Journal of Adolescent Health & Welfare

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Letter from the Editor -

Dear Colleagues,

The following quote struck me as having parallels for those of us working in Charitable settings -

> "There is an aid culture in many African capitals. A small African capital can have more than a hundred visiting aid missions to deal with in a year, each adding to the demands of the local embassies for reams of statistical information about the country and projects. The most capable national officials become fully tied up dealing with donors. There are projects where the professional man hours devoted to monitoring and reporting on behalf of the donor exceed those devoted to implementation."

From 'Famine - A man made disaster?' A report for the independent commission on International Humanitarian Issues - Pan Books 1985

I have made the point before, that for some time at Youth Support we have really needed a full time worker just to complete the application forms for grants. It seems to me that there is a crisis in Charitable funding - too much money is now tied up in the 'top heavy' funds - like Telethon - Comic relief day - Children in need who distribute money inefficiently via a cumbersome beurocracy without direct contact with the work which they are supposedly supporting. The public give by remote control. There is no 'hands on' experience and thus little empathy or compassion.

Anyone who has spent five minutes working in a charity knows that you don't ask for what you want or need - but you ask for what you might get - even if it is much more expensive. You phrase your application in the current fashion and politically correct mode - mini busses are 'out' - homelessness is 'in'.

Again a parallel -

> "The inescapable conclusion of how so many good minds both African and expatriot could have applied themselves to such poor effect in making choices about development is that aid must be democratised. Decisions must be opened up to those whose lives are to be affected. Development to be decided by collusion between technocrats and politicians in a distant city is, however careful the technical preparations, in many cases a recipe for ineffectiveness."

In our recessionary times charity money is greatly depleted and what little there is should be used to the greatest effect. The danger is that money given with good intent - often by those who can ill afford it - is not going to 'needy' causes, but to those who look good in the media. Don't give blankets to a hundred street children when you can put one in a self contained luxury flat. Don't buy incontinence aids for elderly infirm, seeing them propped up in front of a new video looks better on the show. Get a computer for a Russian labour ward - or maybe an incubator for Port Maria in Jamaica - it doesn't matter that they need delivery beds, or that there is often no electricity.

The message is strong - don't even think of giving bread to the poor - Marie Antionette has been reviled all these years - but she was right - LET THEM EAT low cholesterol, high fibre, additive free, vegetarian, humanely produced, carob flavoured, politically correct CAKE!

Best wishes,

Diana Birch
Director Youth Support

What's important in this issue?
- sign up for **membership.**
- sign up for the **RSM Meeting.**
- enlist in the **workshops.**
- write an **article** for us!

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- MEETING NOTICE - MEETING NOTICE - MEETING NOTICE -

Youth Support Forum on Adolescent Health and Welfare
Annual Scientific Meeting at Royal Society of Medicine
1 Wimpole Street London - Thursday 21st October 6-9pm

Our theme this year is **'Young People and violence'** covering both the effect of violence on children and young people and violent youth. - Speakers include child psychiatrists, clinical psychologists, adult psychiatrists, legal profession, and member of parliament. We are a multidisciplinary group and young people are encouraged to join us.

Subjects covered -
Violent families and their effect on the adolescent.
Violent Youth - How do we contain the violence?
'Treatment of young offenders'
'Dealing with the aftermath of violence'
'The effects of sexual violence on young men and women'.
'The role of Government policy'

Free entry to students, young people and forum members.
Visitors £5
Forum membership + meeting £20

....

I am not a forum member. Please reserve .... places for the RSM Forum meeting Thursday 21st Oct 1993. I enclose £5 per person.
I am a forum member and will be bringing ...... guests (all FREE)
I would like to join the forum and enclose £20 membership fee to cover forum entry fee and FREE entry to meeting. I will bring .... guests.

Name .... Designation...............
Address .... Tel No ....
....
....

Youth Support - Professional Training - Courses 1993

Seminars -Wednesday 10.30-12.30 & 2.30-4.30 at YOUTH SUPPORT HOUSE Educational material in the form of videos, audiotapes, reprints etc available during lunch break.
Dates - 22.9; 29.9; 6.10; 13.10; 20.10; 27.10; 3.11; 10.11; 17.11; 24.11. Half day workshop £15; Whole day £30; Ten day Course £250.
Morning Teaching - Practical applications and case discussion. Concepts of therapy and therapeutic relationship. Sessions can be booked separately but are designed to be taken as a complete course. Two one day workshops can be booked separately also.
Afternoon teaching - in the form of workshops - two four week modules and two 'stand alone' sessions.
Content - basic counselling skills and psychological issues but with focus on dealing with difficult areas of adolescent work, sexuality and abuse. The content will give particular insight into the specialised areas of work which we deal with at Youth Support.

Modules -

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

Adolescent issues -
- **A5** - teenage pregnancy.
- **A6** - Sexuality and belief systems.
- **A7** - True self/false self - teenage handicap.
- **A8** - Self Esteem in adolescence.

Morning topics -
- **M1** - Emotional development
- **M2** - Personality types a) Depressive and Hysterical
- **M3** - Personality types b) Obsessive and schizoid.
- **M4** - Individual therapy - the therapeutic relationship.
- **M5** - Working with groups.
- **M6** - Ideas from TA - ago states and scripts.
- **M7** - Alcohol and substance abuse.
- **M8** - Eating disorders.

Whole day workshops
- **D1 Psychodrama**
- **D2 Family Therapy**

BOOK NOW! - PLACES LIMITED
STUDENTS and FORUM MEMBERS - ask about CONCESSIONS

Meeting Transcript -

Youth Support 6th Annual Meeting

Royal Society of Medicine Thursday 26 October 1991

"The Care System - does it work for teenagers?"

Introduction from Dr Birch
On setting the title of this meeting some 6 months ago, we didn't realise the relevance of the topic. Now with the recent issues of Pin Down and the Children's Act coming into force this week it is an ideal time to highlight the issues of the care system.

Brief outline of Youth Support and its services - Youth Support is an independent charity set up 6 years ago to look at the services for young people, especially teenagers who were not being catered for by statutory organisations - Social Services and the Health Service which concentrates on either paediatric or adult health.Teenage health services centred around psychiatric care. In the USA adolescent medicine and health exists in its own right.
We also realised there were not many services offering help support for professionals working with teenagers.Part of Youth Support is the Forum on Adolescent Health and Welfare which produces the annual meetings and the journal.The Forum is run on an inexpensive membership system entitling members to free attendance at the meetings and discounts for the professional workshops, we also send free journals and literature to organisations who benefit from the exchange. The Workshops and teaching of professionals takes place either on site or at Youth Support House.
The services provided for teenagers target the following groups:_**Pregnant Schoolgirls** - Most girls have multiple problems,you are looking after 2 people -the mother and baby. Our residential unit mainly works with **deprived, disturbed** youngsters who have been in care most of their lives. Some are pregnant, most have been **abused**, some have **addictions or eating disorders** we also admit and rehabilitate **whole families.**
Recreation and Travel - Organising exchange trips for school children, students and professionals who stay with families and attend a whole range of summer camps or interest/related visits.
Youth Support House - Residential The 3 upper floors are for the residents, we can accommodate 11 girls. There is also an independence training flat and Family unit flat. A suite of rooms cater for individual, group, dance and art therapy. The unit operates as a therapeutic community.
Day Nursery - Accommodating up to 24 children of ordinary local working mums or children who need assessment or medical supervision, we also provide subsidised places in special cases. Nursery aged residents also attend the nursery as they would if their mothers were living independently.
Baby Unit - Operating as a nursery for the 0 - 18 months.
Large Garden and Playground
Education Unit -_Where we provide school education and practical skills such as child development, work experience office skills depending on the needs of the attenders.
We are currently building up day attenders to the education unit and developing a leaving

care project providing social activities and counselling in the evenings.
The overall effect is that we provide care, education and therapy for residents,while bringing in children and young people from outside so that residents do not feel institutionalized.
An interesting development has been our support of children in institutional care in the Soviet Union and advice on provision of services to runaways and abuse victims. We have with us tonight four of our students - three placed at Kingston University and Doctor Vadim Romanov who is here with us on a six months sabattical. **To begin our discussion of the care system - let us go back 50 years** - let us look at a videotape of children in a Soviet Institution - I give no apologies for reproducing here the commentary I made at the time of my visit. ....

* * * *

My heart went out to the children today ...words were just not enough to deal with the scene before me. The home for runaways in the Urals.Boys looking like concentration camp prisoners, shaved heads, faded blue-grey institution-alised trousers and threadbare charity shirts. Asked to jump to attention and greet me, the television camera whirred on as we spoke.

"Hello, what's your name?"

"Alyosha."

"And how old are you Alyosha?"

"Thirteen"

"Just thirteen - it must be very difficult for you to talk to me in front of all these people but perhaps you won't mind telling me a bit about yourself. How do you like it here? Are you pleased you were found?"

"Yes, at first I thought this was a bad place,but now I think they're alright. I have to stay until my parents come"

"Do you want to see your parents? Why did you leave home?"

"I want to go home. I left because my friends were going and I wanted to be with them, to keep them company. My friend had been badly beaten at home. But I was found by the Militia and they ran off"

"Your friends must be frightened. Being beaten is something very hard to talk about sometimes. Are you worried about them?"

"Yes, I worry very much. They are still travelling. I don't know where they are and I don't know what will happen to them. ..."

"Thank you for talking to me, boys .... You have had a hard time of it lately and I hope things will get better for you now".

"What about a song for Dr Birch. Sasha, sing us a song ..." He sang like a little lark. A plaintive song about home and love, Sung with the expression that belonged to the song, but without the emotion, which he did not know.

"Why are the dormitories just a close row of beds? There are no tables, no chairs and no cupboards or anything for the children to put their things in"

"They have nothing. They come in the clothes they stand up in, dirty and lice ridden. We take their rags and shave their hair. They come with nothing and we have nothing to give them except love. .. They have absolutely nothing to call their own ....."

At the official dinner later, the Militia man sang. A Soviet Pavarotti singing Neapolitan songs in Russian. An enigma of a man, the

singing policeman with a heart of gold who patrolled round the stations checking for runaways.

* * * *

"Why are there so many children in the psychiatric ward?" A row of rooms each not more than fifteen feet by ten held nine narrow beds, six sardine-like along one wall and three lengthwise opposite, just enough room to squeeze between the two rows but not enough to pass between the beds. Sixty bedraggled youngsters per ward.

"Well, they are here because there is nowhere else to put them. Some have emotional difficulties, some are from broken homes, alcoholic parents and are under stress."

"But surely it makes them worse being in here, imprisoned in such cramped, awful conditions, no real treatment, no space, no recreation no rehabilitation .. and ill treated children mixed with schizophrenics, acute cases mixed with chronic."

"Yes, of course it makes them worse, but there is nowhere else for them to be ...."

"No child should ever be in a place like that..."

* * * *

The Children's Society

Hilary Flinders and Danny Calico

Hilary - Acting Project Leader for an independence preparation project in Battersea.

Danny - Care Leaver who has been involved with the society's project, Young People Project for Action.

Hilary began with a joke - What is an expert in leaving care? Is it someone skilled, knowledgeable or in some authority? Or perhaps ..

X - unknown quantity
SPERT - drip under pressure

EXPERT = AN UNKNOWN DRIP UNDER PRESSURE

At 18 years teenagers come out of care to live independently, they have to leave care whereas most people leave home because they want to - through choice. In the UK as a whole only 0.02% of the population is a single houseowner at 18 years of age.

Common themes of care:

1 Stigma - many people think that many are in care because they have problems or have caused problems.

2 Disrupted education - very little consistency resulting from multiple moves

3 Lower achievers - statistics show that youngsters in care are lower achievers beginning with education.

4 Breakdown in networks - resulting through moving around.

Danny

The project was set up two and a half years ago to help young people with employment and accommodation.

The leaving care grants given to young people range from £200 in Liverpool to £500 in London which is not enough money to furnish a home with items such as a bed, cooker etc. often resulting in debt then court cases. The project would like to see the leaving care grant raised to £1500 nationwide, which sounds a large amount but not when you think in real terms including linen and carpets. Most of the people are also unemployed

and for them a breakdown of expenses is -£31.00 per week Income Support £4.29 per week, bills,£2.50 per day, food & toiletries which adds up to £29.79 - leaving only £1.26 (can't afford to buy any clothes etc.)

Housing - Complaints regarding the state of accommodation ie 11th floor, being scared of yobs. Many young people are in care not for causing trouble but because they have been sexually abused or because their parents didn't want them.

Education and Training - Continuing education is hard as expenses such as study books have to be purchased from their Income Support, resulting in a large number dropping out. It is extremely difficult to get a job now without an education or qualifications and also a job without accommodation.

Hilary .. The above points are the responsibility of the system, which is not equipped to deal with individual cases.

Summary - these are the difficulties facing a young person leaving care -

Lack of positive relationships
Lack of money. Having to make decisions at an earlier age.
Not having enough time to plan and prepare for leaving care.
Not enough contacts giving help, advice and information.
Not knowing where to find such contacts.
Suffering from discrimination ie.young,ethnic,sex,disability
Risk of exploitation/abuse.
Not having a family to protect in times of trouble or crisis.
Lack of involvement in the community - affects lack of education and work prospects.
Disruptive education and feeling of being devalued.
Inadequate/Inappropriate housing and lack of choice

The Children's Society has run independent projects for 15 years nationwide and aim to offer support ie. fixed housing project.
9-24 months placement to work with staff and own flats in partnership with the local authorities. From this work and recent conference evolved the **"Young People for Action"** who help with such problems as listed in the summary. Their recommendations are available from the Children's Society.

An income of £1500 should be paid at 1992 prices, income should be restored for 16 & 17 year olds and housing benefits for under 25's should be raised to adult rates. The Youth Training allowance raised to £50 per week - the YTS allowance is currently £29.50 for the first year and £35 for the second which is still as in 1970's. A choice of suitable housing should be available from a range of self-contained flats, bedsits and sheltered accommodation as many do not have any choice.

Training and employment should include access to higher education and should be improved, young people should also be encouraged to realise their educational potential opportunities to make up for previous disruptive schooling and finally giving proper career advice.

Tim Hayter, Knotly Community Hall. (Banardos')
"Providing practical help for teenage boys."

(Refers to Russian Video) In 1967 at Knotly there were 7 staff and 70 boys who were sent away to the country, the fees were £11/week per boy and living conditions would not have even been tolerated by the British Army. They followed a hard regime although some ex-

residents who visit say that it did them good as young people can be very resistant.

Knotley Hall is run by (Dr) Banardos. You don't hear many good stories about residential work as it has a high media profile allthough there are good sides. Riots do happen as people aren't repressed under a brutal regime.

Over the last 20 yrs Banardos have taken their units out of the country and back into the community as it is bad to separate the young people where they are unable to build contacts. The large units have been broken down into smaller ones although they are still not small enough - it is still hard to manage 10 people. The aims are to open 3/4 bedroom houses staffed from central units to keep staff costs down and to offer a wider range of services ie school at home.

They work with people beyond local authority care, in conjunction with the London Boroughs Regional Planning Unit who pick up all people that can't be managed within their own Borough. Most have been expelled from special schools or children's homes.

The aims are to re-form relationships between the young and their families, reintroducing them into main-stream education where possible by working with the local schools. Offering family carers, foster and respite care.The majority are all male homes although they do have mixed homes also. There is a great need for this type of care - last year there were 126 referrals to the school but were only able to take 26. Some cases are not appropriate and many go into the private sector which are cheaper but a long way from home.

There is a problem with emergency referrals as we are trying to run a long term establishment and do not want too many new arrivals who may cause problems and then move on. Many referrals are made by phone on a Friday with a child sitting in a social workers office with nowhere to go although these placements do sometimes work.

Services -Day care, mainstream education, full time residential care, family care, education, assessment, special services and individual programmes. It costs £4,750 per week to run the school and the cheapest fees are £1,000 per person per week (1991 rate) as it proves to be very time consuming. There are facilities to look after people until they are 19/20 with key workers teaching independence and reducing support.

We mainly use unqualified "amateur" staff, not highly qualified specialists or therapists. We cannot offer that service as we cannot attract qualified staff. Banardos try to train their staff but this is limited but provide supervised "on job" training. They rely heavily on volunteers attracted by the name of "Banardos", they are very lucky to have volunteers but this is not always appreciated by the young people. Race is a complex subject and they are employing more black staff although there is still a 41/13 majority of white staff. They are now beginning to train in race relations and there were thoughts that their units shouldn't be mixed but some units for black youngsters run by black staff, this needs looking into but they wouldn't want to segregate other than to serve the cultural needs of the people that they are trying to serve.

A Study of Self Esteem - Measurement and Possible Relationship with early pregnancy and sexual experience.

Diana M.L. Birch

A schoolgirl mother -
Carol was 15 and should have been at school, instead she truanted, met a boy as lonely as herself and became pregnant. He was also 15, rejected by his adoptive parents and gave up on school, he was sometimes violent towards her. For the first four months, neither of them realised what had happened Carol tried to ignore her missed periods.Then she found out she was pregnant and in a panic they fled to sleep rough in a seaside town. The police picked them up five days later and returned Carol home. Her boyfriend left the scene after her parents told him he was not welcome.The birth was traumatic staff at the hospital were unsympathetic and overtly hostile on the postnatal ward. Carol was given no help to breast feed the baby. She returned home in tears and has remained in her parents home caring for her baby and going out only to give her son some air.

Two years later, she is lonely and depressed and acknowledges that she felt sorry for her boyfriend and tried to give him the affection she had lacked, while also fulfilling her need for love. Instead he mistreated her and then deserted her. The baby whom she also thought would bring her love and ensure her boyfriend's fidelity, is needy himself and has trapped her in her loneliness. Self esteem score 8 (very low).

* * * * *

It will come as no surprise to hear that Carol, a young mother has a low opinion of herself and scored at a very low level on a self esteem scale. However, in contrast, let us consider Karen. .....

* * * * *

A pregnant schoolgirl -
Karen, pregnant at 14 by a boy three years older, was abused and rejected by her mother who placed her in a children's home at the age of two. Her half sister, though four years older, is tiny and under-developed, she looks 12 years old and is regarded as the baby of the family, she never knew her father and was the most abused member of the family. Karen has two asthmatic brothers, one a year younger and one a year older than herself who joined her in the children's home. Her mother's third liaison produced two children, a half sister who died at four months (?cot death but possibly suffocation) and a half brother four years younger now in residential school.

She recalls that the staff in the children's home smacked her frequently but that her father appeared not to know about this. He visited sometimes but 'didn't know what to do'. Six years later father took the children to live with him and his girlfriends who mistreated them. Karen was allocated a social worker but when she visits she only speaks to father's new girlfriend and 'cuts Karen out'. Asked if she felt angry or upset about the way her parents treated her she said "No, my Dad, he tried his best to get us out of there. He was the only one who cared about us, my Mum she just gave up".

Karen has known her boyfriend four years and had unprotected sex for one year before falling pregnant. She states that he will get a house soon - he is unemployed but has 'had an interview'. On questioning she

said "I suppose he might be scared because at first he wanted me to have an abortion but he wants a baby now". During her pregnancy Karen had been very hard pressed my a welfare worker who wanted her to have the baby adopted saying that Karen had no right to keep the baby when 'there are women out there who are desperate to have a baby of their own'. Karen remained very matter of fact about this woman, not expressing any understandable anger about such remarks. When asked if she thought there may be some truth in the fact that she may have problems looking after her baby, like her mother had, she was quite clear that her baby would be spoiled and have the best attention.

Karen has so far been let down by every 'mother figure' in her life; her real mother, foster carer, father's girlfriends, social worker and welfare worker. Her elder sister could not fulfil the position of carer for her and needed care herself, the younger sister died. Karen is now determined to become a better mother than her own and at the same time, to be fulfilled from within, by becoming a mother. The boyfriend's idea of abortion and the welfare worker's plea for adoption of the baby were so counter to Karen's emotional needs - to not give up her child (as mother had) and to not let her baby die (as mother had) that they could hardly be acknowledged. Future disappointment may stem from Karen's experience that all men in her life have been weak and unable to help her - father 'could not do anything' to get her out of the children's home, step fathers left, brothers were asthmatic - the odds are that her boyfriend will not be the pillar of strength that she envisages. <u>Self esteem score 22</u>

* * * * *

A tragic tale .. In many ways similar to Carol's story .. But pregnant Karen felt good about herself, she showed very little affect in describing her situation and her statements were devoid of any negative comment on herself or others. She scored a high self esteem score .... What does this mean?

What is self esteem? Why should we devote so much energy to researching the idea and how can such study help us to understand some of the dilemmas of childhood, adolescence and indeed adult emotions?.

To define self esteem, one must of necessity first consider the concept of 'self'. What is 'self'? Can we address this paramount question of existence without resorting either to the crudity of Sartre's self mutilation - plunging a knife into his hand to prove that if 'self' felt pain, then 'self' existed - or to covering the entire spectrum of psychoanalytic theory?

Unfortunately, as is usual with concepts that are somewhat abstract, albeit fundamental, there is often disagreement in terminology and too many verbose theories can be used to provide a smoke-screen covering the lack of real knowledge. The ideas about self are really at the frontier between science and philosophy. Let us consider briefly a few developments in these arguments.

Freud's theories (1923) encompass an idea of 'self' but the relationship between 'self' and his concepts of superego, ego and id is unclear. Jung (1960) thought of 'self' as an equilibrium between conscious and unconscious or in other words an archetype of the struggle for unity and wholeness which he believed

could not be formulated until middle age.

"..... The ego can only be regarded as the centre of the conscious. If the ego can relinquish some of it's own omnipotence, a position can be found somewhere between that of consciousness, with it's hardly-won values and the unconsciousness with it's vitality and power and a new centre of the personality can emerge, differing in it's nature from the ego centre" (Fordham 1953). This new centre of personality, Jung calls the 'self'. "The self is not only the centre, but also the whole circumference which embraces both conscious and unconscious; it is the centre of this totality, just as the ego is the centre of the conscious mind" (Jung 1944).

This unification of aspects of the psyche in the 'self' is reflected in the concepts of Taichi, the all inclusive Tao blending of opposites Yin and Yang, and many of the eastern ideas studied by Jung in his "Secret of the golden flower" (R. Wilhelm and Jung 1931).

- "Cogito, ergo sum" - I think, therefore I am. Descartes (1596 -1650) conveys the intellectual philosophical concept of the 'global self' but thought itself can divorce us from the 'self'. "... The cerebrating person is the alienated person, the person in the cave who, as in Plato's allegory, sees only shadows and mistakes them for immediate reality ... I am a stranger to my self ... I am cut off from the vast area of experience which is human, and remain a fragment of a man, a cripple who experiences only a small part of what is real in him and what is real in others" (Eric Fromm "Psychoanalysis and Zen Buddism" 1960).

In contrast to this 'holistic' unified idea of 'self' others have taken the opposite route of subdividing and dissecting out different elements of the 'self'.

William James in "The principles of psychology" (1890) postulates two elements "... an objective person, known by a subjective thought .... Let us use the words 'me' and 'I' for the empirical person and the judging thought ..." In thus writing, James was expanding on Kant's 'self as object'; 'self as subject' ("Critique of pure reason" 1781) and Shopenhauer's (1788-1860) known (me) and knower (I) ("The world as will and idea" republished 1948).

This idea can be further elaborated whereby the 'self as known' or 'me' further subdivides into two elements - knowledge and evaluation and incorporates 'cognised self' ie self as known, 'other self' ie self as he believes others see him and 'ideal self' ie as he would like to be (Raimy 1943; Burns 1979).

Thus we could say :-
self concept = knowledge (self image) + evaluation (self esteem)

cognised self other self ideal self

This all sounds very theoretical and confusing - perhaps we could simplify the idea by pausing to think about how we see ourselves? Basically we could say that we have a way we consider ourselves to be (cognised self) - in answer to the question -

'What sort of a person do you think you are?'

A way we think others see us (other self) in answer to -

'What sort of a person do you think other people consider you to be?'

and thirdly, we have the 'ideal self'-

'What sort of a person would you like to be?'

At this point in the argument, we have really strayed from our question of 'What is 'self'?' to how we regard self. In other words we are confusing 'self' with 'self esteem'.

Self concept has been used as an index of personality and as a research tool since the fifties and during the span of the last forty years terminology has passed through various vogues and changing practices. At least fifteen different terms have been applied, often interchangeably by authors (Coopersmith 1967; Wylie 1961) and indeed each carries connotations of the other. Such a proliferation of terminology describing the self concept does little to reassure the reader that research workers and theorists are clear in their understanding of the subject.

It is perhaps advisable to consider the views of those researchers most quoted in the field of adolescent research, Coopersmith and Rosenberg:- The former's position is that self esteem is "the evaluation that the individual makes and customarily maintains with regard to himself, it expresses an attitude of approval or disapproval and indicates the extent to which the individual believes himself to be capable, significant, successful and worthy". (Coopersmith 1967). Rosenberg's definition is more succinct "A positive or negative attitude towards a particular object, namely the self" (Rosenberg 1965).

Put another way, self concept is "That individual exceedingly personal, dynamic and evaluative picture which each person develops in transactions with his psychological environment and which he carries around with him on life's journey" (Burns 1979).

In my opinion, the most useful observation to consider in the evaluation of self esteem in adolescence was written a century ago. 'James Law' (1890) states that self esteem is success related to pretentions-

$$\textbf{Self esteem} = \frac{\textbf{success}}{\textbf{pretentions}}$$

in that -"..we have the paradox of a man shamed to death because he is only the second pugilist or the second oarsman in the world. That he is able to beat the whole population of the globe minus one is nothing; he has pitted himself to beat that one and as long as he doesn't do that, nothing else counts..". In other words, self esteem relates to a individuals personal values and not necessarily to those of his peers, his doctors or his teachers. This aspect provides insight into one of the flaws frequently found in measuring scales; the confusion of descriptive statements about self with self esteem. For

instance " 'I am good at maths' being presumed to be something valued by the respondent ..... positive correlations between self esteem and educational performance are likely to be found only in populations in which that self esteem is bound up with aspirations for achievement. There are no a priori reasons why academic achievements or anything else, should be of value to all pupils"(Robinson89;Brookover67)

It is due to this factor that there is a danger in extra-polating tests and results from one culture to another. The Coopersmith Inventory assumes typically 'all-American' ideals and has not 'travelled well'. It's use in British work has added to the confusion surrounding the relationship between self esteem and educational achievement (Bagley et al 1979; Burns 1982).

If indeed self esteem is dependant on a personal value system, presumably a change in self esteem may be achieved by altering these values, rather than by changing one's position within the existing hierarchy. In other words, if you lower your expectations, you can fulfil them more easily without having to improve your achievements. This mechanism appears to be operational in schools where teenagers who have been used to 'failing' academically, form a 'counter culture' of academic incompetence within whose inverted value system they can succeed and constitute a model for younger pupils (Cohen 1955; Berger and Luckman 1966; Hargreaves 1967; Lacey 1970; Ball 1982).

On a practical level, I am sure we all have first hand experience of the way that altered expectations can bring increased self worth. Take the busy housewife and mother desperate to please everybody, feeling that nobody will like her unless she does everything for them, driving herself to have a spotless house, happy husband, wonderful meals, well behaved children. Or the dutiful teenage daughter, working all hours at her school work, needing to be top of the class. She is doing everything she can but she is unhappy, she cannot be perfect so she feels bad about herself. If she can be helped to change her attitude, to stop seeing her mistakes and shortcomings but instead to see her successes and good points, she will be doing exactly the same things, her life will superficially be exactly the same, but instead of being depressed and anxious, she can feel valued and fulfilled.No longer 'imperfect' but 'good enough'. No change in circumstances, just change in attitude.

Schoolgirls who become pregnant have been shown to have experiences of academic failure (Elster 1980; Ulvedal and Feeg 1983; Rosenstock 1980; Birch 1986. 1987b). In becoming young mothers they could be seen as 'finding and accepting alternative dimensions of value' (as Robinson describes failing pupils attempts to repair self esteem) and establishing or joining a 'counter culture' of schoolgirl mothers. This view is strengthened by the frequent observations of 'clustering' of cases of pregnancy at particular times in specific schools (Birch 1985 'Schoolgirl Mum') and anecdotal evidence that many girls appeared to use their pregnancies as a source of self worth, seemed fulfilled and happy during and soon after the pregnancy and appeared temporarily to do better in their individual tuition than they had done at school.

So how could the mechanism by which girls seem to derive self

worth from pregnancy be investigated further? What are the hazards and benefits of early sexual experience and pregnancy to the adolescent psyche?

In recent years it seems that the terms 'self worth' or 'self esteem' have become almost compulsory entries in any paper on adolescence. Papers have perported to show that low self worth is attributable to frequent moves of home (Wooster and Harris 1973), school performance and attitude of teachers (Staines 1985), violence and abuse (Brown 1979). not having sex (Jessor and Jessor 1977) and having sex (Orr et al 1989) and that low self esteem can be a causative factor in prostitution (Brown 1980), alcoholism (Glatt), and early pregnancy (Kane et al 1973) to name but a few.

The North American literature abounds with papers relating self esteem measures to teenage sexuality. There is no common consensus view on this matter, diametrically opposite conclusions are found. For example Irwin and Millstein (1986) found that sexual experience raised the self esteem of teenage boys while a study from Indiana showed no effect (Orr 1989). Similarly virgin girls showed higher self esteem values than non virgins in Orr's first study whereas in a second, girls in families with step parents showed an opposite correlation.

What do such discrepancies tell us? Certainly there are errors in measurements, in not taking socio economic factors into consideration, and in using different scales. But perhaps it also tells us that we are not measuring the same thing or that we have misunderstood the concept of self worth.

After all - is self esteem an inherent characteristic of the individual? OR a variable affected by life events and social circumstances? OR a state between, where a baseline level exists for self esteem which fluctuates about that level depending on external circumstances?

A typical research pattern for early workers was based on large population studies with a heavily statistically oriented approach. They might measure self worth on a 'static' scale on a large high school population and then look at the same group some time later to see how many became pregnant or used drugs or some other parameter and then look at how the original scores related to the facts they were researching. Very little useful information emerged.

In my opinion, self worth cannot be regarded as a static measurement. We are not born, go through the trials of life and go to the grave carrying the label of our self esteem score. Hence the effect of self esteem on our behaviour and vice versa has to be seen as a dynamic interaction - what level of self worth would we expect to see in a given situation why are we seeing deviations from that mean? What influences the relationship between self worth and life experiences? Why do our attitudes to situations and our view of ourselves alter at various times?

Secondly, a 'by definition' subjective principle does not lend itself comfortably to scientific measurement and certainly emotional or psychological factors are not suited to large statistically based research models. The danger is that by insisting on large samples, the quality of information can be sacrificed in seeking after quantity, valuable information can be ignored in the mistaken belief

that it is invalidated by statistics, and there is a distinct possibility of 'not seeing the wood for the trees'.

In order to test out ideas about self esteem and to explore the relationship between ideas of self and sexuality, a research model was tried out comparing a control group (secondary school age girls aged 12-15 recruited at a routine health check), a group of pregnant schoolgirls (aged 13-15) and a group of young mothers (ie former pregnant schoolgirls aged 16-21 with children at least two years old). This was first piloted on a small group (Birch 1989) and subsequently expanded to include a larger sample (twenty in each subgroup) and a second control group (students aged 18-21) to eliminate age effects in comparing subgroups. The findings were the same in both studies. Both control groups had identical scores and thus were eventually dealt with together.

The groups were investigated by a self esteem measure, a 'deprivation score' looking at life experiences and a 'sexual' scale estimating degree of sexual experience or sexual trauma. In the absence of an ideal test instrument, it was decided to use the Battle culture free self esteem scale. Choice was dictated by the need for a short form of scale which could be easily completed by teenagers, which did not need a long attention span and which would be appropriate to a multiethnic population.

As a secondary instrument interviews with the girls were taped with the view to analysing them using Wattenburg Clifford's (1964) method of assessing positive and negative statements about self.

The Battle self esteem scale consists of 30 questions and includes a five point lie scale and a maximum self esteem (SE) score of 25. The deprivation scale (De) was devised specifically for the study and included 25 items known from previous studies to be of relevance in the social background of pregnant schoolgirls ie home life; housing and finance; personal and social; education and employment; self destructive behaviour and risk taking. The eight point sexual history scale covered items of 'unfavourable' or 'undesirable sexual experiences' or possibly one could say 'harmful' sexual experience. It is important to distinguish these experiences from desired, protected sexual intercourse in over sixteen year olds or desired pregnancy in girls over the age of consent. It would be quite wrong to equate 'normal' sexual experience or childbearing with poor self image, none of the items in the scale could ever be said to be desirable viz - unprotected sex under 15, sexual abuse, violent sex, sexually transmitted disease, pregnancy under 15 etc. For a full description of all the test items, their significance and reasons for inclusion I refer the reader to the pilot study paper (Birch 1989).

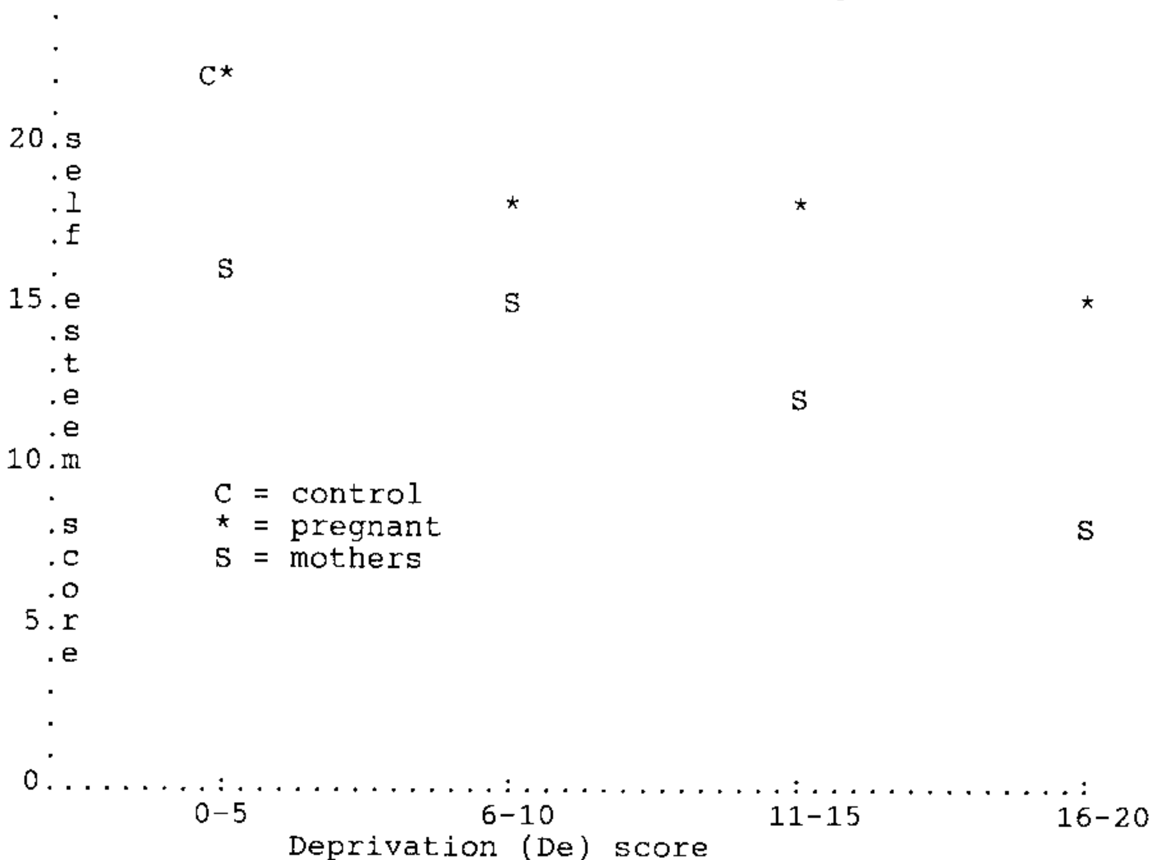
The raw results of the study showed that the control group (C) had a mean self esteem score of 22, the pregnant schoolgirl group (B) had a mean of 20 (not significantly different) but the young mother group (previous pregnant schoolgirls) (S) had a significantly lower mean of 14.

Looking closer at the relationship between C and B, the results show interesting features. The control group were high socioeconomic class, high achieving 'public school' girls with a more or less zero deprivation score whereas group B were deprived, anti school,

low achieving pregnant girls of low socioeconomic standing. The largest self esteem study in this country (Robinson) on Avon school children has shown that as the last two school years approach (ages 15,16) the self esteem measures of anti school girls drop appreciably. So here we have a group of pregnant girls where this is not happening and who are scoring at the level of public school girls. Are they using pregnancy to restore their self worth?

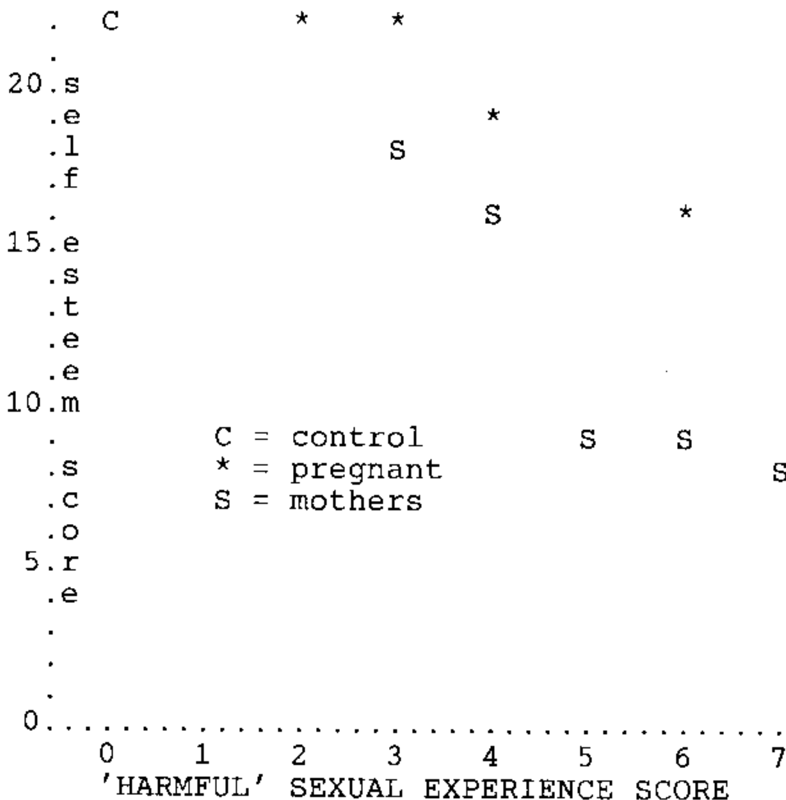
Groups B and S were similar in all social variables, they were basically girls with the same type of backgrounds and problems but seen at different stages. Why such difference in their self esteem scores? Looking at deprivation levels girls who were more deprived, had lower self esteem but those who were pregnant were less affected by these adverse factors. (fig 1).

Deprivation and self esteem - (Fig 1)



Similarly those with adverse sexual experiences were generally more deprived and had lower self esteem measures. Again the pregnant girls were less affected by such influences than their older counterparts.(fig 2). The 'harmful assaults' to self worth occasioned by undesirable sexual experiences appear to be diminished by a current pregnancy although this effect diminishes as the degree of sexual experience increases. Possibly this indicates that a search for self worth through sexual experience may lead to disillusionment which renders this avenue of approach less efficacious as time goes on.

Sexual experiences and self worth (fig 2)



What of the analysis of the taped interviews? We began this discussion by looking at two cases - Carol and Karen and noted that pregnant Karen showed none of the possibly expected negative emotions and in fact little affect at all. This was a common situation rendering the interviews pretty useless in assessing self worth -however this negativity itself is a useful source of information.If girls were using their bodies in getting pregnant rather than using their minds to think and feel about their situations, would this be apparent in short psychodynamic assessment of interviews. Let us look at another 'pair' of girls (names have been changed but one girl was actually called 'Lolita' - a perfect 'script' name!). There are obvious contrasts in the girls attitude to their situations.

* * * * *

A schoolgirl mother - <u>Linda</u>, aged just 17, looks at least 25. She is grossly obese, has dyed, unkempt, straw coloured hair. Three years ago, when she became pregnant at 14, she was a slight, dark haired and reasonably attractive girl. Her pregnancy was the result of a seduction by a Moroccan 'fence' eight years her senior who married her on her sixteenth birthday to avoid deportation - the marriage lasted three months. She had met him on the one occasion that she managed to get out and have a night out at a club with a friend. Her mother hardly ever let her out of her sight and had kept her away from school for two years. She refused to allow Linda home tuition. Her only brother, two years her senior, is a haemophiliac and HIV positive. He also opted out of school and mother says he cannot get a job in case people find out and hound him. He spends all day in his room playing computer games Mother helps look after Linda's two year old daughter

but insists Linda stay at home 'because of the baby'. She does not go out to work but spends most of the day at home with her 'trapped' son and daughter. Mother is a very powerful woman whose presence in the home is tangibly omnipotent.

Linda is able to admit that she feels depressed often, she feels she has made a lot of mistakes and also feels let down and angry towards her ex husband, she feels used. She finds it harder to acknowledge her guilt and anger towards herself but thinks her weight and not going out is related to her not liking herself very much. I felt she was using these as defence against meeting another man who may abuse her again. She feels a hopelessness in the fact that 'men are weak and leave you' - like her father did and as her husband confirmed; or 'are too ill to help you' -like brother; with the net result that 'you are left at home to keep things together'. SE score 10

* * * * *

Linda scores low on the self esteem scale, she feels bad about herself and is able to express her negative emotions. Contrast the emotional cut off expressed by pregnant Sarah who looks at her chaotic world through 'rose coloured glasses'

* * * * *

Sarah was 14 when she got pregnant. She was living with her mother, aged 45, her sisters aged 30 and 26 and a step father who had joined the family when she was one year old. Telling her mother that she was pregnant resulted in her discovering that she was in fact her sister's child; her 'stepfather', who had been ill with cancer, died during her pregnancy and 'mother' (grand-mother) became agoraphobic. Sarah now attends the same special teaching unit as her own mother did. Her boyfriend stopped seeing her when she got pregnant.

During interview she related her story in a pleasant matter of fact way showing no real emotion. Some of her statements were however revealing. Asked how having a young baby might affect her she said "Well, I reckon it's not as bad as what people say about it getting you down, 'cos if you want to go out, you goes out" - Will your Mum (gran) mind looking after the baby if you go out? - "No, she can't go out anyway, can she?" - Do you feel let down by your boyfriend? - "No, he did me a favour, getting pregnant. First time round, I just didn't think it would happen, but he did me a favour".

There are many parallels between Linda and Sarah's stories, both became pregnant 'first time round' by boys who then deserted them. However Sarah managed to 'dump' her anger, and her baby, on her 'mother' who became trapped at home caring for the third generation of offspring. Sarah's 'mother' (grandmother) appears to be using her agoraphobia as a means of coping with and denying her granddaughter's attack upon her, and at the same time her behaviour is reminiscent of Bandler's (1948) description of an agoraphobic girl who avoided sexual encounters in this way. Thus she could be interpreted as acting 'by proxy' to 'keep her daughters chaste'. Meanwhile Sarah is denying her feelings of anger and rejection In reality Sarah has been let down and rejected by her natural mother who allowed her to be adopted (albeit by her grandmother), her grandparents who did not tell her the truth of her origins,her 'stepfather' who died and her boyfriend who left her. A hint of the underlying feelings was given by Sarah's answer to my

question of why did she think her 'mother' had not made sure that she knew about contraception and helped her not to repeat her own daughter's mistakes - Sarah laughed and said "Well, she got it all wrong, didn't she?". <u>SE score 22</u> (high).

*   *   *   *   *

Thus it would seem that pregnancy partially protects the individual from threats to self worth but that this effect is only temporary. By the time the child is two years old (probably sooner) the harsh realities of life seem to be taking their toll once more. The temporary nature of this boost to self esteem probably accounts for some of the frequent cases of repeat pregnancy, in an attempt to re-establish identity with the counter culture and redefine alternative dimensions of value.

Of course the hormonal and physiological changes of pregnancy must not be ignored. It has been suggested that there is a blocking of mourning during pregnancy (Emmanuel Lewis) so it is conceivable that the 'mourning' for an 'ideal self' which could underlie poor self worth may also be blocked. 'Blocking' of emotion is apparent in other ways (vide infra). Barlow (1968) noted that in pregnant inner city girls there was a lack of the normal fantasy about the baby in the third trimester.'Primary maternal preoccupation' - the normal mechanism whereby mothers have 'eyes only for their child' in the first few weeks or months after birth, could also account for some of the lack of negative feelings in the puerperal period.

What is the influence of deprivation?When we are looking at a deprived population, at young people living in difficult conditions, perhaps subject to abuse and other traumata, how can we isolate the effect of one factor from such a morass of detrimental features? Taking the example of child abuse - The traditional view is that young parents from poor backgrounds are more likely to physically abuse their children. Indicators of child abuse have been described as premarital conception, youthful marriages, unwanted pregnancies, illegitimacy (Solomon 1973). It has been suggested that social variables associated with early child-bearing are also common to child abuse and cot deaths (Johnson 1983) So is there a causal or coincidental relationship between these factors? ie does school age pregnancy predispose to abuse of the child of such a pregnancy or do we see a higher rate of abuse in such situations because deprivation predisposes to both abuse and early pregnancy so these factors are likely to coincide? "Adolescent motherhood increases risk of prematurity, sudden infant death syndrome, and child abuse. The common denominator for the risk of the baby of an adolescent mother may be variables associated with lower socioeconomic status." (Simkins 1984)

The same argument can be made regarding early pregnancy, deprivation and self worth. Do adverse socioeconomic and other features of deprivation, by causing a lowering of self esteem, cause increased pregnancy rates or are they independent variables? Many of the factors described above appear to cause a recurring cycle of problems, the children of school age mothers tend to become school age mothers themselves; the abused become abusers. - An alcoholic or violent family background is

associated with a low self image and "emotional relationships between the girl and her parents are severely disturbed forming a fertile breeding ground for insecurity and maladjustment. .... today's deprived, neglected children may grow up into tomorrow's neglectful unstable parents who are again unable to provide a normal home life for their children" (Glatt 1975). Is the fulcrum of this self perpetuating situation a threat to self worth?

It would seem logical that unfavourable life events could constitute a threat to self esteem and that, if that were so, a detailed and accurate measure of such unfavourable events (which could be considered 'deprivations') could give a measure of self worth. This does not seem to be the full story - In this study the deprivation scores were indeed related to self esteem measures but the correlation was not highly significant - not significant enough to consider the deprivation score as a predictor of self worth.

The reasons for this apparent 'damping' of the effect of deprivation could be related to several factors - 1.Specificity of the self esteem scale - what are we actually measuring? 2. Perceived significance of certain deprivation features. Some aspects of deprivation may be less damaging to one individual than to another. For example - if you and your family have always lived in overcrowded conditions, perhaps this is not of such concern to you as it may appear to the observer. 3. Coping mechanisms such as denial which help the individual to deal with the problem may also 'protect' the self esteem measure. An analogy being the chronically abused child's capacity to mask the feeling of intense pain.

So what is the significance of early sexual relationships?

Why do girls with a low opinion of themselves seek out, consciously or unconsciously a relationship where they experience sexual involvement which they are unprepared for? Psychosexual development, lack of abstract thinking, the ability to perceive oneself as a sexual being and to be responsible for one's actions, and the teenagers' belief systems, external locus of control and inability to plan their own futures have been discussed elsewhere. In this respect, some of the motivation or 'sexual decision making' is actually NOT making decisions - splitting, cutting off and being fatalistically pushed or pulled into relationships.

In some ways the fatalistic attitude and 'magical beliefs' such as the 'autonomous womb' concept (Birch 1988), whereby the womb is beyond conscious control and just 'gets pregnant', can be regarded as a 'part-object' use of the sexual organs, comparable with Krout Tabin's " .. the man's penis seems independent of his will". It is also important to consider motivation in terms of the relationship between the young girl and her boyfriend in that 'it takes two to tango' and one can no more regard the 'baby father' as 'just a penis', than regard the young mother as 'just a womb'.

Virginia Satir in "Conjoint Family Therapy" devotes a whole chapter to 'Low self esteem and mate selection' - although she is primarily writing about marriage partners, her ideas are none the less applicable to the 'selection' of a 'mate' for a teenager and the sort of difficulties that young people may find themselves in when establishing relationships, however transient, with the opposite sex. These factors

become even more important when the relationship results in the birth of an infant. Her premise is that those whose opinion of themselves is poor are dependant on what others think of them and present a 'false self' to the world (Winnicott 1960).

The false self is based upon identifying similar aspects in others and thus giving others the impression they want to have. Thus those with low self esteem are likely to form relationships with others having low self worth. "Each partner is deceived by the psychological defences of the other - that is by the false self the other presents to the world. At the same time each has fears of disappointment and difficulty in rusting others, including of course their respective mates". (Barker 1981)

Such a relationship, a meeting of two 'false selves' can result in neither partner having their emotional needs met by the relationship, indeed both will be unable to communicate their emotional needs to the other. In order to achieve this communication a certain maturity is required.

Satir described eight attributes of mature people which are necessary in order to achieve communication and fulfilment of emotional needs and which she believed could be enhanced in therapy. These attributes have all at some stage been described as wanting in adolescence and particularly in those teenagers who experiment in sexual activity at an early age and who, when pregnant, keep the baby.

The eight attributes are - 1. Fully in charge of their own selves; 2. Able to make decisions, based on accurate perception of self, others and in social context; 3. Able to acknowledge these choices and decisions as their own; 4. Able to accept responsibility for their outcome; 5. In touch with their own feelings; 6. Able to communicate clearly with others 7. Able to accept others as different from themselves 8. Willing to see such differences as a chance to learn, not as threats.

Those with low self esteem have remained at a stage prior to internalisation when self worth is dependant on outside opinion, in other words, relationships are formed with others who are seen as a source of self esteem. A low self worth can arise when early experiences leave an individual with exaggerated feelings of inadequacy, hostility and destructiveness (Dominian 1968) - certainly the case for young people seduced or forced into situations beyond their control those who are exploited and sexually abused, those who have endured the 'harmful' sexual experiences enumerated in this study.

A partner can be chosen for their imagined ability to 'make them good' (Lieberman "Forging a Marital Bond".) - the same can perhaps be said of the baby in early motherhood, who is also expected to 'make things good'.

Many adults in present society never reach the stage of ful-filling Satir's eight attributes of maturity, certainly most of the very young schoolgirls who 'decide' to keep their babies, viewing the world through the haze of 'red spectacles' have scarcely reached the stage of fulfilling even one - contrast the following conversation with Charmaine who was able to make a mature decision regarding her pregnancy - ("Are you my sister, Mummy" Birch 1987). In this case she decided to have an abortion, the decision itself is relatively

unimportant, it is the reasoning which shows her maturity.

* * * * *

Charmaine's older sister was typical of the young girl who becomes pregnant at a stage when she is physically developed but emotionally immature. She became pregnant at 16 and left school to have her baby. There was no question of her having an abortion. The situation was very different for Charmaine herself and when she became pregnant at 15 she decide she must have an abortion. She acknowledged that the decision was her responsibility alone and bravely waited until her sixteenth birthday before seeing a doctor.

" .... you see, it's different for me. I've got responsibilities. My sister's got her baby and we all love her. It was the right thing for her to keep her baby. My mum never expected anything more of her, she wasn't very good at school or anything and she wouldn't have got a job. I'm different, everyone has always had high hopes for me. I've done well at school, I've got the promise of a job. If I had a baby now, I'd be letting them all down, my mum, my brothers and sisters, my teachers .. everyone. And I'll let myself down. Later on I'd never forgive myself and I'd blame the baby. I might end up taking it out on the poor baby and that would be terrible because it wouldn't be it's fault. I wish I could have gone to a family planning clinic. I would have had the pill but I didn't want my mum to know. I didn't want to hurt her, knowing I was sleeping with my boyfriend, she would have felt let down. I couldn't go on my own because I wasn't 16. I wish I didn't have to have an abortion, I don't like the idea at all, but I know it's the right thing for me ..."

* * * * *

A certain maturity of abstract thinking and an ability to plan for the future is required in order to plan whether or not to become a mother.

Why does it seem that pregnancy is such a potent source of self value?

" ... Seen from the young girl's viewpoint, pregnancy may not be so undesirable. Certainly it brings heartache and hardship, the extent of which should not be under-estimated, but for under-priviledged girls with little education and non existant job prospects, motherhood is a fulfilment. With the birth of her baby a 'failed' school drop out, an unemployable misfit, becomes an acceptable member of society with a valued role - that of a mother. She is succesful and out of her love-less world she has created her own baby who will love her." (Birch 1989 "Progress in Obstetrics& Gynaecology vol7").

Why specifically is pregnancy used as a source of self value in deprived young girls rather than some other form of 'deviation' or non compliance with the norm of our society? It certainly seems to be a rather drastic way of coping with life's problems since "... changes in the body and mental representations of self, object and object relationships are bound to alter forever the pregnant woman's view of herself" (Pines 1972). Of course one can cite the usual social arguments relating to family patterns of early childbearing, allegiance to the idea of the'value'of motherhood the 'Madonna' image and identification with the counterculture of a particular teenage value system.

Another way of looking at this may be the application of the

idea of 'container and contained' (Bion 1970). It could be argued that while the pregnant girl is demonstrably, physically the 'container' of the 'contained' baby or foetus, she is at the same time identifying with the baby to such an extent that she has become the 'contained'. It is this containment which is sought by the child/mother who has lacked support, love and containment from her own mother and who is in turn depriving her own child of this 'containment' by userping his or her position in the womb.

In our deprived teenage mother or girl living in a world of abuse or 'survival sex'there is a primary need for recognition and love from mother and father which remained unfulfilled in childhood. The search for consistent affection via sexual encounters engenders a hope of "..symbolic fusion with mother, or more precisely with mother's breast and all it's inherent nourishing qualities" (Welldon "Mother, Madonna, Whore" 1988) - a hope which is dashed since this fusion is never found. "...the reassurance they need is not available from the outside so they try vicariously to manufacture it from within by means of pregnancy fantasies". These fantasies become concretised in real conceptions. ".. when insecure about their femininity they feel no longer able to fantisize about symbolisms attached to inner space; instead they use their bodies in a concrete way and become pregnant."

A clue to the mechanisms underlying the 'use' of pregnancy as a protector of self esteem lies in the part of the study which appeared to give no results. Attempts to score the recorded interviews with pregnant girls proved difficult in that statements were overwhelmingly recorded as 'neutral'. Girls remarks about their pregnancies and about themselves were devoid of emotion. As one pastoral care worker remarked "How can they sit and talk about all these awful things that have happened to them, having babies at 14, their boyfriends leaving them, problems at home, being thrown out of school, and just talking as if they were reading a shopping list!" This impression is quite forcibly conveyed by the clinical descriptions.

It appeared that these girls were, in their pregnancies, 'acting' in relation to their circumstances rather than maintaining a capacity to think and feel. In this sense, promiscuity and early pregnancy has been described as 'acting out' by authors who take the broader view of this term and thus include all manner of 'delinquent' behaviours (Bellack 1965). I would disagree with this definition in that these girls are in general not promiscuous or 'delinquent' in the usual sense of the terms - they are seeking pregnancy rather than sex and thus differ from the hysterics view of sexuality that "What I needed was to be loved and all I got out of it is to be whored" (Masud Khan "Hidden selves" 1983). They do not become 'whored' they become 'mothered' Moreover I would regard 'acting out' as being a particular manifestation of resistance within a therapy context (Freud 1905b) and not the appropriate term to use here.

Nevertheless girls were 'concretising' their emotions in the act of getting pregnant. Their feelings and thoughts were projected into an idealised 'self' - embodying their ideal of motherhood - and while they could hold onto their ideal self and identify

with it, they could feel good about themselves. "...in becoming a mother herself a process of identification with an 'ideal' mother occurs..the birth of this baby made her feel wanted from within.Despite their emotional deprivation and their inability to form a female ego-ideal, some of these women acheived the creation of a maternal ego-ideal" (Welldon) So deprived girls may be able to identify with an ego-ideal or ideal self as mothers butnot as young women or adolescents.

The problem is that this 'ideal self' is a false self and their mechanism for feeling good about themselves is a false solution which evaporates all too quickly as the harsh realities of their lives, often exacerbated by the birth of a child, become once more self evident. Here lies the message of the study. Pregnancy can be used by some deprived girls as a source of self worth and as a false solution to their problems. That being so, an alternative solution must be offered. These girls need an alternative source of self worth. They must be given a different way of valuing themselves in order to ensure that, when they become pregnant, this is because they desire parenthood with all its responsibilities, hardships and joys and not merely as the only perceived escape from a catalogue of problems.

Perhaps the solution to this dilemma lies in our education system, that in basing this on competition and a belief that an individual's worth is in ability to do well at school, we are 'setting up' deprived girls to fail. We are thus forcing them to seek an alternative way to succeed.

Adler made some very relevant comments on this. "..We generally find when children first come to school, they are more prepared for competition than for co-operation and the training in competition continues through their school days.This is a disaster for the child"At secondary school Adler did so badly at mathematics that the teacher advised that he should leave and become apprenticed to a cobbler, since he would obviously be fit for nothing better. "If my father had followed this advice .. I would probably have done a good job but I would have believed all my life that there is such a thing as having no gift for mathematics.Fortunately I found myself one day, to my own astonishment,able to complete a problem that had stumped my schoolmaster .. The success changed my whole attitude".

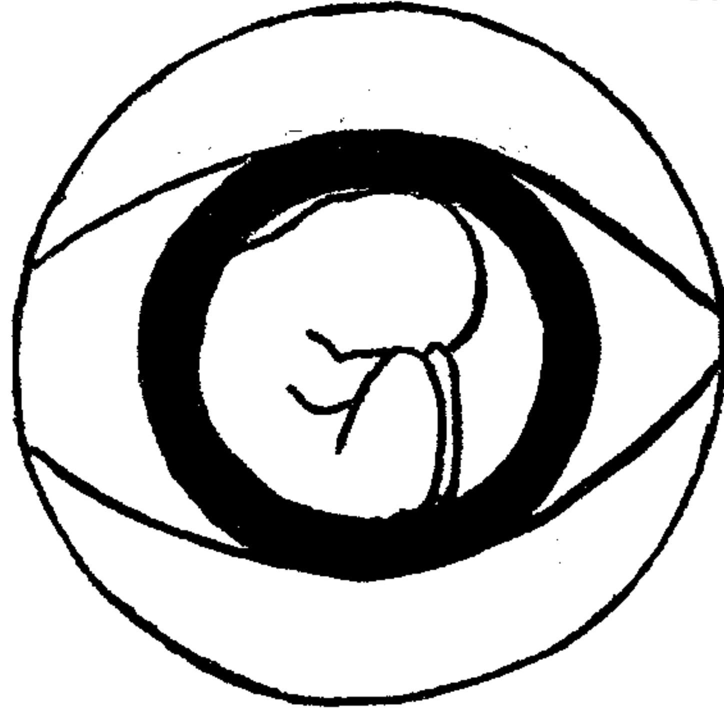
The idea of giving the child or teenager something to value and boosting self confidence and self esteem came across in this quote "His approach had something of the air of the kindly comrade who steps out of the circle of playmates to persuade back one who is moping in the corner.. with his sense of comradeship with the patient, there would be a rebellious twinkle in his eye which would make it seem as if he and the patient were in a conspiratorial league to outwit the pompous authorities of the world 'Let us show them what we can do!' he would often say and the patient would see him not as a solemn father confessor, but as a brother with whom it would be good to enter into the game".

For a wider version including references see 'Inner Worlds and Outer Challenges' (Youth Support Publications) Dr Diana Birch is an Honorary research Fellow at **St George's Hospital Medical School** and the above research was conducted with the help of the department of Psychotherapy.

INNER WORLDS AND OUTER CHALLENGES

INNER WORLDS AND OUTER CHALLENGES

Diana M. L. Birch



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

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

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

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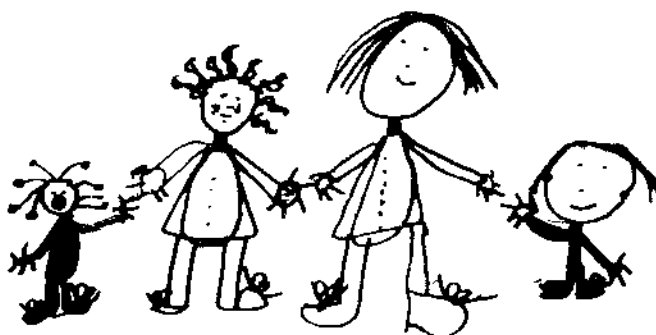

Encounters with Bernhardine - Munchausen syndrome in Adolescence - A case history. - Dr Diana Birch

"He who does not doubt,
Does not investigate.
And he who does not investigate,
Does not perceive.
And he who does not perceive,
Remains in blindness and error."
Al-Ghazali (1058-1111)

It is with this quote that Rutter and Herzov begin "Child and Adolescent Psychiatry". No quote could be more apt as applied to the investigation and diagnosis of 'Munchausen's' syndrome.

My first contact with Munchausen's was when, as a medical student I was coming to the end of a shift in the accident and emergency department at the Royal Free Hospital - an ambulance screeched up, siren wailing and we all waded in to deal with an acute collapse, possible coronary. As I pulled back the clothes to examine this middle aged man, I gasped in horror to see the criss-cross of scars covering his chest and abdomen. The casualty officer, newly arrived from University College Hospital, came up behind me and, rather unkindly I thought, pulled the oxygen mask from this unfortunate's face and said 'Not you again!' Apparently this fellow had a file a mile thick at UCH and had just been discharged after being confronted with the diagnosis of Munchausen's - he had done the same at several other hospitals and thought he was moving to pastures new.

We eventually, several hours later, managed to eject him - and I went to catch my bus home. Suddenly I became aware of a commotion in the street - A man had collapsed - he had a fit - call an ambulance! To this day I remember my embarrassment, trying to convince the 'well-meaning public' not to call an ambulance - 'please, there's nothing wrong with him, we've just discharged him!' - their looks were of incredulity and disgust at my lack of compassion.

Later, as a house officer, I was confronted with a female patient - a doctor's wife - who had recurrent unexplained fevers. Her blood cultures grew bizarre collections derived mainly by rubbing faeces in self inflicted wounds.

The eponym Munchausen's syndrome was applied by Asher (1951) to describe a syndrome characterised by dramatic presentation of physical complaints, pathological lying and wanderings from hospital to hospital. However, one of the most notorious cases 'The Godfather' who had hundreds of admissions was reported as early as 1939. (Stengel). Asher described three types - acute abdomen, haemorraghic, and neurological (fits and collapse) but subsequently a plethora of other presentations have come to light with symptomatology frequently mixed. (Bursten 1965, Birch 1951, Chapman 1957, Enoch and Trethowan 1980). The patients have been described as hospital addicts (Barker 1962).

Munchausen's has been classified as a hysterical personality type (DSM III) with depressive features and lack of clear personal identity. Attention seeking

behaviour with masochistic tendency resulting from a severely disordered personality. Many patients have been involved with the law in terms of petty theft and litigation against the medical profession is often threatened.

Interestingly, it was a legal issue which delayed the publication of one of the first reports of a mother using her child as an extension of her disordered self. The woman had exhibited Munchausen's for 16 years with admission to ten hospitals, fabricated diabetes in her two year old daughter and poisoned her five year old son with Promethazine to induce neurological symptoms. (Burman and Stevens 1977).

"... To find a name for this syndrome we sought the family history of Hieronymous Karl Frederich von Munchausen (1720-97). He married Jacobine von Dunten in 1744, but we can find no reference to any children in this marriage. Jacobine died in 1790 and Munchausen married the 17 year old Bernhardine Brun in 1794. In 1795 Bernhardine gave birth to Polle, who died a year later. As Bernhardine spent her wedding night dancing with another, the paternity of Polle must be suspect. We suggest ... such cases should be known as Polle syndrome - a child of a Munchausen whose life expectancy is liable to be short..."

It was in the previous week that Meadow published his first case reports and coined the term 'Munchausen by proxy' (Meadow 1977) - which formed the catalyst for collating reports which had appeared under varying headings. In the previous year six cases of poisonings in disturbed families were reported (Rogers 1976) and bizzare types of child abuse were understood to form part of this worrying illness. The most common presenting symptoms have been apnoea attacks and fits but fabricated illnesses have included Cushing's syndrome, bleeding from any orifice, repeated infections vomiting, deafness(Lee 1979; Kurlandsky 1979; Witt 1981; Hodge 1982; Waller 1983: Samuels and Southall 1992) My own experience has also involved broken glass added to a feeding bottle and ground tablets in infant food, salt induced hypernatraemic fits and suffocation with a pillow.

The mother or rarely father (Makar 1990) will appear close to the child, appear caring and cooperative with medical staff, be extremely clever and resourceful in deceipt and put on a show of wounded disbelief rising to overt threats of litigation when challenged. It is vitally important that staff support each other in this difficult diagnosis and keep the welfare of the child paramount when facing their own incredulity and wish to back off from what can be a very unpleasant situation. "The importance of maintaining a high degree of suspicion related to the warning signals cannot be overrated" (Mrazek and Mrazek 1991)

A number of authors have reported family disturbance whereby several siblings have been abused (Black 1981), some have died in unexplained circumstances, and Meadow has collated sibling mortality and morbidity (Meadow 1990; Bools, Neale and Meadow 1992). However for some time adult Munchausen's and

childhood 'Polle' were described as if discreet entities. It has been recognised that Polle's mother may have had Munchausen herself but the concept of a continuum in Munchausen is important and has been overlooked too long. We need to look at the Munchausen family dynamics and particularly - what happens to the adolescent?

Young people growing up in an atmosphere of deceipt are certainly prone to develop Munchausen's themselves and a number of authors have reported that children assist their mothers in deception. These unfortunate children are abused by their parents, abused by their doctors in over-investigation and inappropriate treatment - and finally abuse themselves.

Case History -

The following case illustrates a Munchausen family syndrome with **presentation in adolescence.**

* * * *

Kelly presented as a pregnant 14 year old who at the time had 'strong ulterior motives' for becoming pregnant. Pregnancy was in doubt until the results of an ultrasound scan was known since she had a 'pseudocyesis' two months before. She was a difficult, forceful girl - attention seeking and disruptive wherever she went. The family were under threat of legal action for school non attendance and Kelly thought her pregnancy would bring that to an end. Kelly gave a bizarre account of her pregnancy which became more elaborate each time I saw her and her mother forcefully added her embellishments to the story.

My suspicions were raised and on investigating the family history and collating all available information the following picture arose -

Birth -Described as difficult baby - 'mother had to fight hard to keep her alive'

Aged 8 - hospital for rectal bleeding (NAD)

ENT investigations - NAD

9 yrs Audiology ENT again NAD School complained regarding non attendance where upon complaints made against school - noise caused her deafness.

10yrs - welfare officer reports "for the past year I have been plagued by complaits of one medical disorder after another from this child". Mother insisted on keeping her off school.

11yrs earaches, ENT, hearing loss, gastric ulcers (none substantiated)

12 yrs -subject of CARE ORDER but left at home! - workers could not cope with mother.

13 yrs rectal bleeding, psychiatric referral, mal-adjusted school recommended - doctor states "Her mother's influence is certainly strong and can only be described as malignant"

All special help or attempts to remove girl or educate her met with stubborn opposition and more symptomatology. Her papers on education took nearly two years to complete "due to multiple problems within the family"

Family used multiple agencies and set one agency against another, caused dissention and invoked various complaints procedures. A psychologist stated "..Lengthy and widespread support has reinforced rather than modified mother's behaviour with consequent damage to the children who are constantly encouraged to view themselves as ill when this is not the case."

14 yrs - three important placements fell through due

to family manipulation. Kelly was being denied appropriate help. She has so far attended at least six hospitals. Kelly reported to be pregnant - not true. Pregnant 'again' - this time true. Varying stories regarding conception. 'Boyfriend' Mark said to be living in house with mother and said to have made both sisters pregnant. Later said to have got pregnant at a party and both sisters had sex and got pregnant with same boy on same night. Kelly reports she has a hole in the heart, deafness and gastric ulcers (not true).
15yrs - baby born - very demanding of medical attention but at same time refuting advice - took own discharge from hospital but then kept calling out doctor.
16yrs - during first year baby frequently at doctor or clinic - Several minor injuries and infections, moved flat three times, Seen in accident and emergency at 18 months - cut face, 19 months, cut mouth, 20 months fell onto glass cut face again.
17 yrs baby nearly two - grandmother is accusing Kelly of abusing child - child has attended four hospitals. Social worker has closed case.
18yrs flat vandalised, boyfriend Mark in prison, family moved away and untraceable.
Family History -
Mother - described as a very manipulative lady "her one delight is to fight authority whenever possible". She is wheelchair bound and can sometimes use crutches - but when I visited by the back door I found her walking normally and others reported hearing her run into the chair when the door bell rang. Constantly litigating, seeking compensation or threatening legal action. Decided to make a complaint regarding under age sex but the alleged perpetrator was openly living in her home and frequently seen pushing her wheelchair in public.
Father - A -real father left early on and divorced when Kelly was 5 years old. Said to be alcoholic and violent. **B-** Mother's second husband apparently lived with her before Kelly's birth and left when she was 12. Said to be a very violent man and to have thrown a fire bomb through the window of the previous flat. Two of the family's appartments have been burned out and it is generally thought that this was self inflicted by mother or Kelly with father blamed. This man and a friend of his are also accused of sexual abuse of Kelly and her sister but there is no evidence to support this claim. **C-** Mother has now established a relationship with a third man who she intends to move in with. He is the father of another pregnant teenager whose family background is similarly disturbed and enmeshed.
Brother - three years her junior. As baby had 'failure to thrive' and continued to have weight loss, insomnia, enuresis, psychological problems (aged 10) fainting attacks and fits (aged 12). None of these diagnoses were substantiated.
Sister - one year older. Multiple illnesses, ran away. At age 11 started to swallow glass, ball bearings and stones. She was referred for special schooling but the mother obstructed placement and like Kelly she also was placed on a care order which was never implemented due to mother's intimidating

authority. Age 14 - Pretended to have a grumbling appendix. Reported false pregnancy at age 15yrs, reported to have a termination of pregnancy at 15 (untrue), complained of sexual abuse - not substantiated.

* * * *

This family are illustrative of a number of features - falsification of a number of illnesses, use of many hospitals and many agencies to evade detection, frequent changes of address for the same reason. An enmeshed, disordered family with blurred interpersonal boundaries and transmission of Munchausen syndrome through three generations.

The reporting of illness and disastrous events is more than tinged with drama and excitement - the attention of many agencies is gained by exageration but they are not allowed to get close enough to see what is really happening. Many authors have commented on the need for professionals to work together in confronting Munchausen (Black et al 1991) and in family work this is of paramount importance. It is also important to realise that Munchausen is not only a 'medical' diagnosis.

The Munchausen family with it's 'hysterical personality' traits 'uses' the medical profession to gain attention for themselves or through their children - but it also 'uses' social services or police in the same way - by fabricating events and alleged abuses - for example, the fires caused by the family above, the reports of rape and sexual abuse. The legal system is also 'used' in making complaints which while serving to set up a smoke screen - also keep everyone dancing to the family's tune. Just as it is commonly remarked that Munchausen by proxy mothers have a little knowledge of medical matters (the ward clerk or a failed nursing student) so I believe do some families have a little knowledge of the other areas of involvement - such as the social services or the law. In this syndrome the adage 'A little knowledge is a dangerous thing' could not be more true.

Discussion -

The psychological aspects of Munchausen's render adolescents particularly vulnerable. Here we have a syndrome where there is an unclear definition of 'self' - something which all teenagers struggle with and which is particularly difficult for the pregnant teenager. Just as the Munchausen by proxy mother overidentifies with her child - so the young mother can subconciously desire motherhood in order to define her identity through her pregnancy.

Once that child is born - the only role model is that of the abusing Munchausen mother - so you please mother by being sick and identify and so understand mother by making your own child sick also. At the same time the fear grows that mother might abuse, kill or take away your baby - something which some girls are terrified of.

This same fear may lead some girls to terminate pregnancies - the ambivalence towards the child is also seen as ambivalence towards the pregnancy. Hence the stories of pregnancies, false pregnancies, terminations real and unreal. I have known of two disturbed girls who tried to end their pregnancies by inserting

foreign bodies into their cervix and this has been reported elsewhere (Goss McDougall 1992).

Certainly the teenagers mentioned here were abused physically and emotionally and deserve and require help to cope with that. Kelly was fairly certainly abused sexually also, even though she expressed her dilemma in a way which made it blend in with her fabrications. We are probably missing a number of cases of sexual abuse in these families where the boundary disturbance would lend itself to sexual taboos being broken.

The hysterical aspect of this illness also makes it hard to assess and treat. There are a number of cases where hysterical personality and abuse coexist leading to self abuse, cutting, overdosing without the connotations of full Munchausen.

I would argue that Munchausen in the adolescent can be seen as a perfect example of the abuse victim who is destined to becoming an abuser - but that if identified in the teenage mother, can be treated with support and help to overcome her own history of abuse. I am reminded that Polle's mother was actually a teenager - and we would do well to be alert to the cries for help of our Bernhardines. This is not a case for condemnation, but compassion and understanding. However such help can only be delivered in the context of a court order to protect the adolescent from family interference and sabotage of the treatment programme - and to protect the professional from spurious litigation.

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