional environment. £5.
"Mother or Child?" Tape slide presentation - price on enquiry.

Reports, Articles and Reprints - all priced at £3.50 each.
1.1 "Schoolgirl Pregnancy". chapter giving 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? - Belief systems in teenage pregnancy"
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" "The school medical" "Diet and Preparing for the Marathon"
2.3 "Healing abuse - Working with the family that is not there".
2.4 "HIV infection - AIDS and the Young" conference report.
2.5 "Providing staff support in implementing 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 and the origins of personality"
2.9 "The invisible woman -working with the hysterical personality"
2.10 "Fear is the key - the depressed adolescent"
2.12 "One Track Minds - the obsessive part of our personalities"
2.11 "Divided loyalties - the schizoid teenager".

Theses
"Schoolgirl pregnancy in Camberwell- A population study of schoolgirl pregnancy, motherhood and two year follow up" London Univ MD thesis 1986 £50: loan £15
"A Study of Self Esteem measurement in Schoolgirl Pregnancy" London Univ. MSc Psychotherapy 1989 - soft copies £15 - loan £5 for one month.

Research in Progress

All services planned and provided by Youth Support are subject to evaluation and review. Most work is incorporated in continuing research projects.
The cohort of young girls studied in "Are you my sister, Mummy?" are continuing to be followed up at the **ten year** stage and afterwards. This should give interesting long term information regarding the consequences of school girl pregnancy.
Self esteem study and further investigation of the psychological and emotional aspects of teenage sexuality and early childbearing is helping us to identify **preventative factors** in school age pregnancy. The government white paper **Health of the Nation** has set goals of reducing teenage pregnancy by 50% - While better provision of contraceptive services will help reduce unwanted pregnancies in the 16-19 age group - it is only by taking emotional factors into account that any in roads will be made on the numbers of under 16s. Our very young mothers need to be given something else to value in their lives, other than having a baby. Self worth is a very important factor, which needs to be built up right from birth. Adequate parenting, love and caring, good education - these are protective factors.

Homeless and runaway youth -

The Youth Support Forum on Adolescent Health and Welfare held it's sixth annual meeting at the Royal Society of Medicine in October - the subject this year was Homeless and runaway youth. Speches were recorded and will be published in future journals.
We are putting together a study of runaway youth looking at causes of leaving home, particularly the 'abuse' factor. Hopefully the work will be multicentre with some cross cultural factors - looking at a population from UK, Russia and possibly the USA.

International work

Our work in the former Soviet Union has been severely curtailed due to the changing political and financial climate there. We have hosted some groups this year and developed some 'EFL' English as a foreign language courses. Our contact with Kingston University (Kingston Upon Thames) for placement of students from abroad continues and our students have done well. The book "Are you my sister, Mummy?" has been translated and produced in Russia. We are hoping to continue to be able to offer holidays to British Youth and exchanges for professionals.
Youth Support continues to be represented at International conferences and we are hoping to have further student placements and professional sabbaticals from the USA and other countries - these have proved very succesful in the past two years.

Professional Training

In the past year we have participated in training a number of professional students on 'placement' with us - social work students, Btec and NNEB as well as trainee counsellors, mental health nurses and psychology students.
Our seminars and workshops have proved very succesful - a new development is our day release course covering the special fields of work at Youth Support. Attendance has been patchy mainly due to lack of funding from employers (even though our fees are comparatively very low). We will be repeating the course in 1993 with fees reduced even further to allow people to be able to fund themselves (see below).

Youth Support - Professional Training - Courses 1993

Wednesdays 10.30-12.30 and 2.30-4.30 at 13 Crescent Road

Dates - 22.9; 29.9; 6.10; 13.10; 20.10; 27.10; 3.11; 10.11; 17.11; 24.11.

Half day workshop £15:Whole day £30:Ten day course £250

Morning teaching - practical applications and case discussion. Also covering concepts of therapy and therapeutic relationship. Sessions can be booked separately but are designed to be taken as a complete course. Two one day workshops can be booked separately also.

Afternoon teaching - in form of workshops two four week modules and two 'stand alone' sessions which can be booked separately. Subject matter based on particular problem situations.

Content - The course will cover basic counselling skills and psychological issues but will also focus on dealing with the difficult areas of adolescent work, sexuality and abuse issues. The content will give particular insight into the specialised areas of work which we deal with at Youth Support.

Modules -
Child abuse - **A1** - Physical issues and recognition
A2 - Sexual abuse
A3 - Emotional abuse - the hidden scars
A4 - Working with families

Adolescent issues -
A5 - Teenage Pregnancy
A6 - Sexuality and belief systems
A7 - True self/ False self - teenage handicap
A8 - Self Esteem in adolescence

Morning topics -
M1 - Emotional development
M2 - Personality types a) Depressive and Hysterical
M3 - Personality types b) Obsessive and schizoid

Counselling and Therapy -
M4 - Individual therapy - the therapeutic relationship
M5 - Working with groups
M6 - Ideas from TA - ego states and scripts

M7 - Alcohol and substance abuse
M8 - Eating disorders

Whole day workshops
D1. Psychodrama
D2. Family Therapy

Deprivation, Health and Educational need - A demographic study.

Dr Diana M.L.Birch

Introduction

The 'Declaration of the rights of the child' was adopted unanimously on 20th November 1959 by the general assembly of the United Nations - Articles 4 and 7 state that the child shall have -

- (4) 'The right to sufficient food, housing and medical care'

- (7) 'The right to free education, play and recreation'.

Good housing and education - are these just empty words? Platitudes uttered by politicians seeking self glorification or do we really care about providing adequate conditions where our children can grow up?

Even in Britain, a seemingly prosperous western society, over 10% percent of under fives are living in substandard conditions as defined by overcrowding, shared toileting or shared water supply (Bone) and this figure is class related reaching 29% for social class IV and V and only 3% for class I. Many of these examples of poor housing are to be found in the large council estates.

But how does housing affect our children? Does it matter where we live? Rutter demonstrated differences in educational achievement between an inner city area and a more prosperous area in the Isle of Wight. Children from the Camberwell area of London were twice as likely to show psychiatric disorder and had double the rate of reading retardation at age ten. Can similar differences be seen within a single district of London?

The Camberwell district provides a suitable model for study. The population of 218,600 (1981 census) including 14,400 under fives, and 32,000 school children is distributed throughout 22 electoral wards (14 Southwark and 8 Lambeth wards). Social circumstances vary from the affluent Dulwich where former Prime Minister Margaret Thatcher chose a home, to the deprived inner city areas of Brixton and Peckham - better known for the civil unrest of the Brixton riots and the so called 'no go' Gloucester estate where policemen patrol in pairs and the postmen refuse to deliver mail.

Unemployment rates vary from 24% to 7% (inner London mean 14%) and single parenthood runs at three times the national average with more than 40% of births being 'illegitimate'.

Method

The present study was designed to evaluate special educational needs of children within a health district of London.

All children who are considered to be in possible need of special educational provision whether by educational, psychological, medical or other professional services, or indeed by the child's parents, undergo an assessment procedure.

Prior to April 1983 this was known as the SE (special education) procedure and this became the FA (full assessment) procedure with implementation of the 1981 Education Act. Both procedures require medical input. All children undergoing either SE or FA procedures are notified to

the school health service. All children so notified throughout the two calendar years 1982 and 1983 were included in the sample population. The mid eighties provided a convenient sample period since subsequent health and education service reorganisations rendered more recent data unobtainable in comparable form.

Children were divided into groups depending on their home address at time of notification. Groups were defined in accordance with 22 electoral ward boundaries. 378 children were notified in the two year period.

In 61 cases medical assessment had been made by special request on children resident outside the health district, these children were omitted from the ultimate sample as were 14 children resident in 3 additional wards whose population mainly fell under adjacent health districts and were thus excluded from final analysis. The final sample therefore consisted of 303 children.

Information was obtained regarding the presenting problem and the recommendation of the pupils' assessments - in other words what form of special educational need had been identified. In order to compare rates of referrals for special educational need the percentage of cases assigned to each ward group was compared to the percentage of school age population resident in each ward and a ratio obtained. These ratios of observed / expected cases were then compared and correlated with demographic variables for each ward.

Maps were prepared charting the demographic data on housing, single parenthood, abortion rates, child abuse reports, and social deprivation (as defined by Jarman - whereby -20 to -10 is low ; -10 to +10 medium; +10 to +60 high level of deprivation). These maps were compared with the geographical distribution of cases referred for special educational assessment. (Fig 1).

Results

Of the 378 children deemed to require special education 35% had behaviour and psychological problems, in 20% the problem was primarily educational and 45% primarily a health consideration. In the most deprived area, that with the highest referral level - the Gloucester Estate (Liddle Ward), the ratios were slightly different, with higher percentage of behavioural problems -

Reason for Referral - All cases
- **35% behaviour and psychological.**
- **20% primarily educational need**
- **45% primarily health reason**

Referral - Gloucester Estate
- **40% behaviour and psychological.**
- **30% primarily educational need**
- **30% primarily health reason**

Rates of referrals correlated well with unemployment rates (Fig 2) but this can be seen more readily when the two boroughs are viewed separately (Fig 3/4) due to the slightly differing referral procedures in the two sides of the health district which fall into two separate education authorities.

The correlation is seen well when ward levels of educational need and unemployment are plotted as a ratio of district means (Fig 5).

Comparing features of the two 'worst' wards with the two 'best' simplifies the picture (Fig 6).

In the three wards with the highest referral rates, both male and female unemployment stood at nearly twice the national average, abortion rates were four times the national average (Nat average 6.2/1,000). Housing was poor with owner occupancy running at less than 20% (UK average 56%), overcrowding more than 10%, and most housing being on high density estates. The level of single parenthood and illegitimacy was high with the highest levels of schoolgirl pregnancy. Rates of reported child abuse were highest in these wards which at the time of study were the worst in the country.

Discussion

There have been many attempts to define unfavourable social conditions and make quantitative estimates of deprivation. No single scale can accurately pin-point what features are most damaging to children growing up in various areas. The overall picture is coloured by so many differing influences and it is probable that some families have more resilience to certain adverse factors than others.

Jarman's scale considers material influences and social parameters which were certainly related to educational needs but gave little differentiation in an area as deprived as Camberwell where 92% of wards scored 'high' deprivation levels (UK mean 30%).

Looking at individual factors - Reproductive health status puts children at risk at an early stage. The high rates of illegitimacy, abortion and early childbearing indicate loss of control of reproduction, hence the birth of more unwanted children who are thus disadvantaged before birth (Fig 7).

The stresses placed on young families with unwanted children are further compounded by there being the lowest level of preschool care in these areas with only 5% of under fives having nursery places. There is thus no 'early start' programme here. It is hardly surprising that the levels of reported child abuse are the highest in the country and follow similar distribution levels.

There have been many attempts to correlate health with social factors and housing. Perhaps the most convincing and comprehensive being the 'Black report' "Inequalities in Health" which showed that the British class system is alive and flourishing. Educational achievement has also been linked with poverty since the thirties (Burt 1937).

Health, housing and education - it certainly comes as no surprise that these factors are associated. The present study showed a clear correlation between adverse social conditions and special educational need. In other words, children who live in deprived circumstances, who have cramped unsatisfactory housing, who perhaps were unwanted children, lacking adequate parenting and growing up without a natural father and mother are not able to cope with the 'normal' school system. These children have special needs and require additional help in order to be able to achieve adequate educational goals.

Special Education

NO OF REFERRALS PER YEAR _ PER ELECTORAL WARD 1982/1983

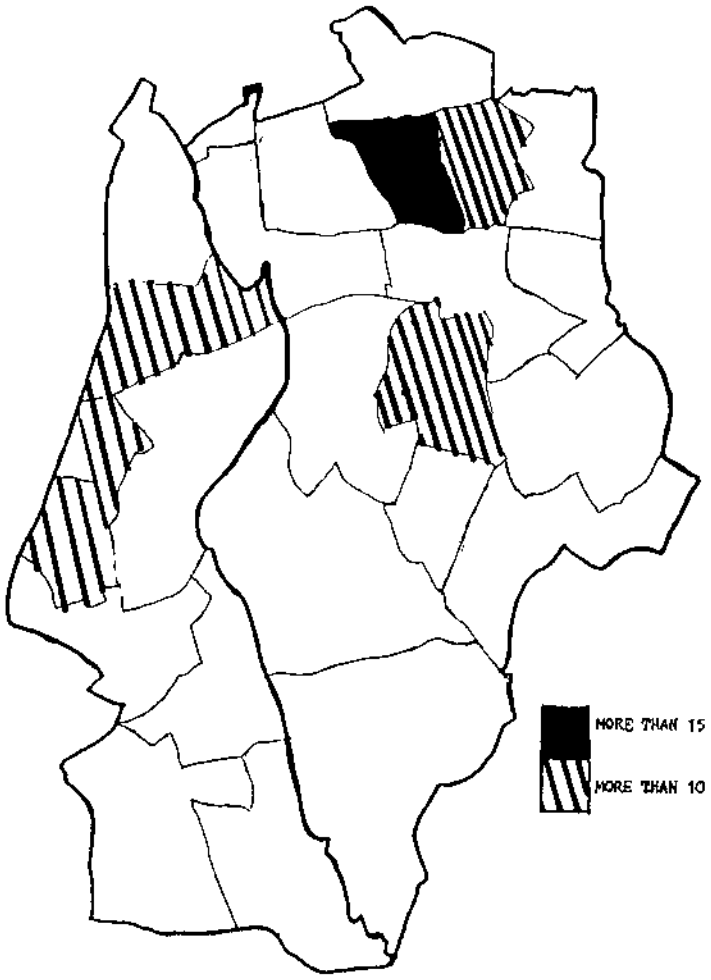


Fig 3

Male Unemployment/ Special Education - Lambeth (DE09)

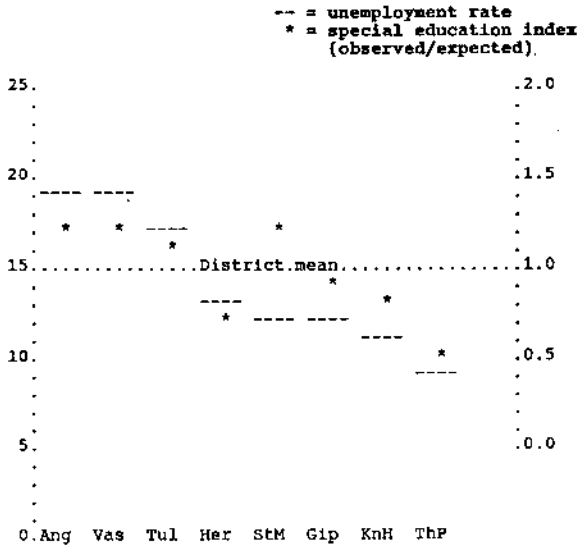


Fig 2 Male Unemployment/ Special Education - Health District
(ie Both Boroughs - education districts 8 and 9 of ILEA)

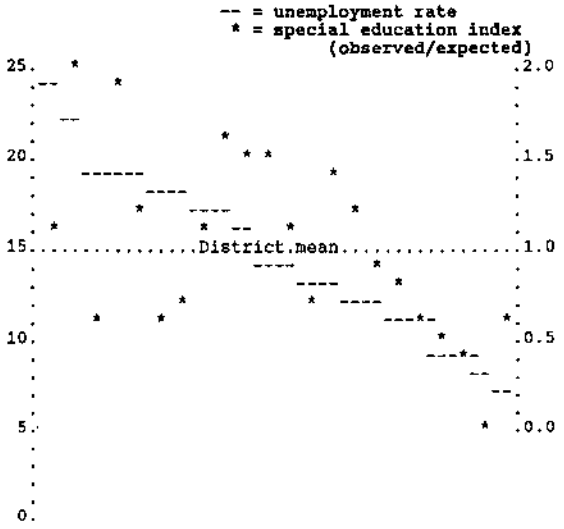
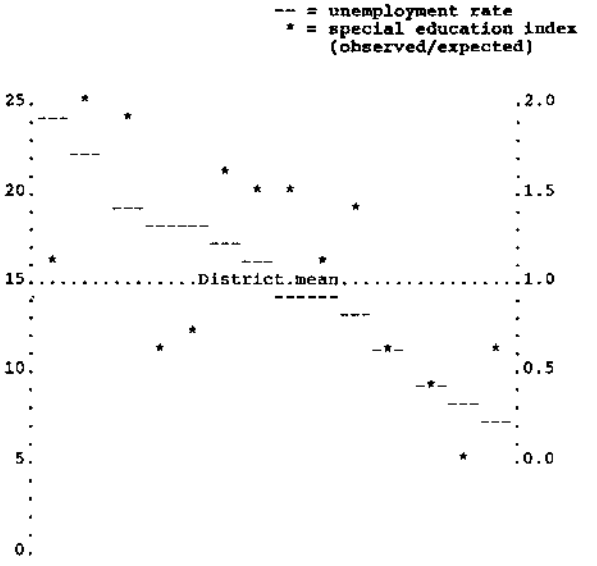


Fig 4

Male Unemployment/ Special Education - Southwark (DE08)



Ratios : Unemployment/district mean
plotted against Special Educational need/district mean

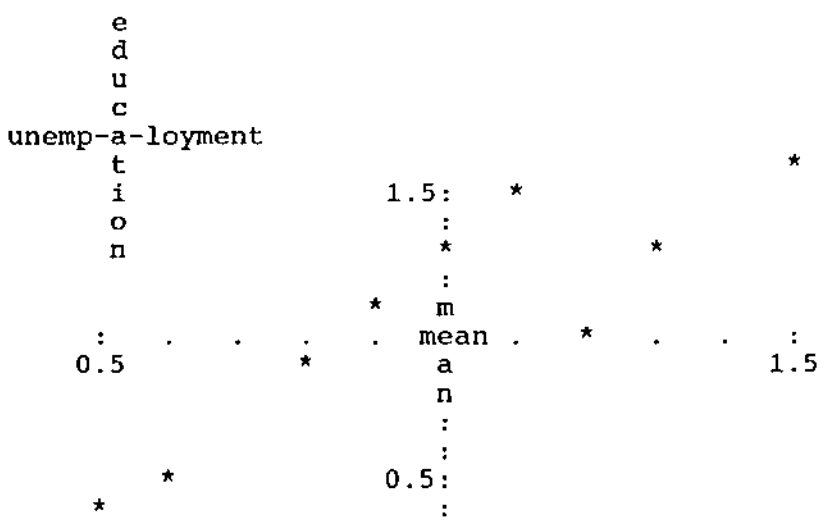


Fig 6 Comparison of Wards with highest special educational need with those with lowest need.

Ward	Education index	Deprivation score (Jarman)	Unemploy -ment (male)	Child abuse cases/yr	Overcrowded housing
Liddle	2.0	38	22	>10	>10%
Friary	1.9	49	19	>10	>10%
The Rye	0.4	17	9	1	<5%
College	0.0	-2	8	0	<5%

Fig 7

Ward	Education index	Schoolgirl pregnancy index#	Abortion Rates*	Single Parent Families@
'worst Southwark'				
Liddle	2.0	1.5	22	30%
Friary	1.9	1.0	25	30%
Consort	1.6	0.7	32	30%
Lyndhurst	1.6	2.4	23	30%
'Worst Lambeth'				
Angel	1.2	2.5	32	33%
'Best wards'				
The Rye	0.4	0.4	14	<10%
College	0.0	0.0	11	<10%

Birch 1986/87 * OPCS/SD52 1983 @ Hansard Feb 1983

They live in areas of poverty and high unemployment, and without special help they will underachieve in school, be unsuccessful in the job market, and they too will become a statistic in the unemployment figures. The cycle will be perpetuated.

In areas of urban decline, which affects many of our inner cities, problems are multifaceted and can become overwhelming. The temptation is to say - so what? What can a Doctor do about street crime, unemployment, poor housing? What can a teacher do about unwanted pregnancy, child abuse, poor health? The greatest disservice that we can mete on our children and young people is to compartmentalize our views, to stick to solving 'our own problems' and to shrug our shoulders at the morass of human misery 'out there'.

Perhaps we cannot individually do a great deal, but by seeing the problems in perspective, as part of the whole - then perhaps we can understand the world which a child has to cope with in becoming an effective citizen, and begin to provide effective help.

Recently the British Government has introduced a national curriculum, and testing of school children's attainments. Exam results are published in a school 'league table' the first of which was produced in 1991. Fierce argument has arisen regarding the tables - schools in 'poor' areas claiming that it is unfair to compare their attainments with schools in affluent areas. The official response thus far has been that good teachers can produce good results in any geographical location. True - if the children were not themselves deprived in more or less every other aspect of their lives, like the children described above. Even if one ascribes to the existence of 'sink schools' I cannot believe that every child with low intelligence or learning difficulties moved to the Gloucester estate and that all the good teachers sought employment in the better off Dulwich!

It is self evident that tired, hungry, poorly cared for children have other things on their minds at school than concentrating on their lessons. A study of the development of 3 year olds (Pollak) showed that the adage 'there is no place like home' was only likely to be true if the home contained an adequate mother. An adequate mother can only be so if she has the facilities with which to care for her children, space, heat, light and sustenance.

Just as children need good mothers to develop normally in the preschool years, so they need good teachers to develop educationally and these teachers need the support of social and health services.

All services need to work together to break through the barrier of social deprivation to enable young people to attain educational goals and a worthwhile future.

References:-

Birch DML "Schoolgirl pregnancy in Camberwell" MD thesis London University 1986

Birch DML "Are you my sister, Mummy?" Youth Support publications 1987

Black D. "Inequalities in Health" Report on the working party on inequalities in health. August 1980.

Bone M. "Preschool children and the need for day care" OPCS social survey division HMSO 1977

Burt C "The backward Child" University of London Press London 1937.

Jarman B "Identification of underprivileged areas" British Medical Journal Vol 286 :1705 1983

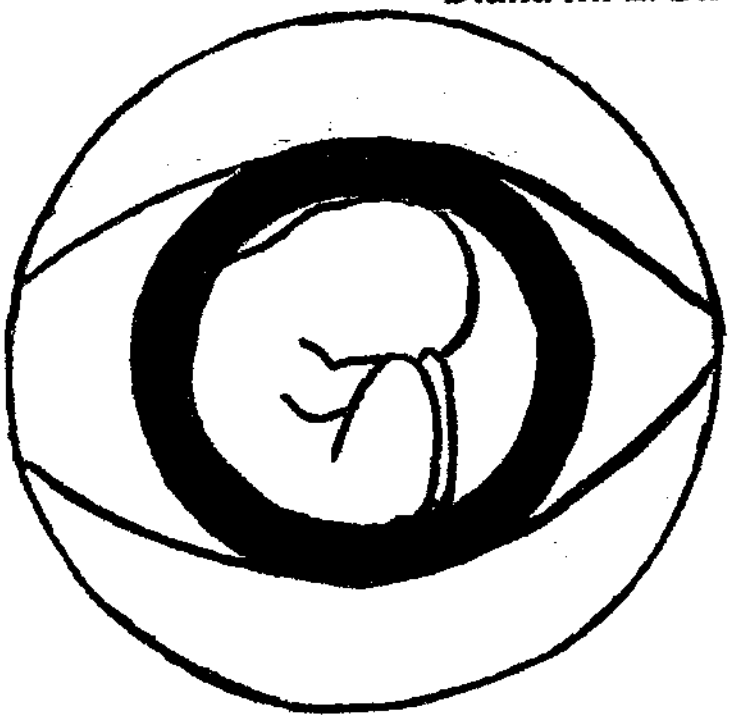
Pollak M. "Housing and Mothering" Archives of Disease in Childhood Jan 1979 Vol 54 No1 54-58.

Rutter ML.; Cox A; Tupling C.; Berger M.;Yule W. "Attainment and adjustment in two geographical Areas I" British Journal of Psychiatry 125: 493-509 1974

POOR HOUSING AREAS ASSOCIATED WITH
HIGH CONCEPTION RATES + HIGH ABORTION RATES
ILLEGITIMACY + SINGLE PARENT FAMILIES
SCHOOLGIRL PREGNANCY
CHILD ABUSE
PSYCHOLOGICAL PROBLEMS
POOR SCHOOL PERFORMANCE + TRUANCY
HIGH SPECIAL EDUCATIONAL NEED
UNEMPLOYMENT + POVERTY

INNER WORLDS AND OUTER CHALLENGES

Diana M. L. Birch



Inner Worlds and Outer Challenges
It could be said that the process of developing a personality, a 'self' begins with conception and ends with death. Times of greatest growth and change can be identified such as the early months of life, and the so called turmoil of adolescence. But in many ways we go through numerous phases of development and pass the hurdle of several 'adolescences'.
Understanding ourselves, getting to know who we really are and communicating that knowledge to another human being can be a task too great for one lifetime. Particularly if the real self is hidden by fear and early experiences of rejection and abuse. Those of us who would work with young people have a double task, we need to understand ourselves before we can be of use to our patients. We must be in touch with the hurt child within ourselves so that child can communicate, empathise with another and help to heal their pain.

Part One - Inner Worlds confronts the question of how we develop personalities and discusses varying personality types.
Part Two - Outer Challenges looks at how our personalities are affected by disability, violence and abuse, sexuality and childbirth and assaukts to our self esteem

Although aimed primarily at a multidisciplinary professional readership, the language is eminently suitable for the general public and would by of interest even to young people themselves. The chapters are well illustrated by case histories which bring the stories alive.

Emotional Abuse - the hidden scars.

"I cannot accept these conditions"
"..They have been accepted for you"

These were the words with which Kiril Lakota was released from seventeen years imprisonment in the film version of "The shoes of the Fisherman". .... So do we, as children enter the world; our conditions laid down for us. The emotional maelstrom into which we are pitched is beyond our control - we are wounded, react, build up defences and become battle scarred.

Emotional abuse is one of the categories officially recognised in Britain as a criterion for placing a child's name on a social services child protection register - but what is 'Emotional Abuse?'.

When I first held a workshop entitled 'Emotional abuse - the hidden scars' I had a fraught conversation with a doctor who wanted to know what the scars were and if he could learn how to find them on a child's body - it gave us all a good laugh - but in reality saddened me that the emotional side is so often forgotten in the search for evidence of abuse. And why do my profession, the medical profession, come in large numbers to my lectures on physical abuse and sexual abuse but drop out almost entirely on the emotional workshops? Have we trained a generation of doctors who cannot think holistically and instead look on the body as so many moving parts - or have we failed to prepare them for 'real life'. Are they as afraid of their patient's feelings as they are of their own?

Perhaps we should begin by considering how we define abuse? The very word 'abuse' carries a world of subjective feelings and ulterior motives. Does it convey a different meaning to different individuals - to the 'victim', 'perpetrator' or 'professional' ? The word has certainly been coloured by the isolation and shame of the victim; by the secret fear of the perpetrator and by the anxiety of the professional dreading a witch-hunt. Physical child abuse has gone under various labels - battered baby syndrome, non accidental injury, NAI. Whatever terminology we use, the effect on the child is the same ...

Abuse can be categorised under various headings - physical, verbal, sexual, emotional - are there others? how about - neglect, starvation, ignoring, withdrawal,withholding.

What therefore is emotional abuse? Perhaps if we consider that physical abuse is - assault on the 'person'- perhaps emotional abuse is - assault on the 'personality'. The whole manner in which that individual copes with feelings and everyday situations will be profoundly affected. There will be damage to - confidence - self worth - ability to feel - ability to communicate - 'integrity' as a person. In place of confidence and self worth, there will be instilled - Fear, Guilt and Insecurity.

Obviously emotional abuse can occur with or without physical harm, although the converse is hardly possible. It is the emotional component of abuse which is potentially the most devastating aspect. This may result in damage on several levels - to the individual's present emotional well-being - in other words causing immediate emotional pain; hindering and injuring the child's emotional development and evoking maladaptive patterns of response.

Emotional abuse -> - harms present emotional well-being
-> - hinders development of emotional feeling self
-> - carrying ' damaged pattern' of emotional response into adulthood.

We can be 'abused' or maltreated either by receiving something bad or by being deprived of something good. Hence, borrowing the terminology of TA (Transactional Analysis), abuse could be defined in terms of 'strokes'.

Abuse could be defined as either - giving negative 'strokes'
OR - withholding positive 'strokes'

Strokes are acts of recognition - acknowledgements of a person's presence or existence. They may be physical or verbal, praise or criticism. A human being needs a certain minimum number of strokes in order to survive - some people are 'programmed' to be able to survive on a very low level of strokes and some external strokes can be supplanted by internal strokes - but without strokes the individual is deprived and declines.

Negative strokes are better than no strokes at all. People growing up in an abusing situation are used to receiving mainly negative strokes, they grow to expect negatives, feel they deserve them and regard positives as suspect.

If an abusing world is the only world you know, that is your reality.

STROKES		
	positive	negative
Physical	Hugs	blows
Verbal	praise	criticism
	positive	negative
Unconditional	"I love you"	"I hate you"
Conditional	"I like you when you're sober"	"I can't stand you when you bite your nails"

Mechanisms of potential emotional damage can follow various routes viz - negative physical strokes causing emotional as well as physical harm - an obvious example being the emotional aftermath of a sexual assault; negative strokes causing a negative emotional response as in a child taunted and called names by school bullies; or the neglected child who is deprived of love and positive strokes and thus suffers emotional starvation.

physical abuse	= -ve physical strokes	--> emotional harm
verbal abuse	= -ve verbal strokes	--> emotional response
neglect =	withholding +ve strokes	--> emotional starvation

Why are we vulnerable to emotional abuse? How do bad feelings begin? Emotional abuse begins at an early age - the seeds have to be sown very early on in life to 'prime' the developing personality to 'expect' further knocks. The first messages can be very subtle, almost going unnoticed ..

Imagine the baby. Lying in her cot.
... when I'm hungry, I get fed, ...when I'm wet, I get changed. When I gurgle they come to listen .... when I smile, a loving face comes near to me. ..... I feel important, loved and wanted.

Then one day I wake up, it's dark, the curtain's flapping ...I'm afraid. I cry .. nobody comes .. I feel so alone .. nobody wants me ... I must have done something wrong .... I'm not so important any more ... I'm not worth loving any more.....

The child who grows up secure in it's relationship with mother - (with good object relations) will not be so vulnerable to emotional abuse. A child learns how to deal with emotions by using the relationship with mother or mother figure, as a 'prototype'. Raw, primitive feelings, profound love, deep hate, cannot be held by the infant without the tempering effect of mother's reactions. The child projects his feelings onto mother who mirrors them back in tolerable form. A child learns to love himself from the way he is loved by others.

If the infant can feel his mother's love directed at him, a unique new child, he will have the ability to develop a confident loving 'self', a self which is protected from the worst ravages of future emotional abuse. However if the child is unloved, ignored or finds himself wanting in his mother's eyes, he will be unable to find the strength and confidence to show his true self to the world and he will hide behind the shadow of what he thinks others wish to see - this false self is forever vulnerable to emotional trauma - the 'victim' par excellence.

So the child will feel bad about himself, will feel guilty that he cannot make mother happy, and will be ready to meet the reinforcement of other abusing situations. He may be unable to show his real feelings, may substitute one (permitted) feeling for another (taboo) feeling. Not be himself.

"Why am I afraid to show you who I am?"

"I am afraid to tell you who I am , because, if I tell you who I am, you may not like who I am, and It's all that I have"

In TA terms, the child acquires beliefs and makes decisions about what sort of person he is, what sort of a life he will lead. These are survival decisions - a child's way of explaining his problems, of coping with harmful situations and of setting himself a mode of behaviour. He makes these 'script' decisions at an early age and uses every life event thereafter to reinforce them and 'prove' how right he was in choosing his life's path.

Beliefs	**Behaviour**	**Reinforcement**
A 'Script' Beliefs and feelings	B Repetitive Behaviours	C Reinforcing Memories
Assumptions and feelings that limit options considered possible in life.	self defeating and frequently result in confirming a persons worst fears and negative beliefs	experiences that are selectively remembered and often emphasised which prove or justify the life position.
beliefs about - self - others - life - destiny	observable behaviour patterns	Recall emotional memories evidence and justification
primary feelings extreme - rage terror despair	'scripty' Fantasies	"There you are - that goes to show"

```
              ->Behaviour->
           ->               ->
         ->                   ->
       ->                       ->
      ->                          ->
   Beliefs                Reinforcement
      <-                          <-
       <-                        <-  <-<- further
         <-                    <-          abuse
           <-                <-
              <-  abuse  <-
```

Reinforcing memories are selectively remembered, just as reinforcing events are subjectively regarded. Everything which 'fits' with the script decision or they way we feel about ourselves is taken on board, emphasised and used to underline and justify the position. Anything which does not fit is discarded and ignored. Hence the child who felt she was bad and worthless will become the adult who cannot accept compliments - "She's only saying that to be nice, it's not really true" but whose supertuned senses pick up every whisper of a slight or derogatory comment "There you are, I knew she didn't really like me".

Emotional abuse can be overtly manifest in hatred and rejection, or subtly wearing away like water dripping on a stone. In whatever degree however it alters the child's very being and leaves a legacy to be carried into adulthood. Ruth, said of the bullies in her school "They changed me, that's what I can't forgive or forget. Whatever happens to me now, whatever I do, I can never again be the same person, or the person that I would have been if I had not been put down and afraid all that time".

Just as adverse situations can cause emotional harm, so favourable conditions can help heal the wounds. We can use such therapeutic events to aid recovery. Perhaps the easiest way to understand the process is to see how it affects ourselves. Emotional 'abuse' is part and parcel of living. There is no human being on this earth who has not suffered in some degree from emotional trauma, it is merely a matter of degree. Hence each of us has a part of ourselves which can empathise with our more seriously affected companions.

How would we answer the key questions which indicate the factors keeping our own 'merry-go-round' turning? What would the beliefs, behaviours and reinforcements be for ourselves? What do you believe about yourself, others, your life. Are you a successful caring person, are you a failure, do you feel good about yourself, do you feel good about your life? Do you believe things usually turn out well for you or do you generally end up making a mess of things?

What situations do you keep finding yourself in? Do you keep giving in to people or find you've been made a fool of? Do you always find yourself in conflict with a dominant boss? Are you always left 'holding the baby'?

Which scenes in your life keep replaying in your mind? The time you got lost in the shopping precinct and separated from your mother (reinforcing rejection), the time you broke your grandmother's favourite vase and hid the pieces (reinforcing guilt).

- Key Questions -
A 1 What do you believe about - yourself - others - your life How do you feel about those beliefs? 2 Do you believe things always turn out in a certain way for you?
B What situations do you keep experiencing over and over again? Do you find yourself saying "Here I go again!"
C What life events seem most significant to you What do you keep remembering?

Having identified 'script' beliefs which are binding us in the pain of emotional turmoil, we can now intervene, challenge these beliefs and release ourselves from the treadmill of repetitive harmful behaviour patterns.

Why do we believe we are bad, of course we are not 'bad', look at all the evidence that we are as good as the next person, or even better. There are alternative interpretations of past events. As children we often took two and two and made five, interpretations and conclusions made in the past may not hold up to the vision of the present. There are also alternative ways of behaving in a given situation, we do not have to always react in our well rehearsed 'scripty' manner. Alternatives may first have to be tried out as 'homework options' before they can be utilised naturally.

Similarly the significance of past memories must be challenged and alternatives suggested. Could the memory, with a subtly different 'selection', also reinforce the opposite premise? Suppose we were to even make up an alternative ending to our childhood 'remembered' stories? How about if the frog got the princess for a change. Suppose grandmother hated the broken vase and only cared in case you had hurt yourself? What if you were a confident explorer in the shopping precinct and mother praised you for your initiative while being overjoyed to find you again?.

	Intervention	
A	Challenge beliefs	
B	Stop behaviour	options - homework
C	Challenge memories	significance opposite experiences create new endings to stories

The transition we need to eventually make is from a 'victim' position of "I don't like being abused" (But can't do anything about it because really I deserve it) through a midway position of "I don't deserve to be treated badly" to a self confident and self appraising position of "I deserve to be treated well!"

----> "I don't deserve to be treated badly"

"I don't like being abused"

-----> "I deserve to be treated well"

FORUM ON ADOLESCENT HEALTH AND WELFARE

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

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

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

Or if you are:–

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

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

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