ISSN 1363-8394

Journal of Adolescent Health and Welfare

Volume 9 - No 3 - Summer 1996

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

*Youth * 1986 - 1996 * Support*

Letter from the editor -

Dear Colleagues,

Our Anniversary Year is progressing well .. I hope you all enjoyed the Souvenir special edition of the journal .. there was one misprint .. I wonder who spotted it ... Youth Support were involved with Eastenders .. not Neighbours .. sorry , my fault - the soaps sometimes merge in my mind ...

*A **milestone** has been reached with the Journal - it is now registered with the British Library - that means that all the past copies are lodged in the Library and all the copies in future will have the ISSN standard numbering.*

It is nice to see new contributors to the journal and we very much encourage colleagues to send in manuscripts for publication. We welcome descriptions of qualitative research, which often get short shrift elsewhere, and personal accounts of interventions or experiences with young people.

Our celebration party was a great success - on Friday 21st June 96 - midsummer day - exactly 10 years to the day when our first Youth Support event took place - the 'Jamaica benefit' fair. Black shades and black pork pie hats were 'de rigeur' as we all danced the night away to the support band 'Scrummage' ably led by two long term associates of Youth Support - Sean and Alistair (available for engagements via our office!) and the 'Blues Brothers Experience'.

Our main scientific event of the year will be our day conference at the Royal College of Physicians on 24th October. .. so far bookings have exceeded all expectations and it looks as if we may have over 400 delegates! Unbelievable! Hope to see you all there. Also don't forget that those who are unable to come during the day are very welcome to sign up just for the evening - why not come to the keynote address and the dinner.

Best wishes and thanks for all your support throughout the years,

Diana Birch
Director Youth Support

Contents

Letter from the Editor	2	Adolescent Contraception; The role of the paediatrician - Ariadne Malmitsi Pucher	15
Anniversary Dinner	3	The Luncheon Club - Daniel Anderson	20
International Chapter News	4	'A Window of Opportunity'	21
SAM -L	5	Case discussions - 'Ann'	22
Tongue in cheek - a look at the 1996 International Dinner. and SAM meeting.	6/7	Case Discussions - 'Barb'	24
SAM Home Page WWB	8	Case Discussions - 'Carol'	25
IRC SAM 1997 - 'Poverty and Neglect - deprived youth in varied societies'	8	Conference - Special Announcement - call for papers.	26
'Qualitative Research'	9	'The Child that Rocks the Cradle'	27
Same time next year?	12	Conference on Adolescent Health	28
Helen - A History Carol Kremer	13		

Youth Support are pleased to invite you to attend our

Tenth Anniversary Dinner

At - The Royal College of Physicians
St Andrew's Place, Regent's Park, London

Thursday 24th October 1996 - 7pm

Dinner preceded by keynote lecture 5.30pm - 6.30pm
"Looking to the Future"
- delivered by Professor Richard MacKenzie -
- introduced by Dr Diana Birch - Director of Youth Support -

The dinner follows our conference - but please note that attendance at the conference is not a prerequisite for those attending the dinner or the keynote lecture at 5.30pm. We very much welcome those who can only attend in the evening.

Tickets for dinner £25

Youth Support Conference Administration
13 Crescent Road, London, BR3 2NF.

R.S.V.P.

- 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

The 1996 SAM (Society for Adolescent Medicine) meeting- *"Assuring Quality Care for Adolescents - Preparing for the 21st Century"* was held at the Crystal Gateway Marriott Hotel, Arlington Virginia March 20-24th.

Our International Chapter workshop on Thursday March 21st - dealt with **"The practice of Adolescent Medicine from an International Perspective"** - The theme was the management of 'difficult cases' with the emphasis on clinical presentation and practical solutions. This was the subject that had been asked for by the membership at the previous year's Chapter meeting. It was thus disappointing that not only was attendance very poor - but those who had asked for this title on the basis that they wanted to present cases - did not turn up and do so. Without wishing to winge too loudly - I would implore members in future to put their committment behind their suggestions!

There are always many conflicting interests at the SAM meeting and it is hard sometimes to choose which workshop to go to. It is worth noting though that the last few workshops have been excellent for those who have turned up and hopefully we can attract a larger participation next year in San Francisco. Actually the timing of this year's workshop could hardly have been worse (4-6pm) and we are looking for a different slot next time.

The plan which was discussed at the Chapter Breakfast meeting was that we would have a session on the day before the main SAM meeting so that there would be not so much competition and conflicting timetabling. We are going to hold an 'Institute' on the Wednesday which will have a morning and afternoon slot with a separate theme for each section. We hope that PAHO may be involved in the programme and Bob Blum has consented to join us for the day.

The suggested theme is 'Poverty and Neglect - Deprived Youth in varied societies'. Presentations will highlight the presence of deprivation in all aspects of youth culture - from street children, starvation in so called 'developing' countries - to poverty in inner city Europe and north America for example. The last part of the day will be devoted to 'free papers' on a variety of subjects - Semi Snajderman has agreed to present on eating disorder and Danny Hardoff has a paper on attitudes of non adolescent health trained paediatricians to adolescent health.Write or fax with suggestions you might have and also any contributions you wish to make.
I would also like to suggest that we all bring examples of our work in our countries - leaflets or display material which could be

displayed in our meeting room and give members a better feel of the work we are separately involved in back in our own countries.

The International Chapter of SAM is an important part of the society and this view has been endorsed by this year's president Gail Slap. The enthousiasm of the members is reflected in the large numbers who do attend the - **International Dinner** - which once more was a roaring success! This time the Restaurant had a 'Cheers' look about it and was owned by a retired famous Football player (I apologise to fans of Joe Theissiger for thinking he played baseball!).

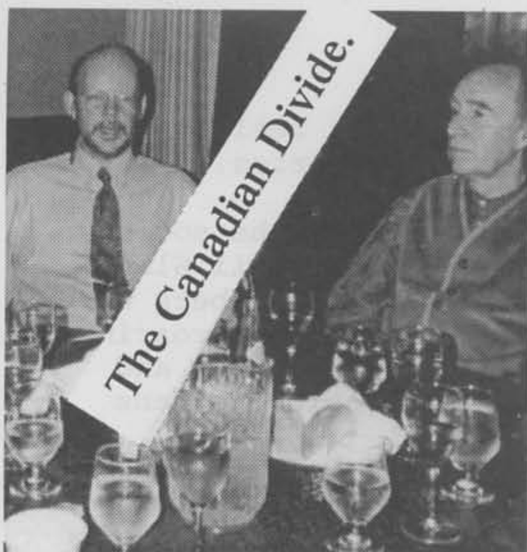
We are trying to get E mail on line for the International Chapter - not as easy as it might first appear for those of us outside the US - but Aric has been working very hard on the SAM technology committee and on the SAM home page of the World Wide Webb.

SAM-L

This is a mailing list where SAM members and other professionals interested in adolescent health issues can share ideas. A partial list of topics covered in the last eight months is included below.

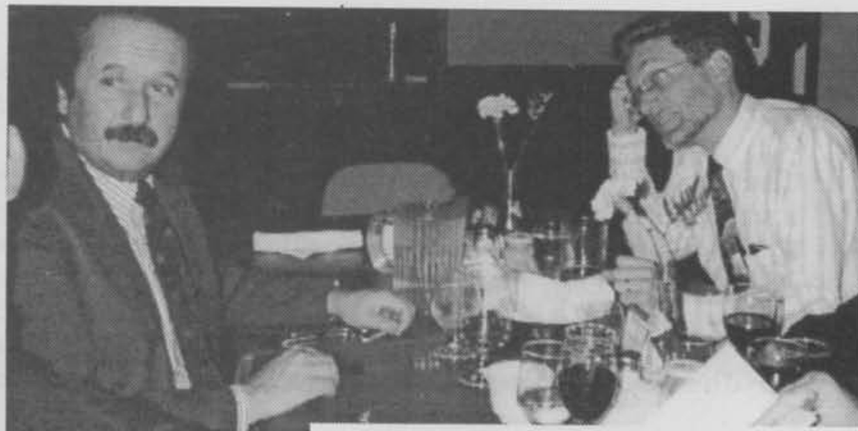
To subscribe to SAM-L you need to have access to the internet and have an understanding of the use of e-mail (electronic mail). Send a message to
listserv@uconnvm.uconn.edu
if you interest in subscribing to the mailing list. The message should be: subscribe SAM-L followed by your proper name (for example: subscribe SAM-L John Smith). We presently have over 150 members on the mailing list. We welcome you to join.

SAM Computer Technology Committee
Contact Aric Schichor (schichor@uconnvm.uconn.edu) for more information.



The Canadian Divide.

Did he get in without paying?



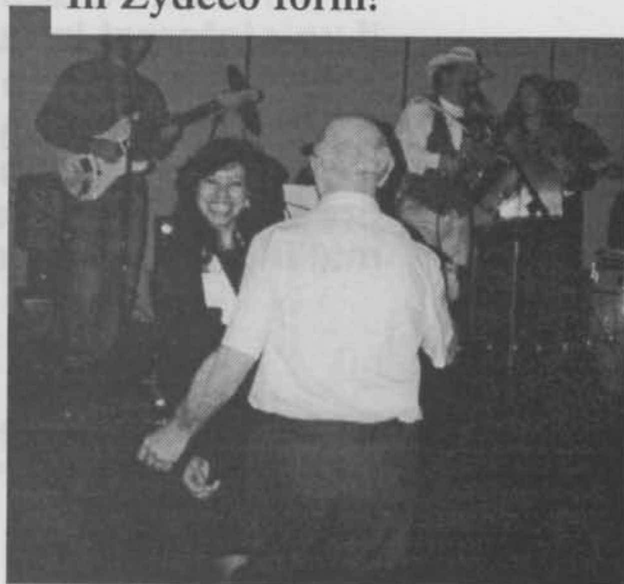
Aric - too many late nights surfing the net?

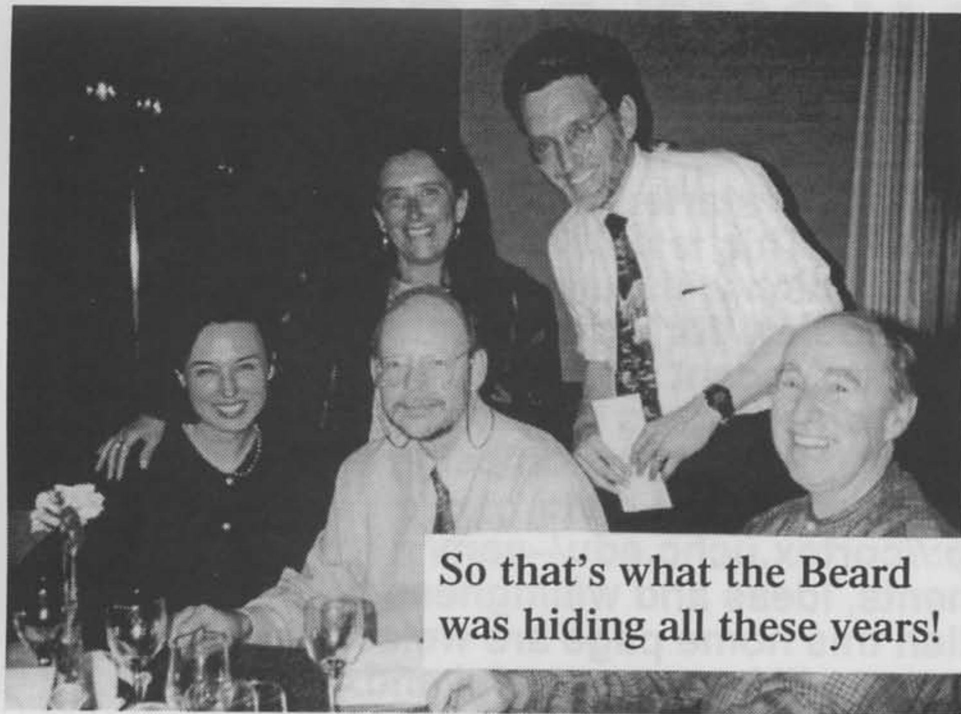
International Incidents!

If I can get her drunk she won't have a chance to start that Karaoke again.

Two thirds of the Youth Support contingent

Manny on the move again ... In Zydeco form!



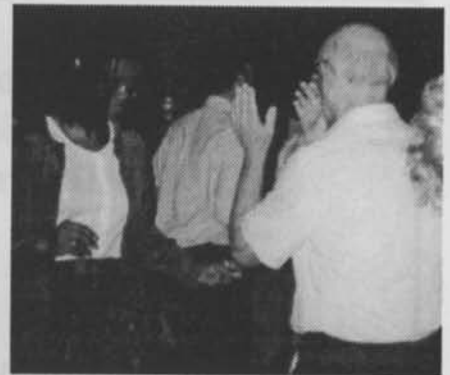


So that's what the Beard was hiding all these years!

Gustavo before the bill was added up.

Manny trying to keep still .....

Gustavo 'Give me the money' Girard.



Manny not managing it....

This is how we do it in England..

Please, God ...
She's not going to ask me is she?

What me!
You want me to present next year!

SAM HOME PAGE

Yet another venture started this year on the World Wide Web. This is an attempt to establish a site which will present information related to the Society for Adolescent Medicine and adolescent health issues in general. This home page is very much in its infancy with only a small portion being active at this time. You can visit it at:

http://cortex.uchc.edu/~sam/

Your comments, ideas and willingness to help establish this home page are welcomed. This home page will be more useful and successful as the more people are involved.

Society for Adolescent Medicine
San Francisco March 5-9 1997
The International Regional Chapter (IRC)SAM
'Institute'

'Poverty and Neglect - Deprived youth in varied societies'.

Contributions and 'free papers' welcome.

Also - for your diary - note that we will be having the following 'events' at the IRC.
Institute - Scientific session - as above - probably on Wednesday 5th March
Dinner - Social event - probably on Thursday evening 6th March
Chapter Breakfast - discussions and recruitment of members. Saturday 8th. am.
'Board meeting' - active members - 'housekeeping' TBA.
Dates to be confirmed after SAM programme decided upon.

Qualitative Research

One of the very welcome aspects of the recent SAM (Society for Adolescent medicine) meetings has been the inclusion of a special interest group on 'Qualitative research' under the leadership of Richard Brown - (San Francisco). It was thus thought appropriate to include the following article which appears in slightly different format in the book 'The Child that Rocks the Cradle' describing the fifteen year follow up of pregnant schoolgirls and their families.

Over the centuries the character and image of medicine has changed. 'Doctors', in other words Physicians, as opposed to surgeons who were called 'Mister' and identified with the 'Barber surgeons' - were not strictly thought of as scientists. Medicine was an art.

With the advent of the 'Scientific method', new treatments and investigations, new ways of 'evaluating' patients, Medicine has become a science ... but patients are still people!

It is important that the 'old skills', the 'art' of medicine is not forgotten in the search for scientific correctness. This statement can be no more important than in the field of social medicine and the emotional territory of psychology, psychiatry and psychotherapy. In fact at a recent meeting celebrating the centenary of the paediatrician and psychoanalyst Donald Winnicott considerable time was given to debating whether the great man was a scientist or a poet and we were reminded that 'The art of Medicine is not always scientifically analysable'. Hence the need for qualitative as well as quantitative research models.

Much of the schoolgirl pregnancy study described in 'Are you my sister, Mummy?' and 'The Child that Rocks the Cradle' falls into the realm of qualitative research. This is a field which has to a large extent been neglected in the past, in the search for quantitative studies which often require large numbers relying heavily on the statistical approach and thus inevitably missing a great deal of valuable anecdotal information.

The word anecdotal was often regarded almost in a derogatory manner; to say that something is anecdotal means that it is not quite good enough to be regarded as scientific research or a valid finding in a research study. However, when the content of the anecdotal information is looked at and moreover when different incidences of anecdotal reporting are put together they can make a whole picture which is extremely revealing and valuable.

This is certainly the case when one comes to researching matters concerning outcomes and success rates for example, in work with teenagers and adolescents, and certainly when one looks at anything to do with emotional responses, therapy and intervention. With regard to this present

study, qualitative research gives us a way to estimate coping skills in girls and families, and to see why certain things happen and certain results ensue.

In many studies, particularly some coming from North America where teenage pregnancy rates are much higher than in Europe, and study samples tend therefore to be large, a lot of data has been collected by means of questionnaires. The data has thus been quantified numerically, often computerised and statistical analyses are read off at intervals according to the need of the researcher. Thus the information ultimately derived is in a mathematical format.

Unfortunately people do not behave like numbers, and although maths can give some answers and allow us to produce some of the graphs and tables in this book they nevertheless mask the true picture. By knowing girls over a long period time on a personal basis one is not restricted just to looking at final numbers, but one derives a sense of knowing 'why' and a better understanding of what those numbers mean.

For instance - looking at number of pregnancies, or the average number per girl, at various intervals after the first birth or at various ages, is just precisely that - a statistical figure of number of pregnancies. But *why* are the girls having this number of pregnancies, and what is actually *meant* by the 'average'?

Looking beneath the crude numbers and knowing *why* certain particular girls got pregnant reveals another picture - the fact that the group is not homogenous, there are different factors operating which tend to draw some girls towards having one child only and others towards repeated pregnancies. Without actually knowing their individual stories it is difficult to come to valid suppositions and conclusions on such a matter.

In qualitative research, the interaction between the researcher and the client or patient and the emotional or psychotherapy input of that interview are very important. With the self-esteem studies, particularly, it was important to look at the psychodynamics of each individual and the assessment made in the psychotherapy interview was, if anything, more important than the actual numerical estimate of self-esteem which is derived from the questionnaire.

Another example here - a mother might be seen as having a matter-of-fact attitude towards her injured child. The casual observer might regard this as callous, lacking feeling, denial etc. whereas a closer study of the mother / child interaction or family situation might actually discover that this is an effective coping strategy employed by the young mother who had experienced a lot of pain; has perhaps been abused, and who has to cut off some of her feelings when dealing with her injured child, taking the child to hospital, being interviewed by medical staff etc.

If she allows her feelings through they could overwhelm her and she would then break down and not be able to cope with the situation or caring for her child. The same reaction could be seen in a positive or

negative light, depending on the depth of interview and the depth of understanding of the totality of her situation.

The difficulty sometimes with entirely quantitative research is that interviews tend to be too limited - perhaps confined to questionnaires alone. Not only does this limit the actual information elicited but the questionnaire itself can be an enormous barrier between the interviewer and the subject.

Some researchers will actually opt for using a questionnaire like this because it provides a protective barrier for *themselves* - they do not actually engage closely with the patient and do not want to because getting too close to some of the pain and difficulty in the patient, or being exposed perhaps to the aggression and anger of the patient, is something they cannot cope with. Perhaps they do not really want to be involved with the ongoing care of the patient or taking responsibility for any outcome of the interview. They just want to dip in, take their information, and run.

Saying it this way might appear rather harsh and in a way condemning the researcher. There are obviously a large number of researchers who would no way wish to harm or use their patients. However, it must be acknowledged that there are a number of researchers who are just using patients in order to obtain information for a research paper which may further their career but perhaps not actually in the end help the patient.
Throughout all the contacts with teenage mothers and their families we very much endeavoured to provide support and service, hand in hand with the research project. To do otherwise is unfair to families.

It is of course possible to look at the esoteric gains in terms of telling the girls that by helping in the research model they would actually be helping to make life easier for other girls who come into the same situation as themselves.

They deserve more than that.

Putting patients into an esoteric group like that is playing into their guilt and low self-esteem. It is like saying "Well - we don't care enough about you to try and make you feel better during this process, but you could make a difference in helping others". Many of the girls we deal with, who may have low self-esteem are already into this mode of caring for others, and not having their own needs met.

As I have said elsewhere, teenage mothers are often criticised for not being able to place the needs of their children above their own, and this is grossly unfair. Until they can fulfil their own needs it is impossible for them to be able to fully love and care for their children. An empty vessel cannot have the resources to care for others. Thus one has to take pains to ensure the research model presented to young mothers does not feed into this dynamic.

They need to be offered help and support at each stage in their own right, and not merely as an esoteric gain. Practical help needs to be provided, help with housing, nursery place for the child, counselling in the widest sense of the word.

Same time next year .. ?

Slowly the mass grows amoeba like as first one by one .. and then in ever larger groups, the members reconvene like insects honing in on a pot of honey.

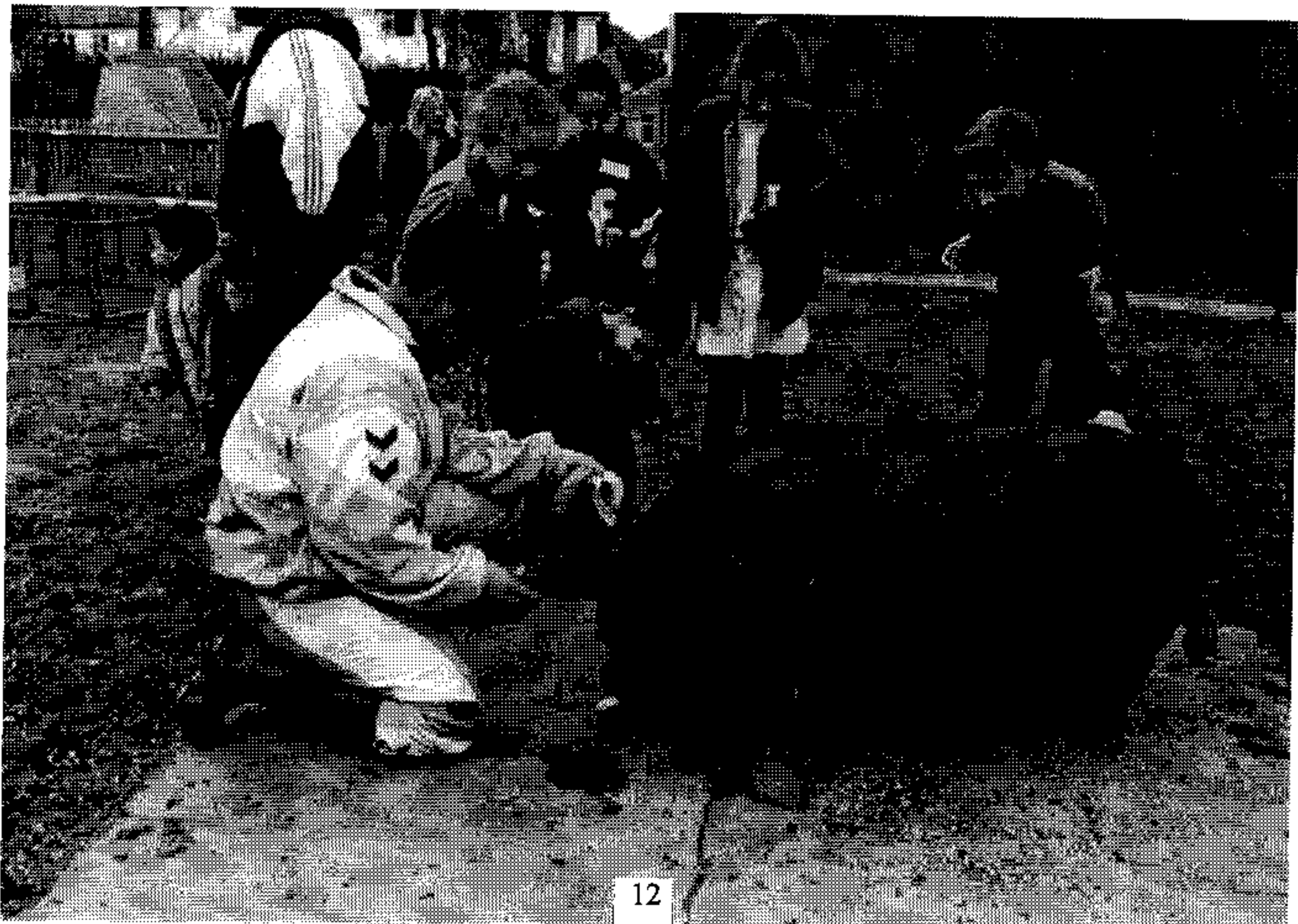
Expectations and excitement ebb and flow with each new wave of arrivals destined to spend four days interred in some concrete edifice which could be anywhere.

Old faces .. new faces, warmth of long lost friends, seeing the years pass on each others features, hearing of deaths, births and comings and goings .. and 'goings on' .. Petty jealousies, disagreements, cut throat networking ... a last night's party .. and then it's gone!

Uneasy inactivity .. last stragglers wandering disorientated past empty conference rooms... strewed literature like dead bones of a carcass picked clean. Dismantled registration desk ... the reference point gone.

Our space occupied by the next delegation - Postal work supervisors .. teeming in slapping registration packs down on desk in deliberate fashion of a clerk used to slapping and stamping.

The evanescent microcosm which was once SAM has disappeared for one more year to reappear Brigadoon like in some other location. ..



HELEN - A HISTORY

Carol Kremer

What happens to a young person who falls victim to a major mental illness? Helen was just fourteen when she began behaving in ways that were out of character: she became withdrawn and retreated to her room. To her parents she seemed traumatised, although nothing had happened to explain the frightened look that she now wore.They went, all three, to the GP who fastened on the idea of food deficiency and recommended vitamins and iron.

When Helen swung into the hypomanic phase (although no one at that stage recognised manic depressive symptoms) her parents consulted a private psychiatrist. They knew, despite the fact that Helen's behaviour had by that time involved the police, that their daughter was ill. The psychiatrist talked about a shock syndrome.

So did the doctors in the adolescent unit of the mental hospital where Helen was next sent, and where she was held for five months while her condition was assessed.For four of those months she was denied any home visits, and she was sedated daily with major tranquillisers. Her parents watched helplessly as her physical health deteriorated. Still, they thought, she is ill and doctors and hospitals are where you turn when illness strikes.

They lost faith finally after Helen had been transferred to an adult ward on the grounds that her behaviour was unmanageable, where she was eventually Sectioned. So deep was her distress that she had not only run away but cut her wrist and cheek. The authorities' response was to lock her up on a secure ward. Any trust that her parents had placed in the system had long gone - they wanted Helen home.

She was now on Lithium - but because her blood levels fluctuated she was accused of not taking it, and her parents were disbelieved when they confirmed she was complying with the medication as prescribed. She spent further time in hospital being monitored. Hopes of a family holiday in Italy were dashed; her brother and father went alone, she and her mother later in the year when she was finally discharged from hospital.

She is now over sixteen years old and almost entirely dependent on her family. Two punishing years have left her isolated from people of her own age, although she attends college for a day and a half each week despite suffering panic attacks and difficulties with concentration. She also attends three sessions a week at a day centre, but the people she meets there are no solution to her feelings of isolation. Her mother is her closest companion, her confidante, and Helen's needs have to be met within the family whatever stresses may be created by that.

Helen's family meet stress with strength and face the future without self-pity, but is this the best that can be done for

young people and their families? Does treatment have to be so punitive? And do families have to cope with so little support? The mentally ill are always vulnerable - a young person's life is especially so. Nowhere in the system is there any real provision for people like Helen, no attempt to assess the special suffering experienced by them and their families.

Perhaps there are countries where these things are handled differently, where there is something on offer at weekends for instance, where parents are not expected to assist the recovery and repair of their damaged children utterly unaided. If so, we must learn from them fast before there are too many other Helens with a story like this to tell.

ADOLESCENT CONTRACEPTION; THE ROLE OF THE PAEDIATRICIAN

Ariadne Malamitsi-Puchner MD
Department of Obstetrics and Gynaecology
University of Athens

The following paper was presented at the 3rd congress of the European society for Contraception in Dublin June 1994. It is reproduced in it's original form.

{Editor's comment - It should be noted that in the United Kingdom paediatricians are not part of the 'primary care' system - this role is taken by the general practitioner - and hence young people would not be in a position to see 'a friend coming from the past' in the form of a paediatrician as described by the author. Most teenagers would never have seen a paediatrician.}

Adolescence is the period of development of sexual activity.

Although it is a normal process during maturation of adolescents entering manhood or womanhood under the strong stimulus of sexual hormones, it is not easily discussed in many societies by parents, doctors or teachers leaving adolescents with inadequate knowledge and occasionally leading to adverse situations (unwanted pregnancies, rape etc.). It is evident that the problem is great. A recent American study reports that the average age of first intercourse for American teens is 15.2 years for girls and 15.7 years for boys. Furthermore in the USA in 1987 more than 1 million out of 9 million girls aged less than 15 up to 19 became pregnant. Of these 47% delivered, 40% aborted and 13% miscarried. 22% of births to teens are repeat births. Three quarters of pregnancies among unmarried women of 15 - 19 years are unintended. In 1987 26% of all abortions were obtained by teenagers.

Although adolescent sexuality leading to teenage pregnancy is a universal problem, the pregnancy rate in Britain, France and Canada is half that of the reported for USA. Sweden and Holland present even lower rates, reaching 1/3 and 1/7 respectively of the American rates. Adolescent pregnancy rates in ten European countries ranged for the years 1985-89 as follows: 12-14 years: 0-0.3, 14-16 years: 0.01-9, 16-18 years:1.2-21. In Greece, as observed by the first Department of Obstetrics and Gynaecology of the University of Athens, adolescent pregnancy leading to delivery increased from 5.3% to 7.2% between the years 1974-993. Creatsas et al report that for the years 1987 and 1988 11% of all deliveries in the above mentioned Department were by girls aged 13-19 years.

One fifth of all premarital teen pregnancies occur within the first month after starting sexual intercourse. Neinstein et al state that in the recent years a

decreasing trend of births to teens 15-19 years was noted. Nevertheless, this fact is primarily due to an increase in elective abortions and not to a substantial decrease in the overall number of pregnancies.

But why are adolescents so intensively involved in sexual activity?

As Neinstein explains, among adolescents sex is justified as physical pleasure and as a new experience. It is considered an index of maturity, reflects peer group conformity, represents a challenge to parents and society, and offers an escape from pressures. Moreover, the extremely powerful media which surrounds us, radio, movies, television, advertisements, constantly promote sex based usually on violence. The situation becomes more serious if the adolescent's parents on the other hand view sex among their offspring as a crime, a sin or even a sickness, instead of discussing with them about the normal development of sexuality and the family values in which sexuality is embedded. This problem is even worse in single parent families, who mostly rely on school to deliver the adequate education and fill the sexuality information gap with a dry scientific description of the anatomy and physiology of reproduction. Trapped among these various controversial aspects, adolescents are confused and frequently pushed to impulsive action - to sexual intercourse without being prepared and aware of it consequences.

Who must help in preventing and managing this situation?

"A friend coming from the past" - the paediatrician.

His or her role is sometimes difficult but always gratifying. Paediatricians have the advantage of knowing the family conditions and particularly adolescents since their birth and childhood. They usually have a good relationship with them, they are aware of somatic illness and have following the psychosocial development of the youngsters. Nevertheless, paediatricians occasionally encounter some difficulties in their efforts to cope with adolescents and especially when the subject concerned is sexuality. Paediatricians have worked closely with the adolescents' parents for many years and teens are afraid of lack of confidentiality. On the other hand, adolescents consider themselves grown ups, because of physical maturity, and feel their ties to their "first doctor" to loosen. In spite of this , paediatricians consider themselves better prepared for the care of adolescents than internists, and teenagers feel more comfortable communicating with the former.

When and how should a paediatrician intervene?

It is crucial that the physician has started a confidential and trusting relationship with the youngster prior to puberty. It should continue with frequent honest talks and a thorough examination, each step of which is explained. This should take place without the presence of parents, unless the child is reluctant. This attitude strengthens the independent identity of the young person and forces him or her to take

responsibility for his or her health. A clear and honest statement by the paediatrician as "I have to know more about you, your life, your behaviour, like sex, so I can take care of you and help you if needed" is usually appreciated by teens. Then the paediatrician must be willing and prepared to answer all sorts of questions. The information given must be always simple, factual and straightforward. Nevertheless, emotions should not be left apart and the physician should not hide his or her own moral values underlining responsibility, caring and trust. "Value free", pure education concerning the anatomic and physiological aspects of reproduction and counselling stressing only prevention of unintended pregnancy and sexually transmitted diseases very seldom provide the environment in which the adolescent feels comfortable to ask questions and solve problems.

What should the paediatrician counsel?

Abstinence is considered the most effective method of birth control and prevention of sexually transmitted diseases (STD). In the 1970s abstinence among adolescents was the norm. Only 4.7% of 15 year old girls were reported as having sexual intercourse in the USA. By the late 1980s that number was five times as high. Peer pressure and media influence are responsible for this tremendous increase. The paediatrician advising the adolescent to postpone sexual activity until the gap between physical and mental maturity decreases should stress that even by age 19, 20-25% of adolescents have not had intercourse. He or she should reassure teenagers that virginity is normal and not a disease and that the alternatives of petting and mutual masturbation can be explored.The counselling objectives should also include the limitation of sexual partners as STD, hepatitis, chlamydia, trachomatis and especially devastating AIDS are nowadays of great concern. A caring and interested paediatrician having won the adolescent's trust is the person who can persuade the youngster to delay coitus until eventually a monogamous relationship can be established.

The paediatrician discussing with the adolescent the various methods and techniques of contraception should not omit to point out that:

a) the risk of pregnancy is considerably lower if two contraceptive methods are used together consistently

b) many pregnancies are due to method failure and not to inappropriate or inconsistent method use

c) failure rates are in adolescents higher than ones reported for each contraceptive method due to ignorance or lack of experience

d) birth control should always be combined with prevention of STDs. Thus oral contraception does not protect against STDs As most adolescent girls are not compliant with the pill and intercourse is mostly sporadic in the majority of teens condoms and foams are usually better contraceptive choices.

A further role of the paediatrician is to help his

chronically ill or disabled patient to cope with contraception. He is the one who knows better than anyone else the torturing problem of the young person who enters puberty and develops sexual drive. Many chronic diseases are prohibitory for oral contraceptives and barrier methods such as condoms, spermicides, diaphragms and sponges are preferable. Nevertheless, physical disability may prevent an adolescent from correct use.

The most important contra-indication for oral contraceptive use is cardiac disease. Epilepsy is not an absolute contra-indication, in contrast to migraine, while oral contraceptives do not pose an increased risk to patients with multiple sclerosis. Asthma attacks are not exacerbated with oral contraceptives which are absolutely contra-indicated in patients with cystic fibrosis.

With caution and only in stable cases of Crohn's Disease could oral contraceptives be used but never in active liver disease or cirrhosis. Although diabetes mellitus is also prohibitory for oral contraceptive use, as the latter causes a decrease in glucose tolerance and exacerbates diabetic complications, paediatric diabetologists tend to favour oral contraception fearing that a teenage unscheduled pregnancy of a diabetic mother is more harmful than the controlled use of contraceptives. On the other hand, thyroid disease is not influenced by its use.

Adolescents with iron deficiency anaemia due to heavy menstrual flow often benefit from oral contraceptives. Also, cases with factor X deficiency or Willebrand's Disease claim lessening of bleeding tendencies. Sickle cell haemoglobinopathy is in general a contra-indication.

No evidence exists that oral contraceptives have an adverse effect on non-hormonal dependent tumours. Adolescents with depression or on anti-depressants might deteriorate with their use. Oral contraceptives should be avoided in teenagers with systemic lupus erythematosus. No data against them exists in cases of rheumatoid arthritis.

Young patients in haemodialysis may suffer from hypertension or thrombo-embolic complications, thus oral contraceptives should not be used. The same applies to teens with renal transplants.

How should the paediatrician cope with the adolescent found by chance pregnant?

Young girls visiting the paediatrician complaining of various symptoms and not aware of their pregnancy pose a difficult problem for the physician who must have high index of suspicion and sensitivity to reveal reality. The young person needs support to express her feelings, to explore all options and make the right decision about the continuation or termination of the pregnancy. The paediatrician should provide her with specific information concerning abortion procedures, perinatal health carer, adoption or foster carer possibilities for her offspring.

The counsellor should suggest the participation of the adolescent's parents and maybe of the putative father to a discussion, before any decision is made. Paediatricians especially have increased responsibilities

towards parents of minors.
Abortion counselling should refer to the procedure and its risks, which are less compared to those associated with birth giving. If the adolescent chooses continuation of pregnancy she should be promptly referred to gynaecologists for prenatal care. As the hard task of caring for the newborn will fall on the grandparents the counsellor should advise unmarried adolescents to involve their parents.The paediatrician should not forget to explain to the young pregnant girl child rearing as babies have been often unintentionally abused by their teenage mothers. Reintegration of the young mother to school and adaptation to the new situation is another field where the paediatrician should offer his help. Last but not least, the importance of contraception in order to prevent a repeat pregnancy should be explained and stressed.

Finally - do paediatricians feel competent for all these tasks?

Although the American and many European Academies of Paediatrics formally have recognised adolescents belonging to the practice, "boundaries of paediatrics since over 20 years" a study published in 1984 states that 66% of graduates from paediatric residency programmes in the States feel inadequately trained in adolescent medicine, especially in gynaecological counselling and contraceptive services. Therefore the help, advice and medical care from the gynaecologist specialising in adolescent medicine is invaluable. But as adolescents feel easier communicating with physicians they know from their early years than with internists or gynaecologists who they meet for the first time it is urgent for paediatricians to learn more about teenagers and their problems rising from sexual activity.

With the collaboration and active participation of the adolescent gynaecologist, physical and psychological support will provided to adolescents aiming at a better health carer for conscious individuals.

THE LUNCHEON CLUB

My name is Daniel Anderson. I am a student at Kingston University, in my first year of the Diploma in Social Work. Youth Support House has been my placement for a three month period.

During my placement I have been actively involved in running "The Luncheon Club". This activity involves staff and residents preparing a two course meal for older members of the local community. Residents develop their life skills in such areas as cooking, communication skills and self achievement. These factors contribute to the promotion of self esteem and value as an individual.

The Luncheon Club was established as part of a philosophy to provide residents and their children with a "surrogate grandparent" figure. Many residents have not had the opportunity to be encompassed within this healthy family dynamic, as many have lacked a positive parent figure within their lives. The three tier, transgenerational aspect provides residents with a good model and positive framework of the dimensions of family life of which they can be part within this context. This activity provides an avenue for conversation and interaction between residents and local members of the community.

The integration of local members of the community and residents is an important aspect. The setting is within a safe and unthreatening environment where active interaction can promote a "bridging" with reference to some residents thoughts and anxieties of isolation and segregation from the surrounding community.

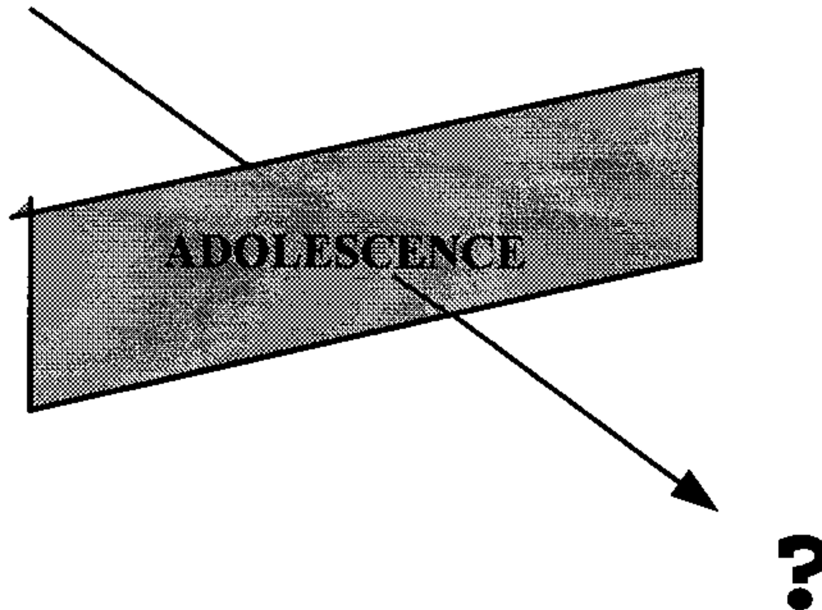
The underlying format acts as a useful therapeutic function instilling within residents a notion of self worth and value, in terms of residents engaging fully and on an equal basis with staff to produce a finished product (the meal) To give something to others and receive appreciation for this is a positive form of interaction which may not have been in existence in their previous home environments.

The programme is run on an informal basis, it offers staff a good chance to talk to residents regarding problems they are facing or experiencing without the structure of a formal therapeutic session. This informal setting can provide a good foundation for relation building and the development of trust.

The Luncheon Club has been running for some time now, and continues to draw upon the need for resident participation. The development of life skills, communication skills, self esteem and value are all contributory elements of the Luncheon Club in respect of the whole therapeutic timetable.

Daniel Anderson
(Social Work Student)

A Window of Opportunity.



Adolescence can very much be regarded as a 'window of opportunity' allowing us a chance not only to see some of the 'early' emotional and psychological mechanisms in action - but also a chance to work with , treat and modify some of these early traumas.

This was the basis of the philosophy of the IRC workshop in Washington March 1996.

The 'Youth Support' contribution centred on three cases. A young girl Ann who had been a street child after a number of difficulties at home, who had been sexually abused and who found it difficult to separate and understand her feelings of love and hate for her step father. Barb who had such a level of undealt with pathology that she had reached a position where her 'object relations were so disturbed that she was beyond help. And Carol who was at an earlier stage in her progression, had been sexually abused by her father but showed signs of being reachable and 'treatable' - a hope for the future.

The initial presentations were as follows -

ANN

Initial presentation as a pregnant schoolgirl
Abusive relationships
?possible sexual abuse

Eventual Outcome ?
Child protection issues

BARB

Initial presentation as a pregnant schoolgirl
promiscuous - First sex at 10
?possible abuse

Eventual Outcome - 'Murder Trial'. Psychopathic personality.
On-going child protection issues.

CAROL

Initial presentation - sexual abuse

Eventual Outcome?

ANN

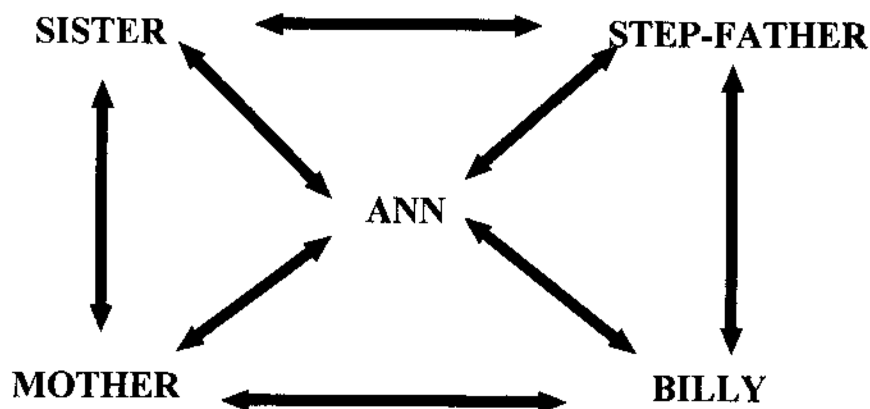
At 12yrs Ann accused her stepfather of abuse. This followed a long period of acting out and being 'out of parental control' at home. Her natural father had left home some years earlier and Ann resented his leaving and despised her mother for taking on another man. Mother threw her out. There then followed a period of drug abuse, vagrancy, 'street child'.

At 13yrs she met Billy her boyfriend in a police station and immediately struck up a close relationship - seeing themselves as kindred spirits. he too was vagrant, had been abused, was using drugs, into crime and involved in considerable violence and she describes how - she alone can see what a beautiful person he really is inside.

Eventually Ann was taken into care although this was not a happy experience - she was sexually abused on a regular basis by an older man who lived near the children's home and who supplied drugs to all the girls in the home. Ann continually absconded to be with Billy on the streets. When she became pregnant she was transferred to YSH where her therapy programme began and at 14yrs Robert was born

The family dynamic for Ann was very much based on competition with Ann at the centre of a wheel of jealousy and family members scoring points off each other. Ann was jealous of her sister, they had children at the same time, organised christenings at the same time. Sister was older and Ann perceived her mother as loving sister more - so when she seemed to get attention directed at her baby - Ann had a baby too - to get mother back. Unfortunately most of Ann's attempts to make them 'love me too' ended in failure and thus her return to an unsatisfactory and harmful relationship with Billy - who would never find anyone else. Their relationship was totally dependant and manipulative for example, would self harm and cut himself if she did not abscond to see him. After the birth of her child , the question was how would Robert fit into this dynamic - would there be any space for him?

CONFLICTS AND COMPETITION



? ROBERT ?

Ann's dilemma was in confusion of roles - in discussing the mechanism whereby this confusion arose we need to consider what the dynamics are of relationships -

Ann / Mother

Ann / Stepfather

Ann / Boyfriend

Leading to influence on ....

Ann / Baby

Ann / 'Carers'

This is very much an exercise in 'object relations' - in that the manner in which Ann was treated as a young infant - the way she perceived her world and the people around her - the way she developed her 'object relations' was fundamental in shaping the relationship with mother - and this relationship formed the basis for all future relationships. Hence there were parallels between the relationship Ann had with step father and other men including Billy - 'expecting' abuse, responding to manipulation, trying hard to please others, not really having her own needs met. We could see this pattern 'mirrored' in her relationship with staff in the unit. Hence we had clues as to how this 'transference' operated, how Ann related to people and how we might proceed to help her modify some of her responses. It also gave clues with regard to the way she might relate to her son.

Only time will tell whether her world will have 'space' for Robert. For some time the future looked bleak - Billy's influence was negative to the extreme - he had no room for a child in his life and he saw the child as usurping his position - hence Ann was manipulated into another 'power struggle' of jealousy - which baby would she care for? At the moment things look better. Ann is responding to therapy and appears to have chosen her son Robert over Billy his father and Billy is currently off the scene - but for how long?

BARB

Barb could have had a similar life course and outcome to Ann but she was more damaged at an early age and had very deep disturbance of her 'object relations'. What the trauma was at that early stage is impossible to tell. Her family know of nothing specific and in some ways she has 'always been like this'. 'This' is cold , cruel and uncaring of others.

She began her sexual history at 8 or 10 yrs and was highly promiscuous. Barb could not be confined, she ran off to meet men and even put a ladder up to her bedroom window to let men in to have sex with her. Pregnancies began at 12 and she had four pregnancies before the age of 16 having given birth to three children by the age of 17. When Andrew was born she handed him over to her parents and was unconcerned with him thereafter.

Pregnancies -	13 yrs	(1)	Andrew
	14 yrs	(2)	TOP
	15 yrs	(3)	Matthew
	17yrs	(4)	Tricia

Soon after her eighteenth birthday - within the short space of 8 weeks - the following had transpired - marriage ended - new partner - Matthew DIED, Tricia removed for neglect and possible abuse. Matthew died in horrific circumstances which were gorily reported in the national press at the time but although found guilty of the

lesser charge of wilful neglect and imprisoned for 6 months, Barb never acknowledged any part in neglect or harming her children. She never accepts any responsibility for her actions or their effect on others.

Her history continued with - 20yrs - Trial - Prison - Pregnant (5) Baby removed at birth. 23 yrs pregnant (6) David - After his birth she was sent to YSH for assessment and treatment. 25yrs(7) TOP.

Consideration of Barb's object relations reveal a depth of psychopathology. A deep splitting between the 'good' and the 'bad' and a total lack of any coming together of these elements. Within the unit we could see the 'transference' aspects of this - she would adore (usually inappropriately) or hate (very frequently and intensely) the same person at different times and have no perception whatever that this was one and the same person - or that the individual might be harmed in any way by her 'murderous attack' - she would have no expectation that there would be any consequence whatever of any of her actions and no capacity whatever for remorse.

Sadly Barb was beyond therapy -all that could be done was to an extent to 'contain' some of her destructive potential. What happened early on to cause this? What would it take for an Ann or a Carol to have turned out this way? What protective mechanisms did they have which safeguarded them from such extremes?

CAROL

Carol when first seen was the least 'deviant' of our three cases. She had been abused but had not yet fallen prey to drugs, self harming or serious acting out. Her history was that at 11yrs her Mother became seriously ill - with heart disease. At 12yrs mother died. Thereafter she and father had difficulty coming to terms with their grief and between 12-13 yrs Carol suffered sexual abuse by her father.

After disclosure of this abuse at 14yrs she was removed to foster care and a year later at 15yrs referred to YSH. Carol made good progress in therapy which was initially on a 'psychodynamic' basis with time spent in our 'animal therapy'. She warmed to the animals and developed trust in the unit. Carol had a very difficult stage following the disclosure by a social worker of her address to her father - she went through a period of acting out and attempted to prostitute herself to mini cab drivers - fortunately she was picked up and brought back home.

Eventually Carol's therapy came to a focus when 'story telling' therapy allowed her to write a tale about the animals with which she subconsciously identified. Her story of a hurt kitten brought out her own hurt, anger and need for protection and was a turning point in her progress. Hopefully Carol will be able to maintain her positive growth and leave her abuse behind.

*Youth * 1986 / 1996 * Support*

The Tenth Anniversary of Youth Support

SPECIAL ANNOUNCEMENT

Conference on Adolescent Health

"Youth - Our Resource for the Future"

Royal College of Physicians
St Andrews Place, Regent's Park, London

Thursday 24th October 1996

CALL FOR PAPERS

Due to the high level of interest in the conference the Royal College are allowing us to use an additional lecture theatre - The new lecture theatre at the College will be completed in time for October and thus we will be able to run two parallel programmes - delegates will have a choice of which session they attend. We are thus in the happy position of being able to invite contributions from additional speakers and to accept a limited number of free papers.

Please contact conference administration as soon as possible if you wish to speak or submit a paper - final deadline for receipt 20th August. Please supply name of author/speaker, institution, title of presentation. Presentations should be limited to 15 minutes. Abstracts limited to 200 words welcome.

Please write in now to :-

Youth Support Conference Administration
Youth Support House,
13 Crescent Road London BR3 2NF

or FAX 0181 659 3309

"THE CHILD THAT ROCKS THE CRADLE"

A FIFTEEN YEAR LONGITUDINAL STUDY OF SCHOOL AGE MOTHERS AND THEIR CHILDREN.

DR 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 * 1986 / 1996 * Support*

The Tenth Anniversary of Youth Support

Conference on Adolescent Health

"Youth - Our Resource for the Future"

to be held at

The Royal College of Physicians
St. Andrew's Place, Regent's Park, London

on

Thursday 24th October 1996

Conference 9.30am - 5pm
Followed by Keynote Lecture 5.30pm - 6.30pm
Followed by Tenth Anniversary Dinner

The Journal of Adolescent Health and Welfare
is published by:-
Youth Support
13, Crescent Road, London BR3 2NF
Charity N0 296080
Tel No 0181 650 6296
Fax No 0181 659 3309