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# Journal of Adolescent Health and Welfare

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

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

## Letter from the Editor -

Dear Colleagues,

Welcome to the twelfth volume of our Journal - and I hope you like the new format. We are continually updating our practices at Youth Support and keeping up to date with new looks and new technology. This is the first Journal to be produced under the auspices of our new enterprise - The British Society for Adolescent Health and Welfare - more on that later.

The Journal is also going to be available on our website. This will make it available to a wider audience - will reach you quicker - and with any luck will save us on postage.

As Youth Support enters the 'Cyberage' with the running of our own Internet Café the 'Cyber Bridge' we are actually having several websites aimed at different aspects of our work. The old website had a great deal of information on it and it was time to split it up - we will keep everyone posted regarding the new sites and there will be hyperlinks to all sites from our main one - so don't worry about losing us! At the moment the Youth Support website is still situated at http://www.youthsupport.demon.co.uk but you will also find us at www.cyberbridge.org and www.youthsupport.org Happy Surfing!

Diana Birch
Director Youth Support

*FRONTISPIECE*
*Pamela Mc Neil - Womens Centre of Jamaica Foundation*
*Lancelot Bryan - Master Carver - Youth Project Jamaica*
*at Youth Support Conference 1998*

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## ~ CONFERENCE ROUND UP ~

*Personal Views of those attending recent conferences -*

Our conference round up is presented in a different format in this issue - since our main focus has been on our own conference at the Royal College of Physicians in October 1998 and we are currently preparing the proceedings for publication. We are also publishing selected presentations in the journal (see below) but we would encourage you to order the proceedings books - both from 1996 and 1998.

**Proceedings of our Conference 1996**

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# "Youth - Conserving our Resource For the Future"

## Diana Birch

Taken from the opening keynote speech – day two of the International Conference on Adolescent Health London 1998

Adolescence is traditionally regarded as a time of turbulence, a cocktail of mixed emotions, anxiety, excitement, pain, fear and joy - though as often as not the joy part is experienced as a retrospective emotion something not experienced until looking back and having gone through several adolescence's or life changes.

Do we as unfulfilled adults look back through rose-tinted glasses thinking 'it must have been good'?. When I as a teen heard the old chestnut 'school days are the best days of your life', I thought that held little promise for the future. For some, the disadvantaged and abused, this carries no joy and this is the sadness for all of us, marking a sense of failure for us adults / professionals that we have not done more to bring happiness and joy into the lives of young people. - A wasted resource.

Adolescence is a relatively new concept, in many ways self indulgent, a luxury of the developed world that youth has a period of respite before entering the adult world, a period to adjust, to reflect, to learn, to study or perhaps a period in limbo, no-mans lands - not child or adult. As Judy Garland sang "I'm just an in-between". Does this period really exist or is a mythical creation of modern society? (Perhaps of those practising adolescent medicine specifically ).

In many societies individuals move from the child to the adult world with no in-between stage, child to mother, daughter to wife, dependent child to worker. The same was true in the western world not long ago, girls changed their short socks to stockings and started work the day after they finished school at age 15. The cult of the teenagers began in the fifties with the advent of pop music, teen fashion, teen culture which was encouraged by commerce who revelled in the new young market.

**A Phase**

So society began to exploit the teenager at first in a subtle, relatively innocuous way and then in more pernicious ways. A market for drugs, for sex, for all that's wrong with society. However, in truth adolescence has a dual concept - it is both ***a phase*** and ***a transition***, but ***the phase*** as we have said is a time to learn - the luxury once afforded perhaps only to university students . But are we also creating an opportunity for risk taking, delinquency, teen pregnancy etc? There is a high morbidity and a mortality associated with this period in limbo, this phase of adolescence. The activities of fashions and cultures associated with higher and higher risks start creeping in to fill this void.

**Danger in Limbo**

For example, recently one of the children attending our pet shop refuge 'P.J', was to indulge in one of these American imports activities after our doors had closed one evening. He went tagging on a railway line and was electrocuted -

another life cut short by senseless filling in of spare time. Let me tell you a little more about PJ - he was street wise - a mercurial kid - the little loveable rogue - either on the street or in the shop. He rode the trains - grabbing the back of a train and riding to the next station - he crossed the tracks for excitement - classic risk taking - his friend John did not speak for a week after it happened and then he poured it all out in a group session I held for the children after the funeral - 'I told him not to go - but he would never listen - I told him that when you hear a click the electricity is coming on strong and you have to run - he was walking behind Perry and we heard him say 'ouch' then we turned round and his body was jumping - then it stated to burn and his mobile phone went off - I was scared to answer it because of the current - but I could see the face said 'mum'." We could not bring ourselves to tell his mother that as she rang her son was dying on the track.

This sad event - rather than stop the kids tagging on the railway lines – has encouraged them to put up memorial tags - ORA RIP. – At the funeral, they could not tear themselves away and physically held the coffin - I'll never feel the same about Eric Clapton's 'Tears in Heaven' which was played over and over again .... Our late night refuge / youth club is going to be called PJs - we have an appeal for that at the moment -

**A Transition**

As a ***transition*** adolescence achieves more of a level of legitimacy, this is an adjustment and we need to look at the needs of anybody adjusting. There are no other periods of our life when we change so much, at no other times do we change more physically, physiologically, emotionally, mentally and within our roles. In many ways modern life has diminished the other changes, the other adolescence's in our lives. For instance, maybe the menopause male or female does not hold the fears that it once did, it is not linked with reproduction and with new understanding of hormone replacement therapy it is not linked with sexual activity either. Retirement is no longer the threshold phase it used to be, it is now a more of a prolonged phase. Marriage, divorce do not have the significance they had in the past, there are often many marriages and divorces so there are not so many big watersheds in life and for some the role changes in adolescence can all coincide.

Who are we? - The pregnant school girl is an example par excellence where all transitions coincide, adulthood, motherhood etc. Interfering with the establishment of identity.

Of course the physical and physiological transition is of very great importance but I will mainly limit myself in this discussion to the emotional and physiological parts of the transition and change. I should not want to sound too depressing or have you going away with a negative image, but we have to look at the problems in order to find solutions. Denial is one of our biggest enemies, so is the very natural mutual patting on the back which can happen at big congresses like this one, but we have to bite the bullet and look the problems full in the face and if we are being honest we will see that the main problems for youths is adults, we create society, we run it, we perpetuate problems because it suits us because we earn money from them and we turn away and don't want to see them.

**Resilience?**

We talk in a blasé fashion that the universal panacea the "resilience" of youth, but basically you develop resilience by being knocked, resilience is in relation to the assaults and problems in life.

Roger Tonkin writes on his email, "lets create opportunity out of challenge", this is good and I find it uplifting to see this on his messages - but perhaps we could try to remove some of the challenges. Of course, just as our bodies develop: somatic strength from physical challenge, training, weight lifting etc. so our psyche develops emotional strength from learning to survive hurt and pain.

What we need to ask is:- 1. Is it desirable to be "emotionally strong" implying a certain coldness, distancing, blocking perhaps . 2. Is the learning process maladaptive. Each concept, the physical and emotional, can be taken to extremes.

Emotional development encompasses a basic necessity to learn tolerance of frustration, we can't have everything we want. Mother can't supply the milk to her infant instantaneously and satisfy the baby's every whim, thus object relations are born. The good breast, the good mother fulfils the child's needs, thus the good object. The bad breast, the bad mother frustrates the child and does not supply immediately, hence the bad object, an essential part of emotional physiological development.

However, in order to develop emotionally one does not need to take this to extremes, the child does not need to be abused, neglected or abandoned. It is when this happens that the response to abuse, the survival mechanism, coping strategy, the resilience if you like, can be maladapted - like Ellen speaking of her uncle's abuse of her "I can take it, he can punch me as hard as he likes, I don't feel it". On her sexual abuse "I didn't think it hurt me until I stopped to think about it, I thought it was normal, she called it just a game, it didn't hurt me because I blanked it off".

So looking again at preserving this valuable resource for the future, perhaps we could break it down into looking at early patterns, prevention of abuse, the early childhood with the long term consequences that it carries through into the adolescent phase and then into adulthood. And then at the additional assaults and stresses that we place upon these young people as they go through their adolescence.

**Abuse**

Abuse of whatever type naturally produces harm in the present, hinders the development and carries a maladaptive pattern into adulthood. The child who grows up secure in the relationship with a parent is not so vulnerable to subsequent abuse, the child learns how to deal with emotions by using this relationship with mother or a parent as a prototype for future relationships.

More primitive feelings, profound love, deep hate can not be held by the infant without the moderating effect of mothers reactions, the child projects his feelings onto the parent who mirrors them back in tolerable form. A child learns to love himself from the way he is loved by others, however, the child

will also learn to hate him or herself by the way he is hated / abused by others. The child will feel bad about himself, will feel guilty that he cannot make mother happy and 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 and will learn coping mechanisms and maladapted forms of behaviour.

The main hurdles we need to confront in helping to heal these wounds are the damaged self esteem, self concept, value system of the young person entering the turmoil of adolescence. So here we do have some advantages in that albeit adolescence is a period of turmoil, and also a period of vulnerability to further assaults with other harmful messages, it is also a window of opportunity for the establishment of positive change. The young abused person enters this scenario of adolescence with a value system which is warped by his or her previous experiences affecting the way he or she feels about themselves, self worth, the way he or she judges others, who is safe who is good, the way the young person judges the world around him, a code of behaviour and a code of relationships.

Such a young person is also a needy child, an empty vessel who has never had enough of mother, who can be jealous of others, attention seeking, insensitive, develops shallow relationships and be unable to give - hence the difficulty of being seen as someone who is unable to place others needs above their own. This comes up frequently in the context of early parenting, a mother who can not put her child's needs above her own, certainly she can not until she is also re-parented and given love, affection and being able to fulfil some of her own needs in the safety and security of a therapeutic relationship or therapeutic environment. This young person will also be entering adulthood with no concept of security or of knowing that someone cares about you enough to show you what's right or wrong. If no one care's about the consequences of your actions then your actions are worthless and perhaps you are worthless too, no one care's about you. An experience of misplaced trust, attempting to trust people who then abuse them, mean they enter the scenario of adolescence unable to trust. They are also unable to communicate and often do so in indirect and more harmful ways acting out self harming, delinquency, suicide attempts, all ways of attempting to break the silence. ..... Can we learn how to listen?

**Wasted Resources**

The other side of the coin which unfortunately often goes hand in hand with the factors we have already described, is how are adolescents abused and exploited during their adolescence? We have seen how they can be damaged prior to adolescence and as the young person enters the scene of adolescence. But this exploitation continues on a grand scale throughout adolescence. Again wasted resources –

Her are some 'wasted resources' - Gary the son of a teenage mother who was brought up by his grandmother and when she died, became a street child and then attempted to use his meagre personal resource to protect his sick mother and younger sisters from an abusive man. He lost his childhood. John who fled from an abusive mother into the hands of a needy damaged

and abusive girlfriend and ended up in prison, taking the blame when she abused their child. Lee who was beaten by his father, led into crime and drug abuse by his brothers and ended up a very angry young man screaming out for someone to listen to him. We need to stop these kids from being trapped in the perpetuating system of abuse

How else can we waste the resource? By professional abuse. By the care system - in the pregnant schoolgirl survey (The child that rocks the cradle) girls in care had a worse history - higher incidence of abuse, crime, disruptive behaviour and in their pregnancies showed more harmful patterns of repeat pregnancy - their children fare worse at 5 yrs - 10 yrs - 15 yrs follow up. By not allowing adequate funding to break the cycle of waste we are perpetuating the problem from one generation to the other.

**Exploitation**

Let us look again at exploitation - let me take you briefly through a progression of exploitation. We had a very successful workshop on exploitation in Atlanta last year in which I concluded that it is very important to regard youth as a resource rather than a commodity, not a commodity we can use but a resource in we value and value together, in so doing we need to encourage youth and not exploit them. However exploited they are, on a number of different levels they exploited because of their attributes which include youth, vitality, vibrance, sexual energy, a need to be independent, a need to get out there and work and earn a living and a need to experiment and explore there surrounding.

All these attributes are exploited in the work force by being used as cheap labour or by unsafe situations, thy are exploited in the fashion market, whether it's in advertising or in purchasing goods ranging from CD's, music, trainers and other more harmful substances such as drugs, alcohol, alco pops, tobacco etc. and they are exploited sexually in pornography, paedophilia, they are exploited by their families, by friends, by other young people and by society and by society at any level.

**Action**

So what can we do about this? The first things is that we need to stand up and be counted, we need to discuss these issues out in the open and we need to confront the denial surrounding some of these activities. Many of these activities are covert and sometimes as professionals we can collude with the covert nature because we don't want to face some of the wider issue's, but the issue's are wide and world-wide and we need to look at them together. Many of the issue's also involve danger, because in speaking out against pornography and prostitution, we are not only exposing activities but we are challenging and taking away the source of livelihood of those involved in the sex industry, the drugs industry etc. The situation becomes and dangerous game of issues money, finance, power and politics are interwoven in a dangerous web, so we need to stand up and be counted not only in order to expose perpetrators and to expose exploitation of youth but also to allow youth to understand and see that we have a value system, that certain activities are acceptable, concern others and are not acceptable.
As we have seen many of our young people from deprived backgrounds and from abusive backgrounds have grown up without a value system of their

own. We do not wish to impose ours, but we do need to show that we have one and they can sample our value system and then decide on their own set of values. Perhaps if you have a value system they can respect themselves and value themselves enough not to allow others to exploit them. So we need to work on two levels, we need to work on those who would harm and exploit youth, who would waste our resource for the future and we will also need to work on youths themselves to make sure that they value themselves, as an important resource for the future.



And in order to value themselves for the future they need to have a sense of future and a sense of future which is worthwhile, we need to give them a future worth investing in. And perhaps we can do that - here is Beverley - 15 years ago as a pregnant schoolgirl and now a solicitor - We can be encouraged by this and buy the positive work done in Jamaica - self esteem boosted - peer counselling; And the Italian earthquake - How many friends in London - and an apt catch phrase - 'Rimarginiamo le ferite ' - 'Lets heal the wounds' Our youth have many wounds - let us help them to heal and conserve their strengths for all of our futures.



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# - International Chapter News -

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

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

Our Chapter will be holding a workshop Institute at the 1999 SAM meeting
(Society for Adolescent Medicine) Los Angeles - March 19th

**SAM 1999 - IRC Workshop**
**"When is a family dysfunctional? - A cross cultural view."**

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

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

# *'Profiles'*

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

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

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

First Announcement
Call for Papers

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

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

# *'Profiles'*

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

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

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

**Israel 15th – 18th November 1999**

## International Seminar on Violence and Adolescence

A series of workshops run by international experts will examine the factors that determine the presence of violence , preventive measures to reduce its incidence and the provision of mental health care for the victims of violence. Among the speakers will be
*D Birch UK * E Chigier Israel * M Christensen, Sweden * J Cohn Norway * S Gordon USA Israel * * Y Harel Israel * J Kienhorst Netherlands * H Tolmas USA * L Verhofstadt Switzerland.*
Details from – ISAS - PO Box 574 , Jerusalem 91004, Israel -
Tel 972 2 6520574 Fax 972 2 6520558

# Adolescents' views of outpatient services

Stevie Miller, Child Health NurseTutor, Bournemouth University

The period of adolescence is described as a time of transition from childhood to adulthood. It is characterised by interrelated changes in the body and mind and in social relationships. In recent years, interest in the scientific study of adolescence has increased considerably. Despite the accumulation of knowledge, however, the effect of much research has possibly been obviated by persisting myths about adolescents, still held to be true by many healthcare professionals and others. According to some adolescents are 'troubled' subject to fluctuating emotions and incapable of rational thought.

Little information is therefore available on the needs of adolescents, potentially hindering the delivery of appropriate healthcare services. But this information is becoming increasingly important. More children with chronic or life threatening conditions now survive into adolescence. At present, they are often cared for in facilities designed either for children or for adults not geared to acknowledging the unique characteristics of adolescents. Hospitals tend to concentrate on addressing young peoples' physical problems but may neglect their emotional needs.

Currently there appears to be no special training for healthcare staff in caring for adolescents. Consequently professionals tend to be less aware of the needs and rights of this age group. Hospitalised adolescents are on a different plane to children and adults in relation to such issues as independence, privacy and social needs and can feel 'displaced'

This sense of displacement may extend to the paediatric outpatient setting. For some time, the provision of services for adolescents attending the children's outpatient department at our general hospital has been a matter of concern. An inductive study of the views of adolescents attending the department was therefore initiated.

**Background**

**Background** The literature suggests that there have been informal attempts to obtain the views of young people about the provision of care. The Court Report, however, points out that their youth and relative lack of secondary disease or handicap may have led professionals to assume that adolescents had fewer definable needs than other groups, such as children or elderly people. Historically, paediatric services have tended to extend to providing care for adolescents and young adults; specific provision for their needs may therefore not be deemed necessary.

An innovatory programme or new service is usually set up because a perceived need is one being met by current provision. Such a discrepancy seemed to be existing in the paediatric outpatients department of our

regional general hospital. The department provides a service for children from infancy to 16 years, but young people beyond this age who have chronic problems such as cystic fibrosis or diabetes may continue to be seen, sometimes until they have reached their twenties.

**Methods** Consideration was given to both quantitative and qualitative methods and the latter was chosen. Qualitative research is based on the inference that knowledge is best gathered from people as they experience situations. These experiences are then described and defined by the individuals themselves. Theory is subsequently based on the information generated by these perceptions. The method chosen was unstructured interviews, which appeared to offer the best means of eliciting the views of adolescents.

**Methods**

**Long term experiences** The sample consisted of seven adolescents, four male, three female aged 12-19 years who were not new attenders to the department. Impressions gained on a first clinic visit may be valid in assessing the service but this study was concerned with exploring long term experiences. All adolescents in the sample had a chronic medical condition which required regular attendance at the clinic. They were randomly selected from the regular attenders aged between 12 and 20 years and were interviewed while at the hospital for a clinic visit, involving minimal disruption to those taking part. The interviews, which took place in a quiet room off the main department, were tape recorded and lasted approximately 40 minutes. All interviewees were given guarantees about confidentiality.
It was considered that for analysis purposes a great deal of relevant data could be obtained from a small sample.

**Long Term Experiences**

**Findings** As the interviews progressed the theme of decision making emerged strongly in the conversations with all seven adolescents. One 15 year old female talked about taking risks. It appeared important to her that she should learn from her own experiences. This was echoed by a 17 year old female who also spoke about the learning that came from making a decision which involved some risk. All respondents said that they wanted to be active participants in decisions about their care.

**Findings**

Risk taking is inherent to change and may be regarded as a catalyst in the process of maturation but it is also likely to increase the incidence of disease or dysfunction. Several of the respondents recognised the need to practise the skills of decision making in preparation for adult life. This was also linked with the importance of feeling a sense of ownership of their condition and autonomy in its daily management.

One 15 year old female with asthma indicated the need for information about her condition to be comprehensive so she could accurately assess her current ability to take part in sport. There was also discussion related to the way in which information could be presented to this age group with visual presentation highlighted by several of the young people.

The importance of information giving as a contributory factor in the decision making process has been acknowledged. Information is deemed essential if informed choices about health care are to be made, and must be offered to young people undergoing treatment as well as to their carers. The Department of Health emphasises the right of children and adolescents to information appropriate to their age, understanding and circumstances.

The young people discussed how a process of transition from paediatric care might occur. Several indicated the need for the process of transition to be a gradual one and the importance of adequate preparation. The literature is not particularly helpful in suggesting when and how a transfer from paediatric to adult care should be effected. Many variables come into play; the medical condition, the available facilities, the young person's level of maturity, the wishes of the individual and the family. Even in a direct transfer of care, it is helpful if there is a common approach shown by paediatricians and physicians featuring good communication and sharing of information. The adolescents then gave their perceptions of the children's outpatient department. They indicated their views on how the department:

- predominantly catered for younger children
- lacked age appropriate recreational material
- had somewhat rigid seating arrangements
- could be noisy and had no separate quiet area they could use

Carlyle emphasises how design considerations are important to environments which support care and promote healing. In healthcare environments where needs are frequently changing there may be conflict between the physical confines of the department and the activity going on inside it; the former is static, the latter fluid. The focus of design should therefore be on how people use the facility rather than the appearance of the physical space. The arrangement of clinics was then explored revealing a belief that separate clinics for adolescents might be beneficial

Missing School

**Missing school**

Concern about missing school appeared to be the prime reason for dissatisfaction with the appointments system. Losing time at school can be a handicap for the adolescent faced with frequent clinic attendance but individual levels of concern are likely to be affected by age and how much school is valued by the individual. Flexible appointments and the possibility of late and weekend clinics would be welcomed by those interviewed. The third component of clinic arrangements was the concept of being seen by a nurse rather than a doctor, and what function the nurse might fulfil. The young people indicated that they would be willing to see a nurse for consultation under certain conditions but their understanding of what nurses were able to do was limited.

**Discussion and implications** Responses seemed to converge broadly on four themes:

- decision making and participation in care
- transition to adult care settings
- the departmental environment
- arrangement of clinics

Each is discussed in turn



**Decision making** Issues related to decision making were most common in the interviews, and encompassed risk taking, autonomy, control and information giving. The importance of being invited to be active participants in the planing, implementation and evaluation of care evident. There are clear implications here for healthcare professional.

A healthy environment in which adolescents feel comfortable in contributing to decisions affecting their lives is facilitated by promotion of discussion and negotiation. If staff and adolescents co -operate in problem solving and discussion it can enhance the latter groups sense of control. A supportive environment which encourages a gradually increasing degree of independence but sets appropriate parameters is likely to foster more positive approaches to self care.The demonstration of respect, which good communication provides, builds self esteem and is perhaps the single most important factor in contributing to healthy development during adolescence.

Allied to this are the needs to provide appropriate information. There are moves in the UK to set up family information centres with a number of children's' units actively exploring feasibility. In North America and Australia such centres are located in outpatients departments and provide a mechanism by which trained nurses can offer health education, advice and support. Adolescents require information to make informed choices about their health care; such information may be provided through the creation of a family information centre.



**Transition of care** At some stage, adolescents must move on to adult services. How and when this is done varies from clinic to clinic. There are three possible models that may be adopted in this process of transition:

- paediatric service - adult service direct. In this model the adolescent reaches an age determined by policy, paediatrician or family when it is felt to be no longer appropriate to continue care in the children's environment. A referral report with a summary of the medical history and the are to date is sent to the adult service and the young person then makes an abrupt change over to the new system of care, often without introduction or preparation. There were indications from the interviews that the change may be well accepted if there has been some preparation and the quality of the service matches the previous one.

- Paediatric service - transition clinic - adult service. This model acknowledges the differing needs of the child, the adolescent and the adult.

In a transition clinic the emphasis changes to recognise the emerging needs of adolescents for independence while acknowledging continuing parental responsibility. The clinic environment is concerned primarily with providing the adolescent with respect, privacy and confidentiality

- Paediatric service - adolescent clinic - young adult clinic - adult service.The third model extends the transition a further step. Young adult clinics extend the personal care that the young person has come to expect and are usually characterised by informality in the waiting area with the opportunity to meet with other young adults. To correspond with educational and vocational schedules these clinics are usually held in the late afternoon or early evening.

Departmental Environment

**Departmental environment** Noise and facilities were two aspects of the clinic environment commented on by the adolescents interviewed. With some expenditure and creativity it should be possible to create a quiet area within paediatric outpatient departments. Consideration should also be given to the type and arrangement of seating available to the differing age groups using the facility and to whether decor reflects the philosophy of family centred care

Active Participation

**Active participation**
If changes are made it is important to consult the users of the service; young people, carers and nurses should actively participate in any new or ongoing design process

Arrangement of Clinics

**Arrangement of clinics**
The respondents voiced concern about missing schooling to attend clinics. For this reason it would seem that later appointment times and Saturday morning clinics could be well utilised by this age group. The practicality of such a change in clinic arrangements would need careful consideration but constraints might be overcome more easily if clinics were held for adolescents as a distinct group

Conclusion

**Conclusion**
The study was on a small scale and therefore cannot be generalised. From the subjective perceptions of these seven individual young people, however, four themes which give insights into the concerns and needs of this client group emerged. Consideration of these themes and how practice must change to accommodate them may help in the assessment of present services provided to adolescents and give impetus to creative change

# Aetiological Factors of Drug Addiction as a Basis for Appropriate Treatment Models.

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Many youngsters will experiment with drugs as part of the developmental process towards individual identity. Many will be unscathed by periodical usage and experimentation, however, a number of youngsters will become dependent upon drugs and develop addictive traits. In treating such, it is essential for professionals to have a good knowledge of some of the primary aetiological factors that result in addiction, to develop appropriate responses based upon individual need.

**Two Elements**

The concept of drug addiction is seen to have two elements. "An individual has to continue usage to ward off withdrawal symptoms" (Plant, 1987) and the dependence is on a substance that "alters the way the body functions". From the introduction of opium to the western world, to the modern epidemics of ecstasy, drug use has remained prevalent within society, whilst often being an integral part of many individuals lives, (Redhead, 1993). Two primary reasoning, based upon societal explanations, (Young, 1971, Kiev, 1975, Plant, 1981) and individual understanding the aetiological factors associated with addictive behaviour, (Plant, 1981). These provide a foundation for which treatment initiatives can be modelled upon.

**Spiritual**

The quest for spiritual meaning and solidarity have long been established within society, (Durkheim, 1912, Bottomore and Rubel, 1963, Robertson, 1970). Since the last century, religious grounding and importance has declined throughout the years, (Robertson, 1970). The need to re-establish some form of spiritual sense in individuals and society, has been offered as a primary reason for the continued terms "religious as the opiate of the people", (McLellan, 1977) referring to how religion seeks to numb the pain of poverty, is no longer a substantial part in many peoples lives, (Turner, 1983). This inevitably turns people to look for other comforts and spiritual experiences, that can namely manifest in continued drug use, (Laurie, 1970). Leary, writing in 1964 about the effects of hallucinogenics, places emphasis upon the spiritual and sensual properties of the drug, (Leary et al, 1964). This has further being supported by anthropological studies, where tribes will use hallucinogenic substances to talk to and see their Gods, (Newman, 1979). The spiritual need of the individuals, need not necessarily reside with religion, but with other aspects of self fulfilment, (Cohen, 1965).

During the 1960's and onwards drug use had been predominant within British Society, (Edwards, 1981). The quest for spiritual meaning and social identity resulted in the formation of sub-cultures, who shared similar ideals, values and the meaning of life, (Cohen, 1955, Downes, 1966,

Young 1971, Plant, 1987). Feeling oppresses by societal constraints, the subcultural groups reacted to the feelings of oppression by establishing their own norms and values as part of the contra culture ideals, (Downes, 1966, Plant 1975). Further to this, there was a need to overcome individual problems, (Young, 1971) of which the substance use within the sub-culture catered for, (Goode, 1973). As Young emphasises, individuals choose there drugs based on individualised need, (Young, 1971).

**Social Identity**

Social identity and sense of purpose is a fundamental pre-cursor to being part of an addictive culture, (Glass, 1991). Justification of illegal substance use is identified as one accepted factor within the social meaning of an individuals lifestyle, (Johnson, 1973, Redhead, 1993, Pearson, 1992), where deviance from the norm and reinforcement from peers provides a form of autonomy of identity, (Young, 1971, Plant and Reeves, 1973, Goode, 1973, Plant, 1975, Redhead, 1993).

In the continuation of escapism from "oppressive controls" the sub-cultures were and continue to be reinforced by the world around them, (Robertson, 1987, Dickerson and Stimson, 1995). The "peaceful" perspective of the "hippy" scene in USA, reinforced by the accompanying musical scene, culminated in a lifestyle where cannabis use was part of a continuum of the culture, (Young, 1971, Wyatt, 1973). The use of the substance reinforced the protest elements that the scene was central to (Glatt et al, 1967, Jones, 1967, Boyd, 1970). Other researchers have concentrated on musical eras, values, (Plant, 1975, Redhead, 1993, Henderson, 1996). The musical drug culture circle is reinforced by drug experienced/induced composers, creating music that requires drug induced listeners, to heighten sensation, analysis and subliminal thought, (Plant, 1975, Redhead, 1993, Henderson, 1996). The recent epidemic of the use of ecstasy within the rave scene, provides further argumentation for these theories around sub-cultural identity and a need to belong, (Redhead, 1993). Anti-rave campaigners, placed full emphasis upon the use of ecstasy, which initially was peripheral to the cultural scene, (Nasmyth, 1985). Consistent media focus then transformed the substance to being central to the ideology of rave culture (Henderson, 1996). Sociological research has argued that the peripheral use not only becomes central due to media amplification (Young, 1971a), however escapes from the boundaries of that particular scene and into mainstream society, (Ford, 1990, Measham et al, 1993, Parker et al, 1995).

The sociological concentration on the aetiology and continuation of drug cultures, rests heavily on the notion that certain drugs within certain situations have sub-cultural acceptability, (Young, 1971, Plant, 1975, 1981, Redhead, 1993, Balding, 1994). Dependency has been argued as a result of when the use of the substance becomes predominate over the cultural context that it was once placed within, (Plant, 1981). Drift theory, (Matza, 1964) provides an explanation for why many individuals may use substances within the contextual aspect of acceptance and therefore do not become dependent, (Goffman, 1968), for example, only at a party.

Drifting into and out of "scenes" at periodical times throughout life, may well include a drug scene. The "episodic release from moral restraints", (Matza, 1964, Goffman, 1968). However, sociology has attempted to understand why some individuals become addicted and others are periodical users, (Goode, 1970, Reeves, 1973), often using the distinction between "hard" and "soft" drugs as a basis for the determinant towards addiction or non-addiction (Hindmarch, 1970). However, the main focus on addiction versus periodical use comes from the social situation of the individual, (Cohen, 1955, Goode, 1970, Young, 1971, Plant, 1975, 1981, Redhead, 1993). Strong social standing and foundations outside of the sub-culture is one explanation, (Goode, 1970, Cockett, 1971, Plat, 1975, 1981). For those whose lives are completely dependent on the value consensus of the drug sub-culture, addiction/dependence may be inevitable, (Edwards and Busch, 1981).

**Poverty and Oppression**

Poverty and oppression within society creates a need for escapism from reality and feelings of hopelessness, (Robertson, 1987, Dickerson and Stimson, 1995). Studies on heroin addicts have shown that the bleakness of existence is the major factor resulting in addictive behaviour and dependency on a substance that offers some feelings of euphoria, however short-lived, (Robertson, 1987, Donoghoe et al, 1992, Pearson, 1995). Khat use amongst Somalian refugees has resulted in an increase in mental health admissions, due to the psychosis of over use, (NWLMHT, 1997). Again, the feelings of failure and oppression are given as direct contributory factors to the over use, (NWLMHT, 1997).

It has been argued that Capitalist society results in a rich/poor divide, (Miliband, 1974), whereby those in poverty need some form of de-realisation from their depravity (Mack and Lansley, 1985). Studies on the crack mothers in the USA, (see Allen and Jekel, 1991) and street heroin users in the UK, (Donoghoe et al, 1992) offers some clarification as to why addictive behaviour prevails in today's society. There is an underlying notion that society needs to change in order to deal with the drug epidemic, (SMC, 1975). A more liberal and "drug friendly" system of prevention needs to be initiated, (Friedman et al) and wider issues around poverty and stratification must be addressed, (Rogers, 1982). To understand the psychological perspectives, which concentrate more on internal theories to societal construct and functioning.

**Psychological Explanations**

Psychological explanations for addiction centre around the dependence prone personality, (Laurie, 1970), psychodynamics''', (McMurran, 1994) and social learning, (Bandura and Walters, 1968). The primary emphasis is placed on the behaviour of the dependent and not the substance itself, (McMurren, 1994). It has been argued that many individuals seem to need a drugs influence to gain respite from their troubles or surcease from pain, (Bakalar and Grinspoon, 1984). Whilst at the same time drugs provide an esoteric mystique that can repress negative experiences and mask pain, (SMC, 1975) in the same vain as perhaps religion once played.

The need for immediate gratification is of the essence within the addictive personality, (Laurie, 1970) where deferment is difficult to contemplate, (Blumberg, 1981). Freud argues that such behaviour in the immediate sense derives from the concept of Eros and the pleasure progresses, deferred gratification from immediate gratification becomes apparent, (urinating and defecating, for example), (see Bee, 1992). Unresolved psychosexual conflicts can manifest in regression, of which within the addictive personality can be in a state of constancy, (Chapman, 1996). The use of drugs in later life provides immediate gratification that cannot be achieved without the use of the substance, (Rhodes and Hartnoll, 1996). This has been supported by the notion of transference of mood states, especially in relation to feelings of anxiety and depression, (Laurie, 1970). The need to transfer to states of pleasure and euphoria are paramount to such an extent, that the addict cannot face the bleak reality of their existence, (Robertson, 1987). Therefore, the addict became dependent on a substance to maintain the state of "high", (Haw, 1985).

Psychological explanations conclude that the constant state of "high" results in the addict not being able to deal with living in reality, where such becomes unbearable, (Dickerson and Stimson, 1995). This has implications of withdrawal and treatment, where the pain of abstinence and reduction is so unbearable, that the need for immediate gratification, (more drug use), will prevail over the deferred gratification of being drug free, (Pearson, 1995). The immediate sense is of paramount importance within the context of the addictive personality, (Chein, 1964, Laurie, 1970). The 1969 WHO definition of addiction provides a useful synopsis of addiction based around psychological understanding. It states that:
"addiction is characterised by behavioural and other responses that always include a compulsion to take the drug on a continuos or periodic basis to experience it's psychic effects and sometimes avoid the discomfort of it's absence". (WHO, 1977). Although the definition rests heavily on psychological presumption, sociological and psychological disciplines do find some common ground within the theoretical framework of social learning and drug addiction.

**Media Influences**

Influenced by the world around us, media projections, peers, family and agents of control, there is a body of research that concentrates on how these factors influence our lifestyles, behaviour and thought, (see Bandura, 1968). Being brought up in a culture where drug use is accepted and seen, may well result in the continuation throughout generations, (cigarettes, alcohol, cannabis) (Kiev, 1975). The need for social identity and purpose requires individuals to be modelled by peers, current trends and fashions, (Plant, 1975, Power, 1995). Such theoretical underpinning has been readily identified in the rave scene, (Redhead, 1993). The continuation of behaviour can be argued from labelling theory, (Becker, 1963) where the words deviant and delinquent are strongly associated with drug cultures, (Becker, 1963). Conforming to the self fulfilling prophecy is a social learning aspect. The psychological process of need for autonomy, social

identity and negative labelling will maintain and sustain such behaviour, (Young, 1971a).



Using the outlined theories around causation and continuation, there are a number of factors that need to be taken into consideration when planning treatment.

Social networks, including the prominence and current involvement with peers, (Robertson, 1987) in balance to supportive networks assisting with risk minimisation or abstinence is an important consideration when planning treatment, (see Jarvis et al 1995). It has been evidenced that it is perhaps the biggest factor of relapse, when a client returns to their previous network of peers and other drug users, (Robertson, 1987). They then subsequently fall into the subcultural world that they were trying to avoid, (Plant, 1981).

Addressing the need for change, be it against the backdrop of societal determinants or internal behaviours should be discussed, (Robertson, 1987). However, one had to be aware of not implementing discriminatory models in relation to cultural norms, for example, khat chewing within Somalian culture is an accepted behaviour, (NWLMHT/Junction, 1997). Risk results from constant over use of substance, (NWLMHT/Junction, 1997). The wider picture should address poverty, social despair and oppression that individuals face, which result in restoration to substance use, (Dickerson and Stimson, 1995). Sociological theory has attempted to address societal oppression as a major cause of drug addiction, (see Young, 1971a, Laurie, 1970, Plant, 1975,1981). With emphasis upon societal change, it becomes apparent that there needs to be some form of acceptance of the addict as a product of deterministic societal constraints, (Farrell and O'Brien, 1995). Such factors should be addressed within the planning stage in conjunction with more individualised emphasis that psychological theory concentrates upon.

Psychology, through its interpretation of addictive causation, requires that factors to be taken into consideration will be far more individualised in planning treatment, (see Prochaska and DiClemente, 1986). Motivation from the individual to want to change is perhaps the largest factor to take into consideration, (Rollnick et al, 1992). An ability to change within, e.g. belief system and patterns of behaviour are essential to the psychological concern of planning treatment, (Rollnick et al, 1992). On the presumption of addictive personalities, issues around abstinence or risk minimisation will need to be identified as a pre-cursor to treatment, (see Jarvis et al, 1995). In dealing with drug addiction on a individual level, assessment of patterns of behaviour and addiction levels is an important feature, (see Jarvis et al, 1995). Such things as frequency of dependency, the amount of substance taken and risk taking behaviour, (see Jarvis et al, 1995) assist in the initial assessment of level of intervention and to whether abstinence or control is appropriate, (Jarvis et al, 1995). It may be detrimental to a

clients physical health to completely abstain from certain addictions, (Heston, 1986).

In relation to treatment plans in parallel to the separate theoretical explanations, there needs to be a distinction drawn in terms of differentiation of approach. Sociological models appear to look at acceptability of drug use within each subculture, (Young, 1971, Plant 1975, 1981, Bakalar and Grinspoon, 1984, Redhead, 1993). Societal constraints, oppression and sub-cultural theories seek to explain the prevalence of drug addiction as being partly caused by external societal forces, (see Dickerson and Stimson, 1995). It is clear that research has influenced treatment in respect of social education, based around harm minimisation on a macro level, (see SMC, 1975, Robertson, 1987, Rhodes and Hartnoll, 1996).

The psychological models place a greater emphasis upon the individual being the focal point for change, (McMurren, 1994), where addiction is the causation of individual abnormality, internalised repression and addictive personality, (Orford, 1992). For these reasons, psychological theory will concentrate upon a cognitive behavioural approach, to treatment, which is individualised and is an attempt to modify the addictive personality, (Goldfried and Golfried, 1975).

Sociological theories of drug use rest predominantly with society, its construct, change, values, norms and ideals, (see Young , 1971, Plant, 1975, Bakalar and Grinspoon, 1984, redhead, 1993). There is a presumption that society needs to change in order to prevent or minimise drug use, (Rhodes and Hartnoll, 1996).

Pro-active approaches in the battle against drug addiction is paramount in minimising risk and providing social education, (SMC, 1975, Rhodes and Hartnoll, 1996). The move from hard line reactive measures, (see Epstein, 1977) aims to provide an acceptance that drug use will continue, whatever societal constraints are developed, (Musto, 1973).

**Outreach**

The use of outreach workers, ex-addicts, street contacts and media information have started to have an effect on issues relating to risk minimisation, (see Rollnick and Hartnoll, 1996, Keene, 1997). Needle exchanges and drug counsellors within nightclubs are providing education and services to persistent drug users in an attempt to minimise risk, (Rollnick and Hartnoll, 1996). Pro-active measures are becoming more of a reality and being initiated and requested by nightclubs, police and politicians alike, (News Broadcasts, 1997). Literature, written in street language, such as Smack In The Eye and Peanut Pete are also being used to provide information that is user-friendly and non authoritarian, (Linnell, 1993). However such methods do have their critics, who argue that providing services as described above, there is not only an acceptance of illegal drug use, there is actual promotion for continuation, (see Bakalar and Grinspoon, 1984).

**Primary Prevention**

However, in response to secondary prevention, primary prevention is targeting young children in an attempt to dissuade usage and how to handle vulnerable situations, (e.g. the playground), (Implemented within school curriculum's) (News Broadcasts, 1997). It will take longitudinal research to conclude whether this is effective, however transcultural research had evidenced promising success rates, (the Dutch model), (DeZart et al, 1994).

It is clear that the pioneering work within the UK, is still not being as effective as some other European countries, (Leuw, 1995). There is still a predominant anti-drug consensus, where addicts and users are classified as deviants, (see Bakalar and Grinspoon, 1984). It had been argued that only when a more generalised liberal approach to the issue of drugs, (Netherlands), which de-values the illegality buzz, then progress will remain slow, (Leuw, 1995). However, it mush be noted that the objectives of social education are directly comparable to individualised treatment programmes, where the overall goal is either a drug safe/drug free society, (Robertson, 1987). For this reason, there is a definite need to continue with the treatment of the individual, which is usually encompassed within cognitive behavioural programmes.

For individualised treatment encompassed around cognitive behavioural therapy to commence, there primarily, has to be, firstly, an acceptance of the dependence as a problem, (Rollnick et al, 1992), secondly the motivation to change, (Saunders and Wilkinson, 1990) and thirdly the scope and support to maintain change, (Martlett and Gordon, 1985).

**Motivation for Change**

Motivation for change must not be confused with motivation in general, as many persistent drug users already have large amounts of motivation, the motivation to continue to take drugs, (see Saunders and Wilkinson, 1990). The use of the ABC model is paramount in tackling these issues, (see Jarvis et al, 1995), where cognitive restructuring, (see Jarvis et al, 1995), works to a prefix of bypassing negative behaviour, (Jarvis et al, 1995). The systems attempts to relate antecedents, such as vulnerable situations and temptations, to thoughts of the consequence of action, i.e. dependence, risk, overdose, crime, (see Goldfried and Goldfried, 1975). This should then help the addict in recovery to bypass the behaviour of taking the drug. Differences in approach of cognitive therapy will be dependent upon the characterisation of the individual client, defined through assessment, (see Jarvis et al, 1995). Rational Emotive Therapy, (Ellis, 1975) where irrational beliefs are modified, to Problem Solving Therapy, (Goldfried and Goldfried, 1975), which identifies one specific problem area can be used to effect. Personal Construct Theory could be another treatment model concentrating on how people view their own world, (Goldfried and Goldfried, 1975). Individual behavioural blindspots and reactions have been successfully modified to help overcome substance abuse, (Scott, 1989). Such models address individuals perception, behavioural traits and embedded belief systems. In modifying the addictive

**Immediate Gratification**

personality, it is essential that these areas are addressed, (McMurran, 1994). The impulsiveness of immediate gratification is addressed and m modified through a process of change that the addict in treatment goes through. Prochaske and DiClemente's model is fundamental as a foundation for successful cognitive restructuring. Pre-contemplation, contemplation, determination to stop, action and maintenance are the transitions that the addict needs to go through during the treatment process, (Prochaske and DiClemente, 1986). Relapse is the reversion stage back to pre-contemplation. Cognitive behavioural models are important to achieve individualised change, however, to tackle the societal effects of drugs there needs to be a combination of approaches, including social education, (Keene, 1997).

**Conclusion**

In conclusion, the sociological and psychological explanatory theories offer two distinct and contrasting opinions as to the prevalence of drug use and addictive behaviour. Each theoretical standpoint has influence for factors planning treatment and treatment models based around theoretical explanations. In current thinking, there is a need to draw upon a number of theoretical explanations to get a fuller understanding of drug dependence within society and reactive measures to respond to these. The macro (sociological) and micro (psychological) aetiology have given distinct contributions on two very different levels in explaining and treating drug use. No one approach has precedence over the other and it is commonsensical to amalgamate a multi theoretical stance in dealing with the individualistic and societal rehabilitation. And who knows what the genetic link on addiction will bring to the debate?

(Full References excluded due to lack of space but will be provided on request – contact editor)

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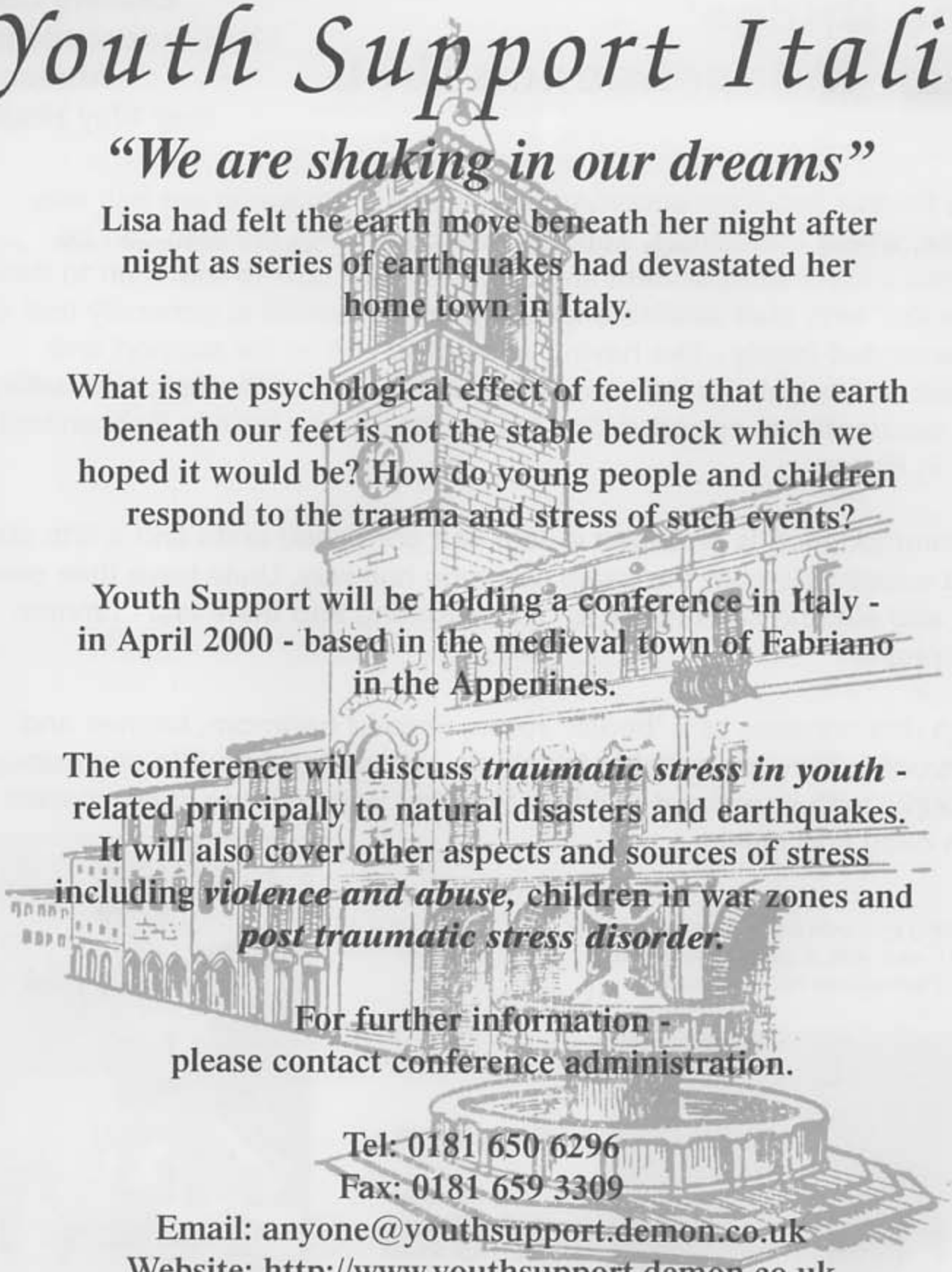
(consult 'International' section)



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