Journal of Adolescent Health and Welfare

Volume 8 - No 2 - Summer 1995

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

- Letter from the editor -

Dear Colleagues,

Working with young people we can sometimes fall into the same trap that they do in terms of believing in their invincibility. It is therefore always a shock when a young patient dies. Kelly had a short life of hardship, neglect and abuse. During her stay with us at Youth Support House she struggled bravely with her addiction to lighter fuel and attempted to heal some of her pain. Sadly she died of cardiac failure precipitated by solvent use. She cared deeply for her little baby, Joshua and tried hard to be a good mother to him. We all miss her jokes and wicked humour! At Youth Support House we have made a 'quiet garden' where residents and staff can sit and remember absent friends. Kelly's garden was mainly funded by a generous donation from John McCarthy, who spent several years as a hostage in Beirut and can thus empathise with the abuse and torture suffered by many of our residents. Kelly and Joshua figure on the cover of this edition. We intend that a copy should be included in Joshua's folder which will accompany him to his adoptive home so that he will know that his mother loved him.

This year we have our tenth forum meeting at the RSM in October and are planning our tenth anniversary celebrations for 1996-do join us!

Best wishes,

Diana Birch
Director Youth Support

Contents

Youth Support Forum on Adolescent Health and Welfare
Tenth Annual Meeting
at the Royal Society of Medicine 1, Wimpole Street London WC1
Wednesday 18th October 1995 at 6-9pm

"Working with Youth - Ten Year's progress"

Subject matter includes - The scope of Youth Support's work School age pregnancy - advances and trends. Self Esteem - Can we achieve change? Bonds and Boundaries in Child protection.

I would like to attend the Tenth Annual Meeting of the Youth Support Forum on Adolescent Health and Welfare at the Royal Society of Medicine on Wednesday 18th October.....

I will bring ..... guests.
I am a Forum member ..... (attendance free + guests free)
I would like to join the forum and enclose £20 annual fee.
I am not a member and enclose fee of £5 per person for attendance - total .....
Name ..... Designation .....

Address ..... Tel no .....
..... (Admission free to students and
..... young people under 21)

***Comment* - Youth and Violence -**

The last issue of the journal dealt with the topic of 'Youth and Violence' as discussed at our 1993 Forum meeting at the Royal Society of medicine. It engendered a wide response. Articles on the subject have appeared in a number of journals over the past year and this does unfortunately appear to be one of our 'growth areas'. In view of this general concern I felt it worthwhile to reproduce here a comment which was originally included in the newsletter of SAM the Society for Adolescent Medicine, relating to an incident which took place in our residential unit last summer. The incident made me reach an unwelcome milestone - for the first time in my career I had to use a Judo technique on one of my patients. Of course I didn't hurt him, but I normally pride myself on my 'hands off' psycho-therapeutic approach - however when you have a scenario of a young girl (his sister) being kicked near senseless, a nurse being laid into and two other staff powerless to stop him 'hadakajime' (a hold from behind which can be tightened into a strangle) was very effective. The police were impressed, but I was not. Ian has witnessed too much violence in his life and I did not want such scenarios to be replayed in our unit.

Ian and his family had been with us for three weeks, on a residential assessment and rehabilitation programme.I did not hold high hopes for success - what do you do when you are presented with a boy who was rejected at birth by a mother who had been so abused herself that she hated the thought of having a male child who could grow up to be an abuser; who regularly witnessed and received beatings from two alcoholic stepfathers; who was abused in children's homes; who ran away and was buggered on the street and who then came back 'home' to be further abused by his teenage uncle ... and so it goes on. All we can really do is continue to pour in unconditional love and affirmation - but is that enough? Such a boy is aching to have that from his mother - and that he can probably never have.

Some hours after the incident I was able to talk to Ian - a very likeable boy - I also examined him as part of a routine check and discovered that he had been beaten prior to his outburst by his mother. Violence is the most stable and immutable behaviour pattern for transmission between generations - nothing perpetuates like violence. This is what worries me when I hear of programmes to reduce teenage violence like "Removing antisocial elements and providing psychological counselling" ... or the Texas idea of group therapy in schools ".. to instil the concept of remorse in teenage criminals". ("The Deadliest Year Yet" David Ellis - Time January 13 1992) Well intentioned, but perhaps too late?

Another of our residents had a threatening telephone call saying that a teenage gang were 'coming to get her' and that they had a gun. I was able to dismiss that as an empty threat - so far our gangs in London are unarmed. We get bricks through windows, eggs on the ceiling, the odd condom water bomb thrown at the front door - but no bullets! But it did set me thinking about how different I would be feeling if I practised in the United States?.

Our gun laws are fortunately tight but we are usually just a little behind in the development of teen cultures. We have not yet reached the stage of it being ".. a rite of passage that you must

go to prison", but we have certainly seen a tremendous rise in violence on a general level. We decided to make violence and youth the subject of our 1993 scientific meeting at the Royal Society of Medicine with psychiatrists, social workers, physicians, teachers and politicians contributing to the debate. Our government is getting increasingly worried about youth crime and is planning special juvenile detention centres - a step forward or a leap into the past?.

Looking for ideas to put forward, I was interested to read "Deadly Consequences - How Violence is destroying our teenage population and a plan to begin solving the problem" by Deborah Prothrow-Stith (Harvard School of Public Health). She describes a developmental model, Kohlberg's theory, which she reduces to three stages. In stage 1 - the Punishment stage (age 5-10) children view relationships in terms of fear and punishment - victims deserve what they get. Violence is on an individual level. She believes that the teenage offender is stuck in this phase.

Stage 2 is the 'fairness stage' - (10-16?) when there is concern for others, Youth are enraged by unfairness - leading to revenge, gangs, and thinking relates to group level. What we need to work for is the development of Stage 3 - moral reasoning, the 'safe zone' when they can see beyond themselves and understand moral and legal contexts and relate to a community of which they can be part.

I find this model useful - but surely we are still stuck with the fact that children learn about individuals, about groups and about the community at large 'at their mother's knee'. The family is the basic group and when the family is disorganised and brutal, when there is no love in your 'community' then the future is bleak. That's why today I will hold another group session with my 'hurt children' recreating a family where they can find positive 'strokes' .. and that is why tomorrow we will go through a psychodrama with Ian's mother enacting the birth of a wanted, loved child. *Family work is hard, ... living with the results of not doing it is harder.*

New Stress Assessment Programme Hits Youth Support!

One of our resident fathers was referred for investigation of 'concealed anger'. It was thought he was liable to become agressive and dangerous under stress. He in fact gave every impression of being a quiet, equable, sensitive person - how could this be tested out? A gale force wind brought the answer - at the end of a very stressful week, the tree at the front of Youth Support House blew over and crushed his car .. did he react violently? .. NO! We had our answer.

Youth Support House

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(24 HOUR–FAX

"Bonds and Boundaries"

- Child Protection and The Family -

Diana M. L. Birch

* * * * * * *

To work in the field of child protection and particularly when it involves assessment of a family and possible rehabilitation is an area fraught with difficulties.

All families have problems of one degree or another. All children make their parents angry at times, most toddlers have tantrums, 'normal' married couples have blazing rows, children will compete with each other for attention and little girls do have crushes on their fathers and get jealous of their mothers. Where do we draw the line, the boundary between what is acceptable and what is harmful, abusive and requires professional intervention?

And if we do intervene - how can we be sure that our intervention is helpful and does not in itself cause more harm than good?

The needs of the individual are not necessarily compatible with the needs of the group - in this case the family - and weighing up these needs and placing them in some order of priority can be nigh on impossible. It requires empathy and sensitivity - but most of all a high degree of professionalism.

Subject matter includes: Rehabilitation and The Family - Working with Families - Bonding, Separation and the Rehabilitation process - Results of Rehabilitation including outcomes of our experience at Youth Support - Disordered Family Structures.

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- International Chapter News -

The **International Regional Chapter (IRC)** of SAM (Society for Adolescent Medicine) held various events at the **1995 SAM meeting in Vancouver**. Our **International dinner** was very successful and hosted the largest turnout yet with eighty participants! The venue, the Prow restaurant was fantastic with sweeping view across the water in central Vancouver. The restaurant staff are very much to be thanked and congratulated for the way they adapted to our invasion! A room had originally been booked for 30 people and numbers were updated on a daily basis - finally the whole of the main floor was turned over to us. - Numbers have been increasing gradually over the last few years and it is great to see how many US members of SAM are attending our dinners and workshops - Can we top 80 next year!
Of course the scope of the Vancouver meeting was somewhat different since the week began with the **IAAH international symposium** and merged into the SAM meeting with an overlap day devoted to **Multicultural issues in Adolescent Health** care. I have attempted to include snippets of these meetings in the following pages but the scope and multiplicity of subject matter and speakers make that an impossible task. **SAM chapter representatives** held their usual workshop at which I represented the IRC and it was heartening to hear how supportive the chapters were of the international chapter and how emphatically they conveyed the message to SAM that they wished us to continue as a chapter.
The **SAM meeting 1996** will be in Arlington Virginia - close to Washington and site of the military cemetery. This is obviously a convenient site for US members wishing to be at the hub of the Washington lobbying scene but perhaps not such an attractive venue for international members. We should therefore perhaps concentrate our efforts next year on showcasing our international views and experiences for the US members rather than 'networking' between ourselves. This seems to be rather the trend in the workshop recently anyway - last year the US attenders outnumbered the international and this year it was very much a case of almost the whole audience being USA based.
The 1995 workshop was entitled **"Incest, where are the boundaries?"** and the content of that session is described below. The workshop was interactive with contributions from Gustavo Girard; Elaine Yordan and Diana Birch. Ideas for the **1996 workshop** are not refined as yet and we would very much appreciate ideas and volunteers to contribute. The SAM theme is going to centre on "Assuring Quality health care for Adolescents". I would like to suggest that we make our workshop quite clinically oriented with **presentations of cases** illustrating how each contributor managed the case and commenting on the level of health care available to such cases in their country.
The IRC officers for the present continue as before with Gustavo Girard and Diana Birch as co-chairs and Aric Schichor as treasurer. Please bombard us with ideas for future meetings! Please send chapter dues to Aric and encourage colleagues to join.
Enquiries to - Gustavo Girard - (Argentina) - Fax 54 1802 6962
Diana Birch - (England) - Fax 44 181 659 3309
Aric Schichor - (USA) - Fax 203 548 5439

"Incest - Where are the Boundaries?"

- An International Perspective on Sexual abuse of teenagers.-

Sexual abuse can be looked at as a boundary issue - but where are the boundaries? Who sets the limits? Do our boundaries vary across international borders? This workshop focused on the difficult area of sexual abuse of teenagers, including incest and sexual abuse within the family. Contributions covered experiences in a variety of cultures and highlighted varying approaches to the subject. This included differences in perception of what constitutes abuse, legal issues and management of cases.

Warm up Interactive Exercise

'Boundaries Game'*

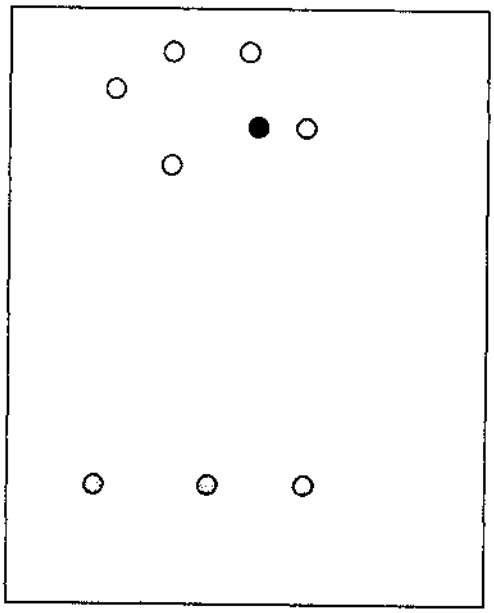
The 'boundaries game' is an exercise which was devised for use at Youth Support in London for exploration of family structure and boundaries. It is a very simple tool which can give a lot of information regarding disordered boundaries and dysfunctional families in a short time period, without overtaxing the patient and which is easy to use with patients who have problems with literacy and communication.
Each member of the group is given a number of coloured sticky dots and two sheets of white paper. They are asked to place a red dot on the paper to represent themselves, they then can add blue dots to represent family members and finally are asked to place green dots to represent friends. The first sheet is configured to represent early childhood relationships and on the second sheet they are asked to show what life is like now.
Workshop participants were invited to try the game as a warm up exercise in order to focus their thoughts on bonds and boundaries within their own families or to imagine what the situation would be for one of their patients.
The following examples were discussed -

A. 'Debbie' - A socially isolated young woman with virtually no bonds.

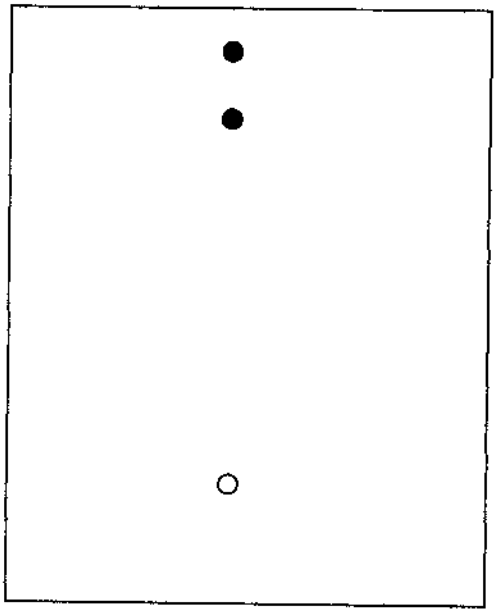
Debbie - Early life
Family rejected her, they were depicted as almost off the paper one sister was closer.At boarding school teachers were her substitute family. Family life was boundaryless with step father sexually abusing her at age 8 after which she became disturbed and institutionalised at an early age.
No containment - No close bond.

Debbie - Adult Life
Alone, socially isolated. Childbearing from early age to fill void and provide focus for attention. Dot for newborn daughter who she colours in same as self -symbiotic relationship. Only other dot is her social worker.

Debbie - Early life



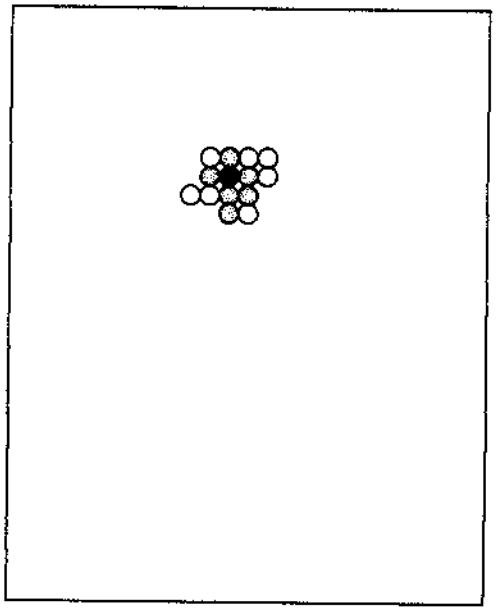
Debbie - Adult Life



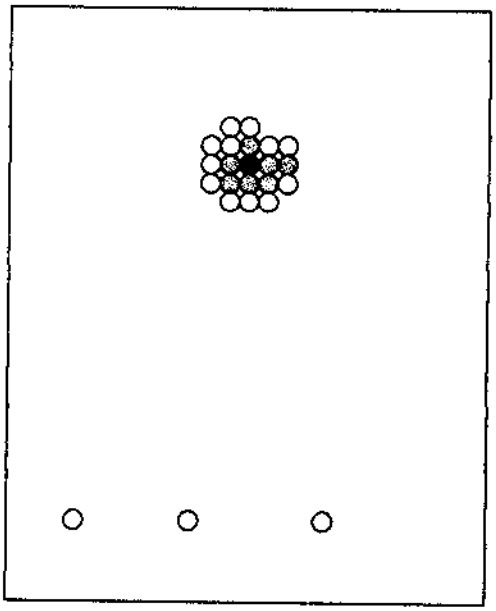
B. 'Gerry' - a very controlling person with psychopathic features. His baby daughter sustained life threatening injuries.
Early life - enmeshment - family members engulfing him. Friends closely adherent. No individuation - everyone overlaps.

Adult life - Extreme enmeshment - almost centrifugal force - tremendous control and power. Not allowing anyone within his sphere to be individuals. No clear idea of self - abused daughter not defined. Three separate dots represent threats- people he wanted to 'get rid of' police, social services, doctor.

Gerry - Early life



Gerry - Adult life



● Self (red)
◎ Family (blue)
○ Friends (Green)

Boundaries, Enmeshment and Identity - Diana Birch

The following case study was presented and used as a focus for discussions of principles of boundaries and identity.

> ..... In the end she set fire to the place.
>
> I had said that she would sabotage herself - but I drew no solace from that as the children wiped tears across their soot streaked faces with blackened blistered hands -
>
> "Why, Mummy, ... why??".
>
> The air stank of smoke and the sort of acrid, cloying smell that pervades from a wet, smouldering dustbin. It seemed to cling to everything and brought with it a sense of despair - an unhappy but somehow inevitable ending. A shivering, pathetic group that could have been a family, huddling against the melted black plastic bin liners holding their last few possessions.
>
> Had I misjudged the situation? Had I underestimated her degree of disturbance?
>
> No - not really. I had known how difficult our task would be - but I wanted her to succeed - she deserved our putting in every last effort to reach her - giving her every last chance to respond. With more resources, more time to work - who knows? But sadly time was not on our side and she knew it.
>
> Unable to face the uncertainty of waiting for the result of the final court hearing, she found a certain security in precipitating the outcome. She found a way of saying - "Here you are, you were right all the time. Stop making me jump through hoops for you. I'm not a fit mother, I'm not worth bothering with. Just get on with it and take my kids away".

Difficulty of establishing an identity.

If you are unclear about your own personal identity you have no clear boundaries of your psychic space - where does your identity end and another's begin? You cannot 'bond' with others or with your children if you are symbiotically linked with them. You cannot bond without first separating.

Separation / individuation results in 'this is me'. - Hence 'you are not me' - leading to 'I can be close to you and care for you if I want to'.

Disordered boundaries have long been recognised as symptomatic of a number of 'abuse' situations - particularly when boundaries are ill defined between members of a disorganised family. This is the classic scenario when sexual abuse may occur - family roles are ill defined, and normal taboos and codes of behaviour are obscured. In such a situation the distinction between having sexual relations with your wife and your daughter - or with your girlfriend and her child is blurred.

In that case it is the family identity which is unclear and individuals are lost within the fused structure. On an individual basis however, the damage to the ego can be quite catastrophic.

How can a child brought up within a disordered fused family mass operate when separated from this - albeit disturbed part of herself? A child 'plucked' from such a situation, without adequate, intensive help, will be forever searching for the missing parts of her 'self'.

Such is Caroline's lot - removed from home at an early age, bereft of love and understanding, she

has very little concept of 'self'. Her identity seems one empty void ready to soak up the pathology and behaviour patterns of others like a sponge. She has a craving need to associate with disturbed individuals who both represent and allow her to achieve some measure of usurped closeness with those original family members whom she 'lost'.

Her misfortune is that her 'lost family' were so harmful to her. A hated father who was violent, drank to excess, mistreated her and rejected her and finally acquired a 'girlfriend' younger than his daughter who he had sex with openly in the family home in front of his children. A mother who had not one ounce of mothering in her, who rejected Caroline, had several violent relationships resulting in children she could not care for. Who was an alcoholic and drug user and who expected her daughter to care for younger siblings - even after she had four children of her own.

Caroline became torn between being the 'good mother' that she never had - trying in every situation to care for those around her - despite her obvious inability to do so effectively - and being or associating with the 'bad mother' in an attempt to understand her own. The end result was that rather than become a mother - she in fact became a needy child - in a family which she created herself. Repeated pregnancies resulting in four delightful children - who became her siblings - while the eldest child at six years of age, became 'mother' to them all.

This little mother was quite unable to protect her errant 'child/ mother' from her continuing self destructive relationships. Each 'hurt child', delinquent and disturbed young boy or girl who came within Caroline's sphere were 'absorbed' as part of her deficient ego.

The most damaging personalities however were those where substance abuse and self destructive behaviour was a prominent feature. Caroline completely identified with such disorder - mimicking their behaviour patterns and attempting to almost entirely assume their personalities. This resulted in Caroline's attending Alcoholics anonymous and 'confessing' to being an alcoholic - when she hardly ever drank - and the most serious event of all - setting fire to her flat in order to identify with her closest 'friend', Dora who had survived an arson attack by her incestuous father. He had tried to kill the family but died himself in the blaze when she disclosed - and so ended - their relationship.

Caroline's first attempt at arson coincided with Dora wishing to break away from her and her second with a final separation. During the first she was on the telephone to Dora throughout the advent of fire-engines and police - having to be forcibly removed from the phone to answer questions. Prior to the second, more serious incident her children remarked - 'We're going to be on television, like Dora'. A prominent feature of Caroline's behaviour during such episodes is her total absence of appropriate affect. No emotion, no remorse, almost one would say, no involvement. Complete detachment from the consequences of her actions. But - of course ....

...if you do not know who you are
- how do you know what you are doing?

[The above case study is taken from "Bonds and Boundaries" - Child Protection and The Family - Published by Youth Support - ISBN : 1 870717 05 8]

THE SEXUAL ABUSE OF ADOLESCENTS IN THE UNITED STATES

Elaine Yordan - University of Connecticut School of Medicine

In the United States the topic of sexual abuse has become an issue of prime importance in adolescent medicine. Victimisation can occur at any age - often it is not until the victim develops the independence of adolescence that he or she has the courage to disclose a situation that may have begun many years earlier. When dealing with the issue of sexual abuse, I prefer to define adolescent females in terms of pubertal development. Sexual abuse can be any form of sexual activity where the perpetrator takes advantage of the adolescent's vulnerable stage of psychological development. Sexual abuse can involve physical contact and can also exist without physical contact.

Physical contact: touching the sexual areas of a victim's body including genital and anal regions, breasts or the victim touching sexual regions on the perpetrator's body; penetration of the vagina, mouth or anus by a penis, finger or foreign object; fondling the sexual areas of a victim's body, sexual kissing, or having a victim touch the sexual parts of the perpetrator's body.

Non-physical contact: exhibitionism, voyeurism and pornography. Verbal sexual propositions are considered to be sexual activities as well.

Abusive: When the perpetrator has a large age or maturational advantage over the victim, position of authority over the adolescent or a care giver relationship; carried out against the victim's will or by the use of force or deception.
In the United States the National Committee to Prevent Child Abuse reports for 1993 that there wee 150,000 substantiated cases of sexual abuse of persons under the age of 18 years.

A federally funded project, The National Incidence Study of Child Abuse and Neglect, demonstrated that between 1980 and 1986 cases of sexual abuse known to professionals grew more than 17% each year for a total of 166%.

Surveys of adults concerning their experiences as children and adolescents probably provide the most complete estimates of the actual extent of child sexual abuse in the United States. As a result of this type of research there is considerable accumulated data to suggest that at least 20% of American women and 5% to 10% of American men experienced some form of sexual abuse as children or adolescents. Estimates of child and adolescent sexual abuse involving penetrative acts range from 25% to as high as 50% of cases.

Abusers can be classified by their relationship to the victim into 3 categories: family members, acquaintances or strangers. in the United States sexual abuse is committed primarily by individuals known to the victim. Who are the victims of abuse? Although there are no clear cut markers, girls between ages of 7 to 13 are considered in a generalised way to be the group most at risk of being the victims of sexual abusers. About one third of all victims are boys.

Socio-economic class status does not seem to be a strong factor to place an adolescent at risk for sexual abuse. The risk factors that do show up most consistently

in epidemiological studies are those elements of the adolescent's environment related to parental inadequacy, unavailability, conflict and a poor parent-child relationship. Those with alcoholic or drug abusing and emotionally unstable parents are also at risk as are those with parents who are punitive or distant. These factors appear to increase the adolescent's risk for sexual abuse in two ways. First, they decrease the quality and quantity of supervision and protection that the adolescents receive. Second, they produce needy, emotionally deprived individuals who are vulnerable to the ploys of physical sexual abusers who commonly entrap them by offering attention,affection and friendship.

In the United States in 1963 the State of California enacted the country's first child abuse reporting law. By 1967 every state in the nation had followed suit. All medical professionals are required under state law to report suspected cases of child sexual abuse. In 1985, The American Academy of Paediatrics established its committee on child abuse and neglect. In 1991, the committee published its Guidelines for the Evaluation of Sexual Abuse of Children for use by primary care paediatricians. In 1992, the American Medical Association published the AMA Diagnostic and Treatment Guidelines on Child Sexual Abuse. In 1987 the American Professional Society on the Abuse of Children was established joining child protective service workers, therapists,law enforcers attorneys and others.

Because the consequences of child sexual abuse vary so widely in severity in duration and in form it is unlikely that a single treatment program exists that is uniquely suited to all victimised populations.

It is not sufficient to merely tell a child to resist inappropriate sexual interaction; as an effective intervention system should also address the conditions that lead an adult to consider the use of adolescents for sexual gratification and should strengthen the environmental elements that discourage abuse.

Currently,sexual abuse prevention is virtually synonymous with group based instruction for children and adolescents on personal safety. However,despite the laudable goals of universal primary prevention many have questioned its utility in reducing sexual abuse rates. To date no rigorous scientific work has been completed examining the degree to which the accomplishment of these programs to improve the adolescent's ability to recognise and respond to threatening situations has led to a real decrease in the rate of sexual abuse. These programs offer an individual an opportunity to reach out for help thereby preventing continued abuse.

The general public must be made aware that child sexual abuse, like all forms of maltreatment, is everyone's responsibility an everyone's problem. Beyond increasing the public's recognition of the problem we must change the social environment that allows child sexual abuse to flourish.

Reference:-The David and Lucile Packard Foundation. Sexual abuse of children. The future of Children. 1994' 4(2)

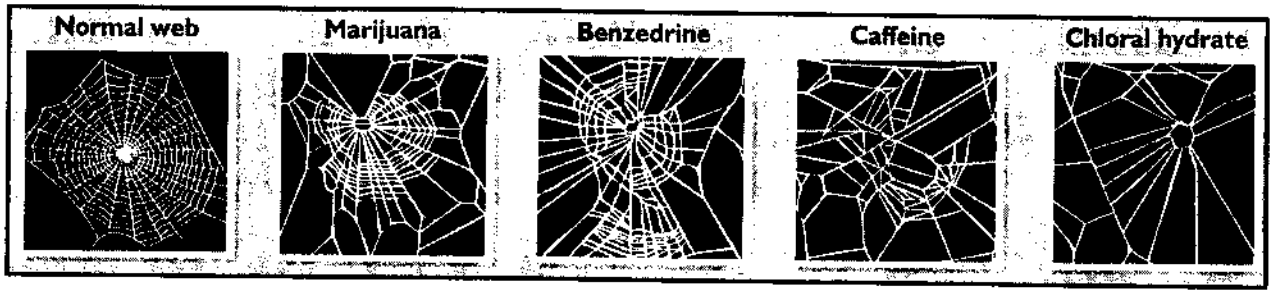
"Heterosexual abuse in Adolescent Males, Cultural differences"

- Gustavo Girard - Argentina

Gustavo Girard gave a very interesting presentation to the IRC workshop. He presented two cases of young men who had been sexually abused by older women. The concept was an important one and something which is easily forgotten - we speak often of female sexual abuse by male perpetrators and less often perhaps of male abuse by male homosexual prepetrators - but the heterosexual abuse of males is seldom discussed. The premise is that in Latin American cultures - where the male is 'macho' strong and in control - there is little room for the concept of the male being 'out of control' and abused within a heterosexual relationship. It is hoped that the entire text of the case histories will be printed in our next edition but perhaps we should pause here for reflection.
Is the situation much the same in other cultures? and do we make provision for such young men to come forward for help? In Britain such cases are more likely to come to light via the tabloid press rather than in a counselling or medical setting. Each year a number of scandals are reported in the popular press of boys seduced by their teachers or by the mothers of their friends - this is often 'covered up' by the boy in a desperate bravado attempting to give the impression that he sought the relationship and is a 'real man' having an affair with an older woman. The film the graduate made comedy out of the seduction of a college boy by the mother of his girlfriend - is this really how we feel about the situation? How would it be if the boy was a little younger - would it still be funny? In reality the woman is often inadequate, dependant and manipulative at best and frankly abusive at worst. Society conspires to shy away from these difficult scenarios - is it not time we protected our young males?

A-CRACK-NOPHOBIA

Seen in the newspapers recently an article titled *acracknophobia* relating to the fact that NASA has been testing drugs on spiders and found that their web characteristics change ..... just wondered if we should be monitoring the shape of spider webs in Youth Support House when we are checking on smuggled drugs??!



USING DRAMA IN THE HEALING PROCESS

This formed the basis of a workshop in the IAAH symposium in Vancouver. Peter Chown and Julia Tressider from Sydney contributed a story telling exercise which they have used with teenagers in Australia. The 'Youth Support' contribution consisted of a series of videotape segments illustrating an ascending level of psychodramatic intervention - role play ; using a 'story'(Cinderella) and changing the outcome; using a real situation and changing the outcome; 'Magic shop' ending. Many thanks to the young people who contributed even though unable to be in Vancouver themselves. Thanks also to Alistair and Leon for producing the 'Rapid Tour' video of Youth Support House. Which was shown at the start of the IRC workshop.

The nature of psychodrama

Psychodrama, according to J.L. Moreno, was born in the "Viennese cradle" in April 1921 as the "Theatre of spontaneity" (Moreno, 1946.) Moreno had experimented with group analysis in 1921 when he placed the group of couches in a circle and tried free association. This produced a disordered mix of individual associations which did not gel together. He believed that psychodrama was essentially a group process, and that the group and the individual are never really separable except by artificially ignoring the one or the other. (Davies, 1987). His idea was that psychodrama was, in some way, the antithesis of psychoanalysis and reported saying to Freud "You analyse their dreams, I give them courage to dream again. His ideas were going against the current flow of thought at that time, counter to the 'fear of neuroses' which he felt prevailed in Vienna. "After purging nature (Darwin) and society (Marx) from creative cosmic forces the final step was the purging of genius by psychoanalysis".

The Italian Comedy form "La Commedia Dell'Arte" provided Moreno with a model of a semi-spontaneous drama whereby the roles of Arlecchino, the Carabiniere etc. are fixed but the dialogue is improvised. Moreno used roles to "enter the unconscious from the social world to bring shape and order into it". By allowing actor and later the general public to enact roles without a script their own subconscious world was brought to life on the stage.

Aristotle (c.350 B.C.) provided the model for catharsis in theatre "A tragedy is filled with incidents arousing pity and fear wherewith to accomplish catharsis of such emotions". Breuer used hypnosis to recall feelings from unconsciousness to produce a catharsis. In psychodrama, however, we see catharsis in action.

Using Drama with young people

The classic format for psycho-dramatic intervention involves use of warm up sessions during which the protagonist is chosen; a great deal of emphasis is then placed on this particular protagonist who undergoes an interview and contract forming as regards what he or she wishes to get out of the session; thereby setting the scene and moving from one scene into another. The scenes are generally linked by a theme and often the contact becomes more and more poignant and challenging as one moves from perhaps an initial low-impact, less

threatening general theme, to a highly threatening and very intense emotional scene during which a great deal of catharsis of emotions takes place. During this part of the psychodrama the members who are playing roles or doubling for the protagonist are very much expected to be a carte blanche on which the experiences and feelings of the protagonist can be painted; in other words - it is the protagonist who puts the words in her mouth and, with the help of the director organising the scene, all the emphasis is on the protagonist. The psychodrama may focus on this same person over the space of one or two hours, or even longer.

In working with young people it is often not possible to keep within the formal format. Very often some blurring occurs between the protagonist and the accessory ego, or people who are playing other roles. Many of the young people we work with have experienced similar backgrounds of abuse and deprivation, and it is thus very hard for somebody who is playing, say, the role of the protagonist's mother not to bring into this role aspects of her own mothering. This is something which is deliberately avoided by the Director in classic psychodrama, but something which we can work with when dealing with young people.

Similarly, with our particular drama group, it is often impossible to hone in on one group member for long periods of time. We also need to avoid some of these more intense cathartic moments that can be engineered in classic psychodrama. The depth of hurt and pain which can be brought out very quickly in some of our young people is too much to be dealt with and contained within our kind of group.

In view of these features, drama work with abused and young people has to take a lighter level. We use a great deal of warm up sessions and games which help break the ice and help give young people confidence to be able to open their mouths and speak in company of others. Even a simple game such as I Spy to begin with has value. Other techniques to use involve role play in varying situations. As these people start on a fictitious level, i.e. a less threatening level, they then work towards an event that has actually happened either within the unit or in the patient's background. Fairy stories also form a fertile ground for psychodrama in that we can pretend that a character in a fairy story is our protagonist and work on their stories in parallel to our own.

Psychodrama is par excellence a group activity. Moreno was in fact the first exponent of group psychotherapy. Thus, although at first sight it might appear that the protagonist is playing out his or her situation alone, the group issues are extremely important and are seen to influence the choice of double accessory egos as well as the flow of the drama. Within a residential unit such as ours these features tend to come to the fore. Our clients live together, and re-enact group / family dynamics on a day-to-day basis. These can then be brought out within the drama.

Moreno is credited with the remark: "Don't tell me, show me". In the drama the protagonist is showing the group how he feels and relates to the world. The protagonist is bringing his or

her inner world onto the stage, and it is left to the rest of the group to pick up words, phrases and gestures of significance and amplify such points in directing the action. The transference and counter-transference issues come alive and form an integral part of the drama.

Young people who have been hurt, abused and deprived often have enormous problems in communication. Hence classic psychodynamic psychotherapy can be difficult in this group. Young people can be very creative and need different avenues in which to express their feelings and emotions. At Youth Support we use Art therapy, Movement therapy, Drama therapy and these different vehicles maybe more acceptable to one person than another, but do allow different ways of expression. The importance of drama is that we can play. Winnecott said that therapy occurs in the overlap of the play space between the therapist and the patient. This is particularly true with young people. Deprived youths have often not been allowed to be children and to play - they have often had to be little adults in childhood and have not been allowed to enjoy themselves or express themselves. Playing can often be difficult but it is an extremely valuable tool in the healing process. Games such as the Magic Shop Workshop , with which we often finish a session, bring people very much into the child ego state; in other words, it helps to bring us into contact with our inner child which carries our hurt and pain, and which needs to be nurtured, contained and loved in the healing process.

References

1 Aristotle "De Poetica" Aristotle and the Art of Poetry, Bywater 1909
2 Breur & Freud, "Studies in Hysteria" 1895
3 Davies M.H.,"Drama Therapy & Psychodrama in Drama Therapy" Jennings Croome Hill 1987

Indonesia has many different attitudes to health and disease. The culture takes a lot of understanding as it is so different from the West. People are encouraged to have two children only; there are signs in the streets saying that two children is best. The religion influences the attitudes. There tends to be a passive acceptance of illness as sent by Allah. But the people live in the present, rather than being concerned about past or future. They are very happy people, always smiling, although they are very poor. Indonesians take great pride in their children and care for the family. If one person is in work he buys shoes etc. for parents, children, aunts, uncles and all the extended family.

People in dominant cultures probably do not tend to spend time and trouble in understanding nondominant cultures.

I didn't learn the language so there were many issues which I didn't get to grips with

(MAGGIE)

Multicultural Issues in Adolescent Health Care

This very important subject was the stimulus for a whole day joint IAAH/SAM workshop in Vancouver. Contributions were many and varied - an interesting collection of comparisons of health measures, disease concepts and service provision in varying cultures; but perhaps leaving one ultimately more than a little perplexed as to 'where do we go from here?'This is a subject that I had pondered over for some years - from the personal viewpoint I knew how it felt to be 'between' worlds in cultural terms - brought up in England but with Italian family. Some of my experiences are echoed in the contributions below. I have also attempted at intervals to raise the issue of culture with staff and residents in our unit (see workshop results below). Nevertheless making concrete and useful changes rather than debate issues is difficult.

One inherent difficulty lies in the fact that cultures change - there tends to be a drift towards others norms - particularly in the adolescent sphere where life moves fast, boundaries are shifted and 'cultures' are exposed to American films and media heroes. Many of the 'cultures' which I have studied have been subject to this movement - in Italy youth were previously much more repressed and controlled than in England, much to my consternation as a teenager - now drug taking, abortion, divorce etc. are part of the scene and Italian teenagers are if anything freer than UK peers. Russian youth were until recently shining examples of polite school pupils who stood up when the teacher entered the room. The groups I brought over to England suffered 'culture shock' in London schools. Now Moscow youth have a very high rate of truancy, teen pregnancy, drug abuse, drinking and prostitution. Something unimaginable ten years ago. The comparative work I have attempted between Jamaican youth in the Caribbean and those who live in UK changes with great fluidity - looking for similarities is more rewarding than looking for differences.This concept of cultural drift is echoed by Bob Blum in his article **"Global trends in adolescent health"** (Blum RW. JAMA. 265(20):2711-9)

.... Increasingly, morbidity and mortality trends for young people in developing nations are paralleling those in the industrialised world. As infectious causes of mortality diminish, unintentional injuries, suicide, homicide, war, and maternal mortality represent the primary causes of death in the second decade of life for most nations where data are maintained. As developing nations increasingly place priority on the education of their youth, early marriage and precocious child rearing are discouraged, and other problems, such as out-of-wedlock childbirth and illicit

> ***Culture denotes a system of inherited concepts expressed in symbolic forms and transmitted through a pattern of meanings by which people communicate, perpetuate and develop their knowledge about and attitudes toward life. (Geertz 1988)***

abortions, emerge. Problems such as substance abuse and suicide arise with the urban migration, increased unemployment, and disruption of traditional social structures that are experienced as developing countries industrialise.

Unfortunately it often seems that cultures learn the 'negatives' from each other before or instead of the 'positives'. In my travels I have attempted to learn what the positive, coping strategies are for a given culture which could be extrapolated for 'use' elsewhere - but have generally been frustrated in this task as such norms 'do not travel well'. With regard to youth of Jamaican origin - in our last journal Dr Aggerey Burke (one of our few Jamaican psychiatrists working in London) made the point that emotional disturbance and the diagnosis of psychiatric illness among black youth is much higher in England than in Jamaica. The level of arousal seen in London is much higher than in Afro/Caribbean countries - he described the most commonly seen syndrome as '*..Sadness, fear, hatred, anger constituting confused emotions - emotions that cannot be balanced; and in it's extreme form it is fury. Extreme and confused emotions are mixed with extreme and confused thoughts in the most extreme and confused persons.*' This situation we discussed, was partly brought about and confounded by the fact that half the children going into care are black and in boroughs with a 20% black population 62% of young offenders are black and 65% of school exclusions. This perpetuating legacy of the care system is something which is not seen in Jamaica where very few children ever go into care. Why can't we in England learn from and use the Jamaican system of intervention?
Dr Frederick Hickling, a psychiatrist in Kingston, Jamaica views the emerging Jamaican system of community care for the mentally ill as a great improvement on the 'colonial style' mental hospital and the idea of institutionalisation. Generally this underlines the difference in philosophy - greater community acceptance of emotional illness and diverse lifestyles, coupled with greater reliance on community or extended family support in personal or family breakdown. Dr Hickling's centre in Kingston has many similarities to Youth Support House - using a multidisciplinary approach and utilising drama, music and media - however there is still something inherently Jamaican in his set up and something inherently British in ours which is hard to define. Basically we do not have the extended family network to rely upon for support of our patients and have to 'create' an artificial support system. Is this support system breaking down because of increased reliance on 'capitalist' values - i.e. an acquisitive industrial society?

This view is argued in the article "**Psychiatric morbidity in developing countries and American psychiatry's role in international health**". (Sugar JA. Kleinman A. Eisenberg L. Hospital & Community Psychiatry. 43(4):355-60, 1992) "....
Economic and social change in the developing countries of Asia, Africa, Latin America, and the Pacific Islands is associated with increased rates of behaviour-related illnesses, including psychiatric disorders, alcoholism, and substance abuse. Between 10 and 20 percent of the presenting problems in primary

care settings in those countries are psychosocial. The authors provide an overview of the epidemiology of psychiatric and psychosocial morbidity in developing countries and summarise its effect on medical care systems in those settings. They suggest that American psychiatry increase its involvement in improving mental health care in developing countries.

Consultation should be directed toward priorities determined locally in those countries, including assessment of current clinical practices, applied epidemiological research, and training of indigenous researchers."

Support systems vary depending on the type of extended family and the role of the family in society. Japanese family structures are based on different value systems from those prevailing in British families as evidenced in **"Connectedness versus separateness: applicability of family therapy to Japanese families"** (Tamura T. Lau A. Faculty of Education, Tokyo Gakugei University, Japan. Family Process. 31(4):319-40) This article, a product of the two authors' multicultural experiences, contrasts British and Japanese families in order to examine the applicability of the Western model of family therapy to Japanese families. Areas where the Western model is incompatible are identified, and modifications to fit the Japanese indigenous model are suggested.

" .... *The most significant difference in value systems between the two cultures is the Japanese preference for connectedness. The Japanese person is seen as a part of the embedded interconnectedness of relationships, whereas British norms prioritise separateness and clear boundaries in relationships, individuality, and autonomy. This value orientation is manifested in the Japanese language, hierarchical nature of the family structure, the family life cycle, and the implicit communication style.*

Systemic thinking, which deals with the pattern of relationships, is valid for all families regardless of cultural differences. But therapists should note that the preferred direction of change for Japanese families in therapy, is toward a process of integration--how a person can be effectively integrated into the given system--rather than a process of differentiation. An authoritative therapist style, the use of individual sessions, silence, and other non-verbal techniques are relevant to bringing about the desired change toward better integration of the individual with his or her networks."

Bob Blum presented an overall view of culture health and illness in adolescence which to an extent brought together some of the themes expressed in the workshop. He drew attention to the recommendations of the Wingspread conference on Culture and Chronic Illness - to

- Include persons from diverse cultural and ethnic groups in all aspects of research, training, service delivery and policy formation
- More understanding needs to be developed of distinct cultural groups and variations within ethnic groups rather than focusing on aggregated racial groups
- More attention should be given to the way language is used in communicating with persons from diverse cultural groups.

FROM CAIRO TO ENGLAND

My father is Maltese/Italian and my mother is Egyptian/Italian. They married in Cairo and came to England just after the war with a boatload of other relatives and immigrants. My father's parents and sisters settled in Somerset and they went to live in Kensington. I don't remember English being hard to learn; I understand Italian, but it sounds awful if I try to speak it.

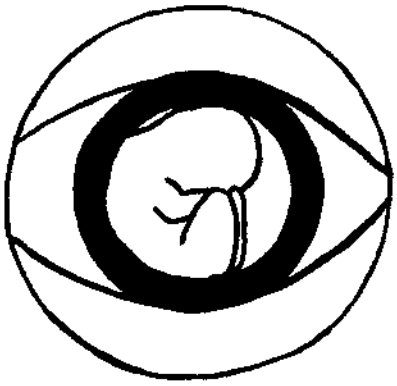
School dinners were a shock. I was used to Mediterranean food and found them dull and tasteless.Tea at friends homes was an experience I was used to food and eating being social.My English friends had to eat and not talk (and no wine!) My best friend was a Jewish girl, I liked eating at her house (me a good Catholic girl). Religion was a bugbear. I hated it. It seemed so unfair, even at my young age.I learned to keep my mouth shut and not to question too much. My own children are not christened, much to my parents disgust. Clothes were also different. I have lots of photos of me dressed for the Arctic in trousers dress and jumper even though the photos look as if they were taken in the summer.

The only real problem I had was when I was older. My father wouldn't let me go out. He would have liked me to meet a 'good Italian' boy but there were few and far between. So I became a home girl. To make matters worse I was a teenager during the sixties and they were worried I would go on the Pill and run away with a hippie. I was allowed to go next door to a wedding party and met my future husband. His saving grace was that although English his stepmother was Italian. He was my first boyfriend and I was 20. Our children are English and have no Mediterranean traits, so the era ends.

(ANNE)

INNER WORLDS AND OUTER CHALLENGES

Diana M.L. Birch



Part One - Inner Worlds - Confronts the question of how we develop personalities and discusses varying personality types.

Part Two - Outer Challenges - How our personalities are affected by disability, violence, abuse sexuality and assaults on self esteem.

Equal Opportunities and prejudice.

The recommendations of Youth Support workshop and working party of residents and staff. Autumn 1993

PREJUDICE.

1 Definition of prejudice.

Coon[1982] defines prejudice "as a negative attitude or prejudgement tinged with unreasonable suspicion, fear or hatred." When this happens there is a danger that sterotyping may occur.

2 Issues.

Most people have, or had prejudiced views. These may be around the following issues - age, appearance, disability, dress, education, handedness, H.I.V.status, housing, money, occupation, politics, poverty, race, religion, sex, sexuality, size, speech, success.

Have you come across any other examples?

3 Feelings.

These prejudices can be expressed through insults and name calling and also in other hurtful ways. When this happens, it may stir up difficult and painful feelings and emotions for example, anger, confusion, disgust, embarrassment, hurt, isolation, jealousy, loneliness, pity, rejection, repression. There are many others.

4 Reasons for prejudice.

At the meeting there were 18 residents and staff, from over 26 different ethnic backgrounds and a cross-section of social backgrounds. We think that it is true to say that the majority of people present have prejudices around different issues. Rather than concentrating too much on this, it is important to try and gain some understanding from where this prejudice comes.

- Many prejudices are passed down from a parent to a child. When a child reaches adolescence s/he has their own / parents view. These ideas may be conflicting. It is important to recognise that everyone has a choice as to whether or not to hold on to these prejudices or to let go of them and to become open-minded.
- Prejudice is a two way process. A person may be prejudiced as they know it will hurt somebody - it is connected with power.

5 Education .v. Ignorance.

We discussed that people with qualifications may still have prejudices. We talked about "education" in the broader sense of the word as being a way of overcoming prejudiced attitudes. If a person continues to have a prejudiced view having being educated then this should not be tolerated.

6 Positive strategies to overcome prejudice - The way forward.

- Positive images around the community i.e. Nursery, Baby Unit, Schoolroom.
- Celebration and discussion of multicultural festivals.
- Review of our Equal Opportunities policy to see if it meets the needs of residents and staff at Youth Support House.

SUMMARY

_ We are all human beings. We all deserve to be respected and should respect others.

- We all have the right to equal opportunities.

Reporters: Rachelle, Wendy, Alistair, Viv, Karen, Rosie,

Compiled by KAREN and ROSIE.

I am an Indian living in Britain. I was born and brought up in India. I come from the upper middle class and hence led quite a similar lifestyle as here. I have experienced a variety of differences due to the cultural backgrounds being different.

My meeting with my husband was arranged. The compatibility between families was checked out and photographs were exchanged. I had the full freedom of saying "yes" or "no" and was engaged within a week, married in three months. I am now a mother of two living in a joint family and have a part-time job.

Pre-marital sex was a taboo. Joint family systems is a very usual aspect of India but not common here. I play the role of a modern, Eastern working mum outside home and am a typical Indian daughter-in-law inside.

Kissing, cuddling and even holding hands is considered disrespectful if performed in public especially the In-laws. We have family meals, discussions and outings.

There is plenty of give and take which is the essence of our family stability. Broken families, broken homes, divorced parents, broken engagements and separated partners are looked down upon.

Obedience, care, love, togetherness, plenty of giving in, loads of patience is the secret of our type of family unit. This is not the normal practice here and hence I face a cultural conflict and am constantly debating within myself as to what is truly good for me

Interference in the bringing up of children is another common thing in Indian families. This is annoying but any argument or questions lead to the breaking up of the family unit. Thus we need to strike a balance and enjoy both situations. This is tough but can be achieved.

Cultural conflicts and confusion should be dealt with very carefully especially with kids to avoid big and major personality problems in the future.

(PRIYA)

NEWS NEWS NEWS NEWS NEWS NEWS NEWS

New York International Conference on Eating Disorders - April 26-28 1996 Details from Preston Zucker Montefiore Medical Centre 111 East 210th Street Bronx NY 10467 tel 718 920 2176 FAX 718 920 5289.
Youth Support Tenth Annual Forum Meeting at the Royal Society of Medicine Wednesday 18th October 1995 6-9pm.
Advance Warning - 1996 is Youth Support's tenth anniversary year - Whole day meeting on Adolescent Health at the Royal College of Physicians - October 24th 1996 - keep the day free.


Esther caught on the hop!
First Prize winner!
Just clowning around
Donna smells a rat
Steve thinks the cat's up to scratch
Finding the day a real "hoot"
A problem of overidentification?
Betsy eats the Mayor's Shoelaces

Youth Support Animal Day

Animal day was enjoyed by all in typical Youth Support manner! The animals were all into their animal therapy keeping everyone happy. 'Warm Fuzzies' pet shop project was officially opened - TWICE! There was a mix up over the arrival of the mayor and so one of our visitors, Anne Widdecombe MP for Maidstone kindly declared us open and cut the ribbon ... which was deftly sellotaped together again when the Mayor's car was spotted approaching. Embarassing, yes .. but good fun too!

Opening Number 1
Anne Widdecombe MP

Opening Number 2
The Mayor gets in on the act

Winners of the 'Draw a Pet'
Competition receive their awards

The Tenth Anniversary of Youth Support will be marked by a

Conference on Adolescent Health

to be held at the

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

on

Thursday 24th October 1996

Conference 9.30am - 4.30pm
Followed by Keynote Lecture 5pm-6pm
Followed by Tenth Anniversary Dinner

The conference will highlight advances in Adolescent care over the last ten years and will deal with a number of important areas of young people's health. Sections include Teenage pregnancy and sexuality; self harming behaviours and substance abuse; eating disorders; emotional problems; youth and violence.
Our speakers are renowned experts from the field and we hope to include some of our international colleagues.

Please write in now to :-

Youth Support Conference Administration
Youth Support House,
13 Crescent Road London BR3 2NF or FAX 0181 659 3309

if you wish to receive further details or to make advance bookings

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