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THE BRITISH "JOURNAL OF ADOLESCENT HEALTH AND WELFARE" is the journal of the Youth Support "Forum on Adolescent Health and Welfare".

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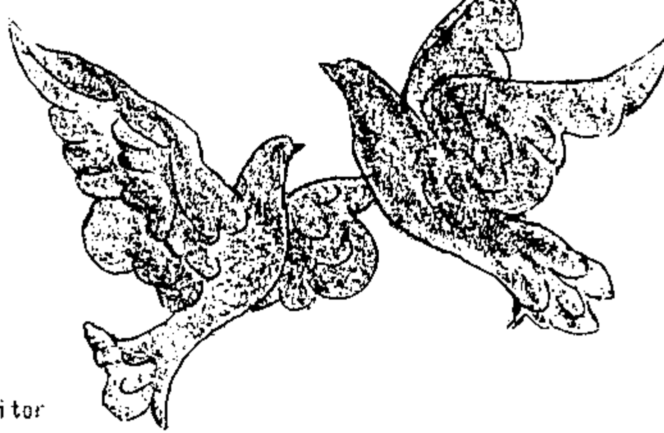

Letter from the Editor

Dear Colleague,

I am pleased to be able to send you the winter edition of our "JOURNAL OF ADOLESCENT HEALTH AND WELFARE" which means that we have now covered our first year of production.

This has not been an easy year for YOUTH SUPPORT. Illness, postal strikes and financial problems have all taken their toll but somehow we have risen above these in the end. I understand that some members never received the summer edition which was caught up in the strike and some of you may be receiving the autumn and winter editions at the same time due to delayed mailings. We have some back copies left in the office so if anyone has missed any issues please let me know and we will try to rectify this as long as stocks last.

I would like to thank you all for joining the forum and give special thanks to all those people who have spoken at our meetings and contributed to the journal. Many travelled long distances, at their own expense to be with us and I am sure you will agree that all our speakers have been excellent. We have tried to keep a balance with not too many 'medical' contributions and hope to concentrate more on education in coming issues. We will also be covering teenage adoption in one of this year's meetings.

This issue contains a directory of members. I have been generous in this 'season of goodwill' and have kept on the list also those who have not paid their current subscritions, since I am sure that they will do so soon. We have also included some people and organisations who have expressed interest in our Forum but are not yet members. I would be very grateful if everyone could check their entry and notify me of any changes or omissions. It would also be helpful if everyone could send in their renewals or notify me if they do not wish to remain on the mailing list.

Finally may I wish you all a merry christmas and a prosperous new year to you and all our young people.

Dr Diana Birch MBBS DCH MRCP MD
Director "YOUTH SUPPORT".

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APPLICATION FOR MEMBERSHIP OF THE "YOUTH SUPPORT"
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"'YOUTHSCAN'- A Survey of British youth" PROFESSOR NEVILLE BUTLER

(A.L.) - NEVILLE BUTLER is the director of the International Centre for Child Studies with offices in LOndon and Bristol. He was formerly a family doctor and is now professor Emeritus of child health at Bristol University. It was stated in the Guardian that few people can know more about teenagers than Neville Butler - how many big macs they eat in a week to whether they make dirty phone calls. This is as a result of his survey of 15,000 children born in the second week of April 1970 - surveyed at birth, 5 years, 10 years, and now in YOUTHSCAN.

* * * * *

I was interested to hear that Barnardo's had dropped all their doctors, I think all doctors should be dropped - then they might turn out to be a bit more human!.

They were carrying out surveys of young people 300 years ago and as the majority of people were adolescent, the life expectancy of most people was only 25, 26 years on average in 1600, it is interesting that perhaps there were more people interested in adolescents then than there are now!

What I am going to tell you about is a longditudinal retrospective study. We followed the same group of children every 5-10 years and look backwards. You see them every five years and look back 5 years.
Three have been done, one in 1946 all born within a week, 15,000 of them 95% seen: the national chilbirth study which I started as a perinatal mortality survey in 1958 - they are now 30 years of age and are being followed up at the City University in London. The 1946 study have been followed up at University College Hospital in the department of community medicine, they are 42 years old now. Our group born in 1970, we first called it 'British Births' we then called 'CHES' (Child Health and Education Study) and then when they became adolescent we had to call it something else, we called it Youthscan.

We looked at 95% of the group of 17,000. We looked at them at five and ten and found that at the age of five 1 in 10 were living with one parent; at the age of ten 1 in 5 were with one parent and now it is 1 in 4. We found some terrible social differences which are probably even more polarised now than they were when the children were ten, with the present legislation. I mean young mothers. Within the least fortunate 10% who had virtually nothing, no car no television set etc - young mothers were 15 times as frequent in that group, large families more frequent and council housing more frequent, more in the north than in the south - they were more isolated and six times as many had no preschool education.

So we are looking at the same sort of deprivation as was so in the 1660s - things don't change too much.

Accidents, 40% had accidents by the time they were 10 and more of these had young mothers or single parents. Accidents are one of the serious problems we have to deal with in this country, diet is another. If you look at those who are eating a large quantity of sweets or chocolates daily, as social class goes down and income goes down the proportion of sweets and carbohydrates taken in the diet goes up and the protein is in inverse ratio.

At the age of ten 18% of children had been reported by their parents as having some physical problem and interestingly about 6% of these had not been picked up at any preschool or schoolage medical. They were picked up afresh at the CHES medical and some were quite marked. When we looked at them again at 16 we found that there was still 18% of the population with medical or educational problems and we found that 5% had not been picked up earlier. Now if that is not a recommendation for school examination or better screening in adolescence, I don't know what is. In Sweden they are seen at 13, 15 and army entry at 18. We have no such examination and there is an article in the archives of diseases of Childhood this week suggesting that we also abolish the five year school entry medical - it will of course save on personnel but there will be an interesting lot of disabled adults walking around.

So let us now look at the 16 year olds, the third national study, we are going to follow them again at 20 and 25 and then look at their children. We have to keep in touch with them and keep an eye on them so we have started a club, YOUTHSCAN CLUB, we are meeting on April 8th at Alton Towers. For their birthday 17,000 of them! It is costing £100 per teenager.

Of all the problems affecting our teenagers I think alcoholism is the greatest, 92% drinking at some time, 54% having drinks in the current week and 4% having to be carried home. This is hardly surprising, drink is socially acceptable, smoking is not and less than 1 in 5 seventeen year olds are now smoking. Half of those who smoked are already ex-smokers at the age of 17. That is a combination of local propaganda and making areas in buses etc no go areas for smokers. It would appear that solvent abuse is prevalent at 12, 13, 14 but that at the age of 16 we can find very

little nationally except for little pockets of resistance in the Edinburgh, and Glasgow areas. Risk taking behaviour is normal at this age.

10% of our school leaving group are illiterate. Youth crime and violence is going up and if you cannot communicate you are in real trouble.

In my opinion some activities of adolescents lead to early heart disease. We have the highest incidence of heart disease in middle life so we ought to be looking at stress whatever that means, type A type B, I do not think we have even got to the beginning of talking about stress. We also ought to be lloking at exercise and the average 16 year old spends a great deal of time sitting on his bottom watching television and listening to records. Then what about diet, salt and fat consumption smoking and alcohol. They seem to be living on chips with everything and potato crisps six times a day; does it matter? We will have to wait and find out. We have changed our eating habits completely. The time taken to eat meals has gone down to one third of what it was ten years ago, they eat on the run and take less than an hour and 'take away' fast foods are the norm. Families only really get together on Sunday evenings, weekend breakfasts have gone and lunches are going, only 60% of 16 year olds eat an evening meal with their parents.

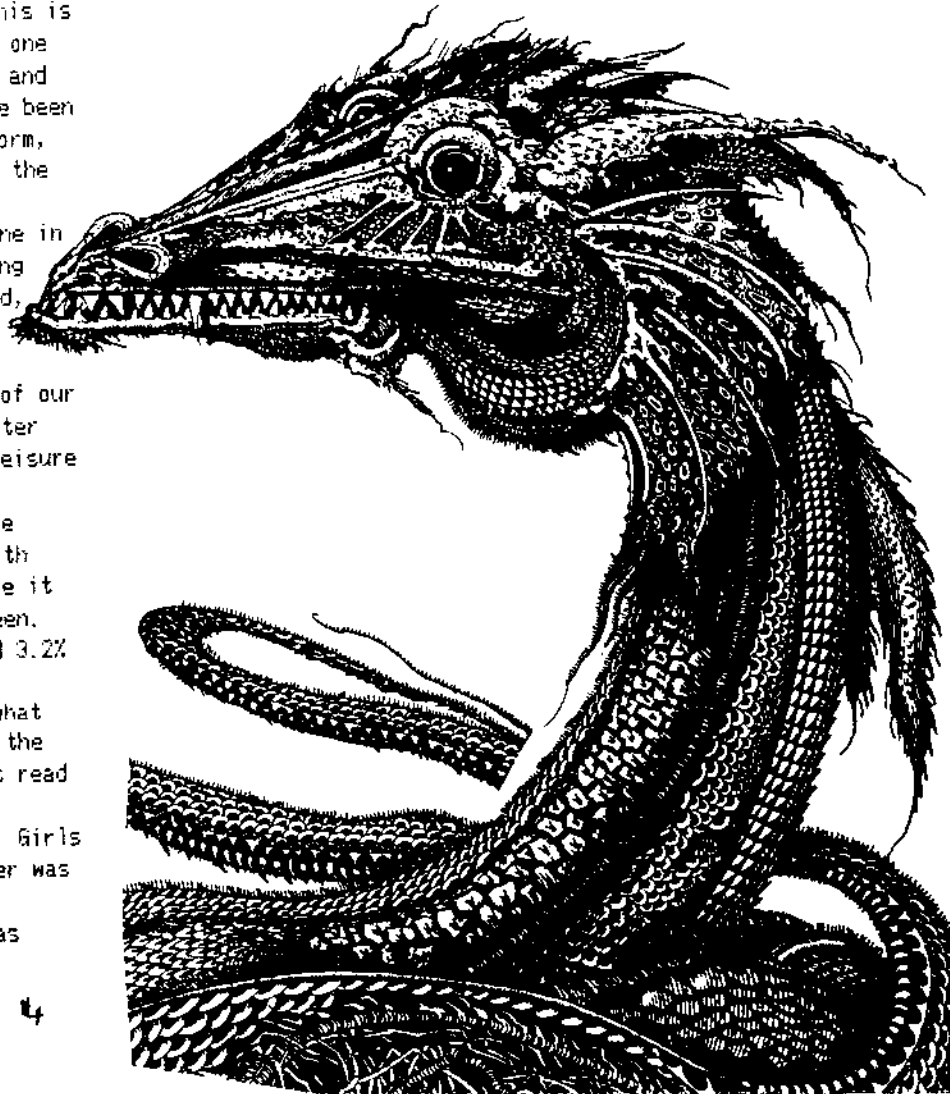
The figures we are looking at now refer to only the first 500 cases, the computer has not yet given us the results of the whole group so this is a preliminary analysis. Looking at excersise one third took no exercise the previous saturday and two thirds did, ten years ago that would have been very different, walking is the most common form, very few doing outdoor sport, keep fit is on the way out, indoor sport never got started and swimming is least of all so there is a decline in sports with the increasing technology of being able to sit in your chair and order your food, watch Television, etc - what sort of a civilisation are we going to live in.

So what are the needs? The cardinal needs of our society are better education, more jobs, better health, better nutrition and better use of leisure time. I am now going to refer to rather a disturbing statistic, that relating to single parent families. Children not living with both parents number 7% at birth by the age of five it has risen to 12.5%, 20% at ten, 26% at sixteen. 17% are with their natural mothers alone and 3.2% are with fathers.

One more statistic, we tried to find out what they did at home, we asked a question about the hours spent reading, 70% of children had not read any book on the previous day and in many households there were no books in the house. Girls read more than boys and of the reading matter was - novels 15%, books about pets 22%, 14% biographies. The commonest book strangely was

Youthscan

Tolkien's Lord of the Rings - rather surprising!. A very high number, 20% had been in hospital for an operation between 10 and 16, 75% of girls had problems with their periods and 12% had been on the contraceptive pill. With regard to sexual experience, among the girls:- 32% didnt feel ready; 8% did it once; 11% had sex more than once; 17% had sex regularly ; 14% with one partner; 10% more than one partner; 52% never had sex; 13% were glad to have done it; 18% enjoyed it; 11% wished they had done it; 40% thought they would do it soon; 37% said their parents would be horrified at the idea - one wonders about the 63% of parents who would not have been horrified if their daughters had sex at or before 16 years of age!.



Round Table Discussion
Professor Butler, Eric Tayor, Peter Newell, Audrey LLewellyn

Audrey LLewellyn - Could I ask how representative the Youthscan survey was since in deprived areas it was more difficult to follow up the teenagers and by 16/17 many had left school. In Camberwell I know we had difficulty getting replies because we had no staff to follow them up?
Prof Butler - As far as I am aware our social class mix has been the same as in the country as a whole.

Audrey LLewellyn - I would like to ask Dr Taylor, I have a newspaper cutting here, about survivors of suicide, an he tell us something of self help groups for parents of suicidal teenagers?
Eric Taylor - Well of course this is very important that parents who have lost a child in this way should be able to support each other. The society of compassionate friends is a support group for relatives of suicide victims, I do not myself know of survivors of suicide but I am sure this is a very important area.

Robert Birch - I would like to ask Dr Taylor, about the very high statistic of teenagers who take an overdose and then over dose again I found it much higher than I expected.
Eric Taylor - Yes It is very high. If you take the teenagers without a specific disorder then about 10% of those who have taken an overdose will do so again within the year, this rises to 50% for those with an associated disturbance, such as a serious depression or conduct disorder. About 1% are at risk of death by suicide.
Robert Birch - I suppose this means that the facilities for treating these first overdoses are inadequate.
Eric Taylor - Yes that is certainly so. Services are very sketchy, very often these children are sent away from casualty without any follow up. Sometimes they are told to contact a psychiatrist - what an empty thing to be told. Sometimes they are sent away in fact still intoxicated, with the drug still active. So you are doing mental state examinations on peole who are tanked up with benzodiazepines or antidepressants they took in their overdoses and how can you make an assessment on that sort of person.

Nona Dawson - I would like to comment on the confidentiality issue and address Peter Newell. When sexual abuse is raised by a girl I have to make sure, in a supportive way, that the girl knows that this must be discussed elsewhere and by doing that she can either continue to discuss it with me or she may stop. We are held by our county guidelines down in Avon and that is waht we have to do. I would welcome your comments on that.

Peter Newell Well at the moment the social services and the police are the only agencies who have duties to investigate when they are told, on the one hand that the child is at risk, and on the other hand that an offence may have been committed. Outside that there is no legal duty, so that is the first point. Also there is a belief and working together is the first emphasis that one must work togethr and share information to stop the abuse and so on and it seem sto me that the dilema is obvious which is are young people going to come forward at all and talk about these things if there is no adult outside their family that they can go to knowing that their confidence is going to be respected and that no action should be taken without their agreement. I am noew talking about that difficult to define group of young people who have a capacity to understand and I feel that it is important that this group have a right to establish a confidential relationship with a doctor, teacher or a number of other people who they may approach in this way. This is not just our opinion, the official solicitor who went round and talked to all of the children in the Cleveland affair and acted as advocate to the children in the enquiry also held this view. This raises to points, to what extent is breaching confidence another abuse and making services acceptable to young people. This issue has also been discussed by the Health Visitors association and it would seem that heir guidelines will follow more on this line - they have been worried about the stance of the General Medical Council. This is an issue which tests ones feelings about children, whether they are people and when they become people and how one should treat them. I think that the idea that as soon as one is informed about something one must take action even if the child does not wish this is understandable in the face of the sometimes quite awful things that are happening, but this may not be the best action to take. 'Childline' had this experience in that when they started they placed quite a lot of pressure on children to reveal where they were, with the result that thousands of children put the phone down on them. The child was in control so they could do this but later they changed their policy and were able to talk to children without putting pressure on them - this was more succesful. I think that if we could all guarantee wonderful outcomes in terms of our interventions in child abuse we could all feel justified in overlooking children's rights, but as it is at the moment one needs to think very carefully about his.

Sue Allen I run an IT centre in Southwark and we

run an open file policy. The young people have open access to everything which we write about them. This can cause difficulties because we work in the middle of other units which do not have this policy. So we have young people who perhaps have been in care or under social services from an early age and at 18 still have no knowledge of why they went into care in the first place. I wonder if there is any work going on regarding access by young people to their files.

Peter Newell There is a DHSS circular that young people should have access to all files regarding them. Also under the data protection act, any information on computer is available to them. In this way the DHSS have been more open than education. There is actually a special clause entered by the government which I find extraordinary, this was put in by the education department who went through parliament to stop children seeing their own educational statement. They made an exception to the data protection act that if there is a statement of special need for education purposes stored on computer then the subject of the statement should not have access to it. Things are improving and open access is not far away, the question really will be what to do with old files which have obviously been written with the idea that the child will not ever see them and might contain damaging information. I think the answer is to burn them.

Teacher There is a dilemma here in that if you are writing a report on a child who has learning difficulties, you want to give positive messages and encouragement to that child and yet if you are writing a report which is say going to the educational psychologist and you need their help - you have as a teacher to write a report that tells the truth and expounds the learning difficulties, but to the parent you write a more positive report. The teacher will not get help unless she writes a different confidential report to the psychologist.

Peter Newell My view is that it is that sort of dichotomy which we have to get away from, that we have to be truthful to children and if that means that you are going to write differently about them for someone else, for a specific purpose then that is part of what one needs to tell the child. It means that one uses different and more positive language as recommended by the 1981 education act.

Teacher I think that one problem is the lack of resources for special needs, this shortage places a burden on the teacher to highlight the childs difficulties and emphasis the needs in order to compete for resources. This is often not in the best interest of the child in some ways because positive reinforcement works better than emphasising difficulties, so there is a dilemma.

Lorna White I work in intermediate treatment for the london borough of Lambeth and the issue of reports is one which we work with a lot. We have reports from many agencies, social work, education (psychologista and the lot. I think that it is perfectly possible to write a report about a young person where you give positive criticism, I think that when we talk about issues like children's right we actually patronise young people terribly. Quite often they are perfetly aware that they are having difficulties and our role is to put to them, look these are the difficulties and this is what we are actually going to do about going to work on those difficulties together to acheive an end and I think that if we use that kind of approach we actually work alongside someone, then it is perfectly possible to work through a report with a young person even though some of the things in it may be negative. I also think that when we are sending reports to other people for resources it is equally importanat that we do not give a totally negative report of that young person too because there are points about that young person which are positive and negative.

Geoff BAll I would like to ask Prof Butler whether any data came up on sexually transmitted disease, presumably these teenagers were coming up to the age when this could be a problem.

Prof Butler No we had no data on that, they were 16 when seen, we got them to write an essay on AIDS and sexuality and where they were getting their knowledge. In actual fact they knew more about AIDS than their parents. I think that when we get on to 20 and are looking back at this age we will get a better view.

The following article formed the basis of a presentation to the international workshop at the Society for Adolescent Medicine (SAM) meeting in New York in March 1988. The theme of belief systems in teenage pregnancy was further expounded when Dr Birch was asked to present a workshop to the annual meeting of child guidance units in October 1988. It so happened that Dr Birch was prevented by illness from giving the workshop personally and a workshop package was therefore devised that allowed the group to conduct a very sucessful workshop and discussion. This package consists of a videorecording, 17 slides and an audiocasette and is available for hire from Youth Support, price negotiable depending on the audience.

"That old black magic"..... Teenage belief systems   DIANA BIRCH

A belief is a conviction adhered to often in the face of factual evidence to the contrary. This paper inevitably represents my beliefs moulded by my experience of working with teenagers in London and tempered by my knowledge of the work of my colleagues.

It is only by understanding the belief systems of the adolescent and his or her peer group that we can effectively interact with that young person in a way which has relevance and meaning. The very best of counselling, contraceptive, antenatal or any other service will fail if the client group, in this case the adolescent, does not believe that he needs them.

Where do these beliefs stem from? (fig 1) Parental, cultural and religious beliefs and myths form a basis upon which more contemporary 'up market' beliefs are built- for instance the current peer group stance or the 'dish of the day' in terms of the media 'hero'. Currently 16 year old Tiffany is at number one in the pop charts encouraging secret sexual encounters ...

"'Children behave'
that's what they say when we're together,
....

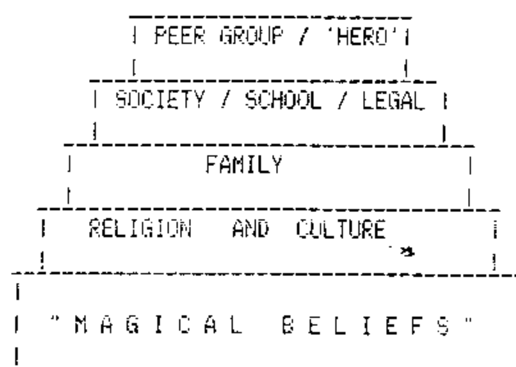
look at the way
we have to hide what we're doing,
and what would they say
if they knew ...."   Tiffany

These belief systems, however bizarre and contrary to our own personal beliefs are at least tangible. We can understand where they stem from and we can to some extent modify them with appropriate input in the style of cognitive therapy, sex education etc. In psychotherapeutic terms we can say that they are messages from the internalised parental ego state (Transactional analysis) or superego (Freudian) whose intensity can be modified by educating or activating the Adult ego state (ego) (fig 2).

For instance peer group beliefs such as "You can't get pregnant the first time" or "It's OK if you do it standing up" can be confronted with factual knowledge such as 1 in 20 pregnant schoolgirls got pregnant as a result of the first time they had sex and sperm can swim up hill!!

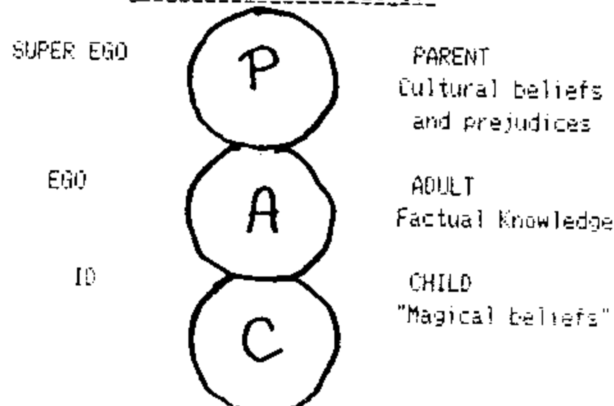
Unfortunately though, these beliefs can also be manipulated by pressure from less ethical factions such as pressure groups attempting to 'sell' their own brand of quasi religious dogma. In Britain we have had several such attacks on the adolescent's right to accurate information and free choice with regard to sexual decision making.

FIG 1   BUILDING BELIEF SYSTEMS



Pressure groups such as 'Life', 'The responsible society' 'SPUC' (the society for protection of the unborn child) and the supporters of Victoria Gillick have enjoyed an enormous amount of publicity in campaigns to ban sex education in schools, to stop doctors prescribing contraceptives to under sixteens and to delegalise abortion. The current campaign against termination of pregnancy waged by the MP David Alton is using highly emotive material such as engineered photographs of foetuses sucking their thumbs to hit at the belief system surrounding life and birth; to regard a fertilised ovum in the same light as a child and to brand all termination as murder.

FIG 2   'PART OF ME BELIEVES IT'



At a deeper level are what I would describe as 'magical beliefs'. Intrinsic ideas with a high emotional content, a feeling of instinct and intuition and which may have no perceivable basis in current reality. These 'magical beliefs', acquired at a very early stage of development may be ascribed to the child ego state (TA) or perhaps the Id (Freud). They are very firmly adhered to largely out of awareness and profoundly affect the individuals sexual and reproductive practices. Failure to understand such beliefs can entirely sabotage a treatment or contraceptive programme.

'Magical beliefs' centre on fundamental concepts such as feelings about self, body and control and on the nature of life itself. The adolescent, during psychological development is much preoccupied with the question "Who am I?". Confusion inevitably arises when "Who am I?" becomes "Who are we?" Establishing a personal identity may be an almost impossible task for a pregnant adolescent who suddenly finds that her identity is changing beyond her control, she is no longer a 'little girl', she is a fertile woman. The role of mother is thrust upon her before she has established her own identity, hence the belief that she cannot get pregnant and frequent denial of pregnancy.

"I knew about sex and how girls could get pregnant but I never thought it could happen to me".

"I thought I was too young to get pregnant, you don't think that a girl like me could end up pregnant, do you?".

"I never thought I could get pregnant".

Many girls deny they can become pregnant, they believe they are too young. (Zelnick and Kantner 1978) Belief in the impossibility of pregnancy can become almost a 'magical protection' like a lucky charm used against the evil eye 'well it won't happen to me'. These teenagers are still at the stage of concrete reasoning and cannot identify with the experiences of others (Blum & Resnick 1982; Piaget 1972; Coleman 1972; Babikian & Goldman; Luker 1976). This explains why health education methods based on 'shock tactics' do not work with this age group.

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

"You hear about things happening to other people but you never think it will happen to you. When my friend got pregnant, I sort of thought she must have been a bit stupid but then I realised that I had'nt come on (with a period) and I realised that I had been doing the same as her".

"I knew we were having sex and that we weren't using anything and I suppose I knew how girls got pregnant but somehow I just didn't put the two together"

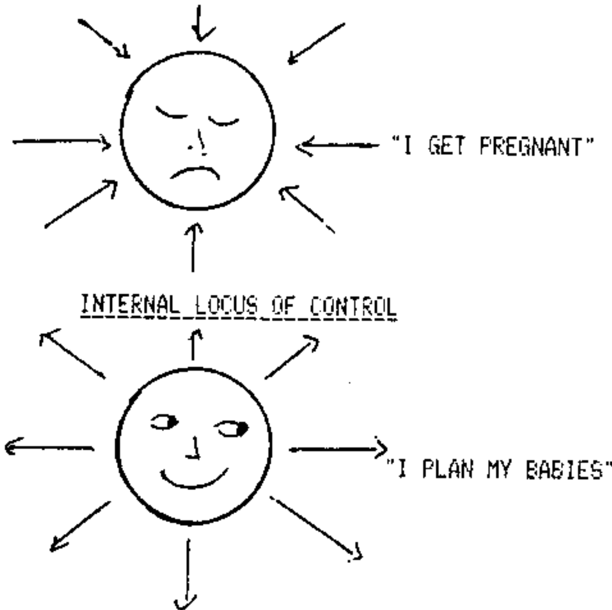
Beliefs about "who I am" can very easily become negative for a deprived teenager with little chance of acheiving adult goals such as doing well at school, getting a job and setting up their own homes. It is easy for the answer to the question to become "I am a school drop out", "I am an unemployable person", "I am a failure" hence the loophole of "I can be a success if I can be a mother".

Teenage sexuality is profoundly affected by beliefs about control. A feature of adolescent development is an internalising of the 'locus of control' ie an assumption of responsibility for one's actions and one's body. Many do not reach this stage, remain with an external locus of control and believe that they have no control over their bodies or actions. They are not in control of when they have sex and they are unable to control whether they get pregnant. They are not responsible for their actions or their bodies, pregnancy is something that 'happens' to them, it is a matter of fate. (Novicki & Strickland 1973; McKenry 1973, Blum & Resnick 1982; Kandell 1979) (fig 3).

Many South London girls said that they hoped they would not get pregnant but never considered doing anything to prevent it. (Birch 1986; 1987) Such girls are accustomed to having little control over their circumstances, they live in poor housing, have little money, do badly at school and are unable to change their environment. When an unplanned pregnancy occurs this represents the ultimate loss of control, even their bodies are acting independantly of their wishes. In fact, within this belief system there appears to be an element of belief in the 'autonomous womb'. It is as if the teenager believes that the body consists of three areas; the non sexual body over which one may exert some control for instance in running, walking; the sexual erotic areas which are under less control but can be fun to use such as the penis, breasts and vagina; and the third area over which there is no control, the womb.

The belief in the autonomous womb explains why "Teenagers .. do not believe sex will result in pregnancy" (Katchadourian 1980). It also explains some of the denial.

FIG 3



".. I kept convincing myself I wasn't - I kept missing periods but I kept putting it off, saying nay, it's just .... I was saying to myself, I've had sex so it's most probably changing my body or something. Just giving myself any old excuse." Janet 15, 'Schoolgirl Mum'.

"Well I knew someone was pregnant, but I didn't know it was me"

Missed periods, feeling ill and tired, putting on weight and feeling the baby move all add evidence to bring home to a girl the realisation that she is pregnant, despite this one fifth of schoolgirls do not face up to the situation until a third person, their mothers or sisters tell them that they are pregnant (Birch 1986;87). Girls seem to be spurred into taking action by missing further periods, and lull themselves into a false sense of security in the middle of the month. It is as if each expected, but missed, period reminds them that they could be pregnant and should be doing something about it, whereas as this danger time passes they can deny it again with another 'magical belief' "Well perhaps I was only a little bit pregnant".

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

"I didn't need the pill because I wasn't going to have sex".

"My mum asked, did I need to be on the pill but I didn't want to admit that I'd been to bed with him"

The belief is that unplanned sex is an accident. Nobody can be blamed for the occasional slip, for 'getting carried away', 'swept off her feet'.. the cliches are endless. However premeditated, planned sex is inexcusable. (Katchadourian 1980, Bury and Harrison 1982; Russo 1984; Bury 1984; DeAmicis 1981; Zelnik and Kantner 1978). Here cultural beliefs also have a bearing; different standards of behaviour are still applied to boys and girls. A teenage boy will not mind his friends knowing that he is sleeping with his girlfriend but for a girl, being on the pill means that she is intending to have sex which is not socially acceptable.

"I never thought I'd be doing anything like that. I went to a party and I suppose I got a bit carried away, you know how it is"

"I did think of going on the pill but then I thought, if he finds out he won't want to go out with me any more, he'll think I planned it all".

"I know it's a risk but what can you do? You can't say 'It's OK I'm on the pill' or 'just a minute while I put my cap in' or 'would you like a sheath, It just so happens I've got one here'. Right away he'd think 'fucking slut who'se she got them for, then?'". (Cathy, 18 year old mother of 3 year old boy).

FIG 4

BELIEF SYSTEMS RESULTING IN NON USE OF CONTRACEPTION

SYSTEM	BELIEF
PEERS	YOU SHOULD GET 'CARRIED AWAY'
SOCIETY	YOU CAN GET CONTRACEPTION BUT.. ...they'll tell your mum
FAMILY	GOOD GIRLS DON'T NEED THE PILL MY MUM WANTS LOTS OF BABIES
RELIGION	CONTRACEPTION IS WRONG
CULTURE	A GIRL'S WORTH IS HER FERTILITY
"MAGIC"	I CAN'T GET PREGNANT IT WON'T HAPPEN TO ME I AM NOT RESPONSIBLE

Hence belief systems interact; the table (fig 4) illustrates how the various levels of belief systems influence a sexual behaviour such as contraceptive use. Similar analyses could be made of other behaviours. In planning delivery of services it is essential to take such belief systems and cultural norms into consideration and also to assess how our own beliefs influence the situation. What belief are we fostering when we calculate gestation from the last menstrual period - ie before ovulation? or when we talk euphemistically of giving a woman 'something to bring on her period'? Is it possible that you can indeed be a little bit pregnant?

The message is thus that in order to make what we as professionals are doing acceptable and useful to young people we must talk the same language, be in harmony with their belief systems and, just as Popeye created a belief system to give spinach an acceptable image, perhaps we need rock heroes to promote a new belief in birth control.

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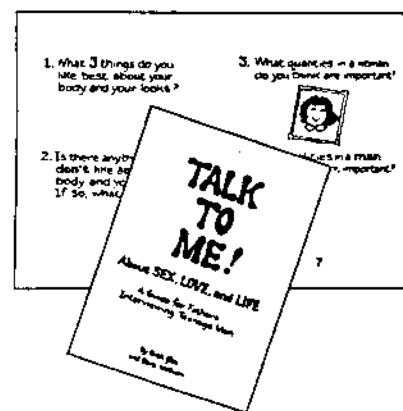
Talk to Me! About Sex, Love and Life



Father-son communication is the goal of this lively and innovative discussion aid. Two booklets, one designed for teenage men to use in interviewing their fathers and one for fathers to use in interviewing their sons, help both explore difficult topics such as self-image, sexuality, marriage and future plans. According to the instructions, "Use the book for interviews, not conversations—the interviewer will just listen. That makes the interviewer practice *really listening!*" For ordering information, contact: Planned Parenthood of Seattle-King County, 2211 East Madison, Seattle, Washington 98112, USA.

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Adolescent ward Congratulations to St Mary's Hospital Praed Street on the opening of their adolescent ward - Grand Union Ward. The nursing staff have joined the forum and we look forward to meeting them all in due course. Do you have a ward or unit for teenagers in your district? Write in and let us know.
Directory of services We are still working on this and it will not be ready for some time yet. The information so far is patchy and we would like to fill in more of the 'gaps' before printing. Please send in details of your services if you have not done so already.
In the Club? This is a series on birth control this century produced by the Television History Workshop for channel 4. Liz Kemp, who has been to our forum meeting last year, researched the programme and included a YOUTH SUPPORT client, Julie. Viewers will also recognise other familiar faces from the forum, FPA and Brook. The series goes out on three consecutive Monday evenings Dec 5th, 12th and 19th at 9pm.
Computers and sex We have now received the information about the sex education computer programmes from Hawaii. Some of the items are not suitable for a British group of teenagers and we are thinking of producing something of our own eventually. We have now ordered some disks from Hawaii and will be bale to try them out on the office 'Apple' - more to follow....

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A MERRY CHRISTMAS TO ALL OUR MEMBERS!

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