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

Letter from the editor -

Dear Colleagues,

This is the last edition before the 1998 conferece so make sure you are signed up - we would not want you to miss it!

In this edition we include some of the presentations from our October 1997 RSM meeting on self harming. Please note that the contributions to the 1996 conference are published separately as a book of 'proceedings' - they have actually made up quite a nice textbook of adolescence - so please write in and ask for a copy - price a very reasonable £5.

Diana Birch
Director Youth Support

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* CONFERENCE ROUND UP *

- Personal views of those attending recent conferences -

The Adolescent with addictive / dependant behaviour: Risk and Resilience - Lausanne September 1997

Sonia Lucia - Psychology Student - Youth Support House.

Having lived in Lausanne all my life, it was a surprise that after training in London at Youth Support House, I was asked to present a paper on Youth Support and it's drug project work at the 1997 IAAH European conference in Lausanne.

The conference centred around addictive behaviour and resilience. I heard presentations on addictive behaviour in America, Sweden, Switzerland, Poland and other places around the globe. The strange thing was me presenting a paper and knowing more about drug use in the United Kingdom and then hearing from other speakers about the situation in my own country of Switzerland where there is the highest percentage of addicts in Europe.

It was a nice experience for me to attend the conference which I enjoyed thoroughly and to present the paper on the drug project work in Youth Support and the interest that other people showed towards my presentation.

(Sonia's presentation is printed below).

"Using 'Project work' with young drug abusers in a residential setting"

Presented at IAAH European Chapter meeting - Lausanne September 26 and 27th 1997 - The Adolescent with addictive/dependant behaviour: Risk and resilience.

Authors - Dr Diana Birch - Director; Esther Mensah - Senior Care Worker; Sonia Lucia - Student.

Institution - Youth Support - London, England **Presented by** - Sonia Lucia.

Youth Support House is a residential unit which provides care in a therapeutic community setting for troubled young people suffering multiple problems. Many of our young women are also pregnant or are young mothers and their problems are added to when drug use or addictive behaviour complicate their presentation.

Difficulties arise when the drug taking history is confused or unclear, the extent and nature of use prior to conception and during pregnancy can be underestimated or concealed with serious consequences for the baby - withdrawal symptoms and complications at birth, problems in feeding and developmental patterns in early life.

Baby Chad was jittery and difficult to feed while withdrawing from his mother's methadone treatment, Charlotte took in an unknown cocktail of cannabis, alcohol and possibly amphetamine during her gestation

and needed to be tightly wrapped to control her shaking, fed slowly and carefully monitored for several weeks after birth. Kelly was using solvents - lighter fuel particularly during her pregnancy and died of a heart attack when her baby was only three months old. He also was jittery and slow to gain weight and showed slow early development.

Janet was primarily an alcoholic and also used some cannabis. Jamie showed signs of foetal alcohol syndrome. Fourteen year old Zoe used and experimented with numerous substances, her baby was small, difficult to feed and had bilateral talipes.

Covert drug use after delivery will cause behavioural and emotional problems as well as interfering in parenting and may place the baby at risk. Cathy would get drunk and abandon her children while she 'self harmed' - including throwing herself into the Thames. Charmaine would become too stoned to feed her baby. Susie showed psychotic episodes on Cannabis with violent outbursts and extreme paranoia which were witnessed by her confused children.

Placement at Youth Support House provides an opportunity for the young parent (and this may include young fathers also) to receive treatment for their addictive behaviour whilst at the same time being able to continue caring for their child under the supervision of staff. Observation and assessment of parenting can take place without the trauma and damage to attachment and developing bonds which would occur if the young person attended a drug rehabilitation unit whilst the child was fostered.

Our treatment programme includes group and individual therapy plus attendance at self help groups such as AA - Alcoholics Anonymous or Narcotics Anonymous (NA). An important part of treatment is the 'drug project' work on which all residents spend several hours per week. We will describe the drug project work and outline the value of this approach.

Although substance abuse is common among youth, being equipped with basic facts and having accurate information about the drugs used is rare. Use of substances is often seen as a way into a peer group the benefits of which appear to outweigh the costs. Peer group myths and beliefs about the drug culture are assimilated in preference to the 'health education' message. Street wise does not necessarily equate with knowledge.

The first goal of the 'project' is thus the acquisition of accurate knowledge. Here the learning process is self directed and patient centred.Our residents come from very different backgrounds - some have left school at age 12 years and may be semiliterate or illiterate some may have school qualifications and one girl worked on an open University degree. Each works at their own rate and level using sources which use language they can understand and aiming to produce a piece of work which is useful and informative to herself. They are finding out the information they want and need and not what others may think they ought to know.

Most of the 'project' work results in the production of a

booklet or drug guide which can be useful to others also. They are encouraged and helped to visit libraries, centres, health information resources, rehabilitation units and drug clinics to obtain information. They also share experiences and knowledge.

Project work begins with warm up exercises and brainstorming of ideas on various factual and emotional levels. Topics might include substances usually abused - knowing names and street names; feelings about and effects of substance abuse - which can be a very interesting part as they include their own experiences - 'I never felt like that' or 'I'm lucky to be here' or 'It did this to me..' The work then progresses to the information gathering stage and finally to production - looking at art work and choosing a style for the booklet.

It is acknowledged that effective prevention or drug treatment education should be based on a) correct information and knowledge, b) exploration of attitudes and feelings , c) acquisition and development of life skills. A young person with low self esteem and lacking in self confidence forms part of a vulnerable group who are unable to make informed choices about a range of health issues including drug use.

An important element in our approach is the need to build the young adult's confidence and help them develop their self esteem and a positive image. It is only when someone feels good about himself and confident as a person, that he can fully utilise knowledge and draw on personal inner strengths, attitudes and feelings in making decisions regarding his behaviour patterns.

Youth Support House has been using the above approach as part of the therapeutic programme incorporating self esteem building into group and individual sessions. Project work aids in the acquisition of self worth since the finished product is an expression of personal creativity - it is a unique item, stamped with their individuality in which they can experience pride. They are in fact so proud of their productions that they jealously guard them and it is difficult to get them to then share their work - the original idea was to produce a booklet which could be printed for more general use but each project participant wants to create their own special work and keep it after they leave. The personalisation of the work lends itself to self discovery and self disclosure - 'Oh yes, I did that' which in turn leads to deeper insights regarding drug use and behaviour.

The project can thus be seen as an important therapeutic tool in the recovery process. Information gathering begins a creative process enhancing self worth and aiding self discovery which leads to insights which channel and focus the process of change which is begun in the more formalised therapy sessions.

(This paper was also presented by Esther Mensah at our RSM meeting October 1997)

Youth Support Forum on Adolescent Health and Welfare

Twelfth Forum Meeting 1997 - At The Royal Society of Medicine, 1 Wimpole Street, London WC1, Thursday 23rd October 1997

Self Harming Behaviours and Eating Disorder

An Introduction and discussion of general principles - Dr Diana Birch - Director Youth Support

SELF HARM or SELF ABUSE may be seen either in terms of - Depriving self of … Needs and/or - Engaging in harmful behaviour. For example

Depriving self of - Needs …	**by Behaviour** .
Shelter	running away
Warmth	
Food / nourishment	starvation
Safety	Risk
Company	Isolation
Education	Drop-out
Love and caring	Self hatred

and / or Engaging in:- Harmful behaviours
Risk taking
Harmful relationships
Self Abuse - physical/ chemical

WHY? - Why do young people self harm? There are often complex multifactorial reasons which are dependant on individual experience - what does it mean for this particular person - for example - Early patterns Abuse and neglect - what is normal - What do I deserve?

Communication - how do I show my pain - I can't tell you what happened - but if you see my pain you may guess - or ask me. You can tell by the way I look, by the way I act … etc

Guilt - The abuse must be my fault - so I'll punish myself some more.

Concretisation - making the pain visible - reframing it - making it tangible - a cut , bleeding, - the pain is now my wound - not my inner scars of say sexual abuse.
Release and expression - pent up feelings - I want to scream - I can't bear this pain -

Avoidance - of people / situations - I'll make myself unattractive, unwanted, unlovable (on the outside) because that's the way I feel about myself (on the inside)

Power and Control - I have control over my own abuse (scoring a point against perpetrator) . Eating disorder prime example of 'control' of family.

Self Injury - **Sheena Brown - Senior Therapist - Youth Support House**

I should like to talk about self injury in the context of survivors of documented sexual abuse. I shall briefly examine this complex phenomenon and its treatment from a psychodynamic perspective. Initially I shall do this in theory and then through a case study that is very representative of the numerous young women who have attended Youth Support exhibiting this behaviour.

During self injury a woman causes physical damage to herself by, most commonly, scratching biting, cutting, gouging or piercing parts of her body. Most women hide the evidence although latter stages this is sometimes not the case. It is a generally held belief that this behaviour is often an attempt to expiate feelings of guilt, shame and emotional pain. It is also, for some survivors of sexual abuse, the only available way to express feelings of extreme distress. Brienes study of 1984 which is supported by other researches noted that 31% of survivors of childhood sexual abuse exhibited a desire to hurt themselves as opposed to 19% of a non abused group

I should like to consider self injury as an idiom of distress, indeed a somatic response to distress. By this I mean a bodily expressed response that has no apparent meaning in words. Bearing this in mind and noting that a commonly observed feature of surviving abuse is dissociation from the original trauma. This is done to effect psychic survival. Self injury can therefore be seen as a way for the survivor to be able to concretely feel that they and their feelings do exist. In dissociation the mind 'splits' from the body in order to avoid the effects of pain. This is in order to bring a sense of emotional detachment, of unreality and of not feeling the body's existence. Cutting, therefore, is a way of feeling alive and associated with ones body. Additionally, in abuse, pain and love can become entangled. This, in turn, may result in the survivor needing to re-experience the pain which is inextricably linked with love that she felt for the abuser particularly if the abuser was a parent.

Self injury is also linked to self punishment. Part of the process of abuse is the internalisation of negative feelings about the self. Survivors self esteem is often very low - they believe themselves to be worthless, bad etc. and as a result they could be seen, via self injury, to be destroying themselves body and soul. I have long felt and noted the pervasively silent and silencing properties of abuse. Thankfully, change is happening and abuse is not the taboo it once was. However, for many survivors - especially children - there might have been no acknowledgement by the parent that abuse was taking place; so for them self injuring was the bodily expression of the hidden scars, the emotional damage, a concept noted in the work of Dr Diana Birch.

Can I therefore ask you to consider self injury from the perspective of a cry for desperately needed nurturing, that was after the original trauma denied and even, more tragically, withheld?

I should now like to consider this embodiment of distress

further via a case study of a young woman I shall call Anne. Anne came s a resident to YSH with a long and terrible history of life experiences. Some of these included 30 or so care placements before the age of 13 years. She had three suicidal experiences, including one where she leapt off a high river bridge when in the fourth month of pregnancy. As a child she had been repeatedly sexually abused by a close family member. Diagnosed as having a personality disorder, an alcohol addiction, bulimia /anorexia and a disastrous personal life Anne was still only I her early twenties. She was to be assessed for her ability to parent her two lovely toddlers.

Originally Anne lived until the age of sixteen near a Kent market town. She was one of many children, born in great poverty and rural deprivation, to a very much older father and a young vulnerable apparently learning disabled mother. The family life that Anne witnessed was disordered and her visits home were of short duration usually when social services had run out of funds or placements. Anne described mother as taking "old men home from the local pub for drink and sex sessions". Father also a drinker beat her mother on occasions, this whether he was drunk or sober. Anne as a child witnessed much of this. She went on to re-enact unconsciously a lot of her early experiences in her teenage years. She truly had survived abuse but with a lot of damage.

Despite the tragedy of her short life to date Anne had an ebullience, an optimism and an infectious sense of humour. It is to be noted that her humour was revealingly an angry humour with images of pain. She once memorably described a person's distasteful expression as being "like a rottweiller chewing a wasp". Helman notes the metaphoric use of pain in our day to day speech, i.e. "she hurt him deeply" or "I was sore with them" etc. We are using pain words to express feelings. Engel says of pain that it is 'private data - the sufferer has to tell us, we cannot see the pain'. It is generally noted that the prognosis for healing is better for children whose abusive experience is heard and believed by the parents. So what happens to the child who has been allowed no expression of their pain as was the case in this situation? Anne came from a family where there was little hope of any distress or pain being heard. Her parents were engulfed in their own dysfunctions and with many children born virtually one after the other there was nobody to pay attention to the needs of one distressed little girl.

Placements in large old fashioned children's homes did little to help Anne

so as an abuse survivor she took into herself, she internalised, feelings of guilt, shame, blame and a huge feelings of anger - all of which were destructive. Consequently her feelings of lack of self worth emerged. A child who feels unworthy does not believe or see themselves worthy of being loved and cared for. For them, being nurtured is an alien feeling.

In an attempt, begun when she was 8 or 9 years old, to try to communicate her anguish Anne cut and gouged her body, particularly her arms and legs. Her arms were a mass of ugly livid scars. She was also determined to show these scars to the world, to externalise her feelings and give them expression. She wanted to

make her feelings real. One bitter cold day she refused to wear her coat in a public situation and put on a sleeveless T shirt instead.
Her cutting had another purpose, she told me, it offered a release. She said that when she was 'worked up' she cut to feel a relief. Engel notes that pain has two components, the original sensation and the reaction to that sensation. Perhaps the original pain of the cut was redolent for her of the pain she felt as an abused child and her reaction to the pain was the gratification of having a tangible sensation to mourn. Perhaps, also the resultant scars were an embodiment of her distress and suffering that had not been noted before. I also suggest that each cut or gouge represented another attempt to understand and conquer the original trauma. Whatever

A Case history - Self Harm - Mike Bracken - Therapist - Youth Support.

This young man called Kevin who visited Youth Support House because his girlfriend since 15 had his child and was subject to an assessment and there was no support from families etc. Because he was the father arrangements were made for hi m to be included in her assessment. My first impressions were that he looked a typical National Front type, had a bit of a put down look about him and it is important to remember initial impressions. It soon emerged that once you got through his shell he was very approachable. I will briefly go through his background so you can see the connection with the theme of self harm. He had one brother 2 years younger who seems the only constant in his life when he was growing up, his parents werent' together, his father had left when he was a baby, and when he was 4 and he remembers this vividly, he can't understand why he had gone to bed and when he awoke his mother had left. He had some contact with her, but he was left with his stepfather and brother and the stepfather went off to work early, Kevin looked after his younger brother and got his breakfast and at 9am when the childminder came he went off to school. In the evenings they were alone until the stepfather came back late. Aged 7 he was aware he could not trust anyone, had to look after himself, and was referred to the Maudsley because of his sudden outburts of angry feelings towards his stepfather. He also remembers episodes of sexual abuse by his uncle without his stepfathers knowledge and was very much alone, self sufficient by this time. Aged 15 he had a fight with his father which was a particularly bad one, and his father ordered him out. As a final blow he told Kevin he was not his child anyway. From then on until being admitted to hospital at the age of 18 he was very much on his own. He stayed with his nan for a while which did not work, but was mainly on the streets. He was often part of a group which set up homosexuals and took money from them. His girlfriend became very important in his life, we noticed at YSH he was far more interested in his girlfriend than his child. He said she was the only person he

could trust, when he met her he was suicidal and she was the only person he could chat to. He did not spend much time at YSH but we felt he was pushing barriers all the time, and was often not allowed in.

We looked at the process of what happened when he was depressed, feeling empty and suddenly he would feel he had to do something to relieve the depression.. He sometimes whilst staying in hostels cleaned his room twice a day and this would help. At other times he could only get relief by cutting himself and would be fascinated by watching the blood flow. He says he felt no pain at this time. The interesting thing was the distancing between himself and his body and he said he rarely experienced pain, he could harm himself and not feel anything. He was seriously cut about the neck in one incident and spent 7 days in hospital and still has to go back for checkups but had no experience of that pain. Sexually he said he could take it or leave it. Taste also, he could not taste anything. He had an eating disorder because his stepfather would be rushing him to finish up meals, very impatient, and when he had the bustup and left he didnt eat at all, so a pattern of punishing his stepfather had by not eating had set in by then.

He had 15 sessions until he broke up with his girlfriend and disappeared. He seemed to like the opportunity to talk, and as it turned out he was intelligent and he said once he understood the person he was talking to wasn't putting him down he could take off his mask. There was a sense of hostility, he expected rejection and people to let him down, so there was a self-fulfilling prophecy about his whole life. He had a big tough exterior which he needed, to be on his guard, and had adopted this very early on so his feelings of pain both physical and mental were numbed.

I felt he was someone who self harmed but was a particular example of how problems are complex and multifaceted.

A Case History - Alcoholism - Sheila Atherley - Senior Nurse - Youth Support.

Alcohol is the most widely used drug in Britain. People drink for many reasons; for example- to enhance meals and celebrations,to relax with friends and family,to escape problems, to block out feelings of guilt, loneliness etc Alcohol is quickly absorbed into the bloodstream. It does not need to be digested. Alcohol slows down the brain affecting judgement, co-ordination and emotions. The body burns off alcohol at the rate of about one unit per hour, most removed by the liver. Time is the only thing that can sober you up,not coffee, exercise, fresh air or cold showers.

Background of case study

Mrs X aged 39 is the mother of six children ages ranging from 3yrs to 20 yrs. Two of the children died at an early age, at four weeks and two weeks because of cot death. Baby k was born prematurely at 34 weeks and was diagnosed as foetal alcohol syndrome and a heart murmur Mrs x divorced her violent husband but became involved in another violent relationship - in addition she had a drink problem. She also spoke of her loss i.e.

the death of her mother, two babies dying at an early age, and a baby being adopted her self worth has been deeply damaged by her experience of loss and particularly her experience of being judged as a bad mother. The records state that she has a long standing chronic alcohol abuse problem and consequential child neglect, with continual exposure of her daughter to gross incidents of domestic violence. MrsX revealed no insight at all into the damage her lifestyle had caused to this child and would be likely to cause in future. In view of her lack of co-operation and inconsistency working with social workers and the poor school attendance of her daughter social services applied to the courts for a supervision order The Guardian Ad Litem came to the point where Mrs X was recommended for psychiatric assessment, hence the admission to our unit (YSH).

Mrs X was admitted to YSH in May 1995 for rehabilitation. A six week intensive residential alcohol treatment programme, to look at personal issues regarding her dependency, relationships and parenting ability. Her programme included attend A.A.meetings; To agree to random bag and room search; Complete abstention - hence no alcohol, no medication, no tranquillisers, sedatives or mood altering substances such as cannabis or other drugs. Mrs X was a secret drinker as reported by her partner. She was in constant denial of having a drink problem. At times she appeared intoxicated with a strong smell of alcohol on her breath. She was involved in an incident of violence on the street, outside pubs and in the neighbourhood whilst under the influence of alcohol.
When challenged Mrs X would deny having taken alcohol but admitted to having the odd glass of beer or lager. Sometimes she would leave the house to attend meetings or contact with her children accompanied or escorted by a member of staff, then refused to return with staff. Other times she would go out and exceed the agreed time to return On return she would give an alibi such as having met her partner, friend or her dad. More often than not she appeared intoxicated There was also evidence of facial bruising, black eye or missing broken front teeth indicating she was involved in a violent episode. When confronted, she stated that the injuries were an accident, but more likely they were a result of confrontation with her violent partner. She attended AA meetings initially with a member of staff then requested to go on her own which was short lived because of her compulsion to drink. In view of her denial, lack of co-operation and inconsistency the treatment programme was unsuccessful on this occasion although she at a later date had a change of attitude which allowed her to accept her alcoholism and she then responded to treatment.

The Role of the Eating Disorders Association - Joanne Seymour - Eating Disorders Association.

Eating disorders in Young People gives information about eating disorders for young people by young people. We take messages and contact young people at a time which suits them and also run a help line Mondays to Fridays, and an ansafone at all times. We can recall and save them a cost of a phone call. Phone is answered by trained helpers and in 1996 the Youth

Service was further developed by the addition of three information leaflets specifically aimed at young people.

Eating Disorders gives information about anorexia, bulimia etc. and examines the various ways young people can get help, what is available and what to expect. Friends and relatives write about their experiences and why they get disorders, how they can be helped. The third leaflet explains confidentiality and their rights, the issue which many young people who contact us are worried about, involving their family etc. The leaflet gives information about the Law and rights, suggestions how to get support and gain confidence. The latest edition has 'Talkback' a feature introduced in August 1996 with the intention of encouraging young people to express themselves by letter or postcard, to share their experiences with others.

We also prepare articles for Talkback, each focusing on different topics eg bullying, self harm, friends, recovery, self esteem - this month looking as aspects of growing up. Because of cutbacks we have cut the issue to two pages but hopefully we are sending it to the young people who are signposted as the magazine is sent out. The other main function is telephone calls from young people mainly connected with school projects but later on their own behalf, in desperation and needing an outlet. Ongoing correspondence is often used to encourage and point the girls in the right direction. The telephone lines can be useful when someone wants to talk in confidence, apart from the girls sometimes from friends and youth workers involved in their care. They can often feel hopeless, like the girl desperately worried about her parents relationship and did not want to burden them with her own worries, or the friend who could hear her friend being sick in the cloakroom and didn't know what to do. They often simply unburden themselves and we try to help to show there is more than one way to look at the problems.
I would like to add that callers come from all walks of society, not just middle class girls as is sometimes thought.

Many schoolgirls find themselves getting fat and try to diet quickly - a problem increasingly common especially teen magazines read by 10 yr. olds which present an ideal fashion figure. Information about healthy eating and aspects of puberty which many girls know little about is given in our leaflets. A large part of their time is spent in their own rooms at this age with a decline of family mealtimes, possibly with entertainment away from the family and many people find that snacking replaces lunch. Sometimes if they have an eating disorder they may need to know what weight gains are ideal so they do not put too much weight on too quickly which would be counterproductive

We have a network of self help groups across the country which passes on details to its members, they may call a contact for a chat and also give useful directions to youth counselling services. Young callers who do not want to talk to their parents or teachers may find our leaflets useful.

In the February issue of Talkback we decided to tackle the

sensitive issue of self harm. Both Ann and I have been receiving letters about experiences, eating and self harm often go together whereby the girl could hurt herself both inside and out. We thought it important to bring this topic into the open because girls may be suffering in silence and not know what to do, information on how to get help from an article and several letters from self harming girls. One letter was:

I am Katy Wright, a self harmer, and I would like to share my experiences with others so they know they are not alone and can identify with me. I had secondary anorexia for the past sixteen months and during this time although my weight never dropped severely low my mental state did. Every month I would go through scenes of self hate, so mixed up and when people asked I could only say I don't know, very angry and very hurt. I was constantly crying. Soon all this was too much for me. I was confused, I was still trying to starve myself and could not cope with my feelings trying to block them out and become numb to emotions. At first I started constantly digging my nails in and scratching my hands drawing blood then it became all out cutting my arms, I had to feel the pain. Somehow people always found out, a "caring friend" who told teacher who then told my parents and could not understand why I did it. It was just my painful life. Along with people telling me to eat they were now telling me what to do and how to do it to my own body. The crunch finally came when I scratched along my ribcage and was threatened with being admitted to the psychiatric unit. No one understood that the hurt inside was too bad, I had to get it out. Life is getting easier bit by bit, I managed to go three months now without hurting myself. My eating is still not regular but I am starting to sort that out too. Things in life can get so bad, the pain and anger so bad, but for anyone out there please hang in because things do get better.

Whilst EDA cannot claim to sort these issues out it does seem to be able to provide a balancing role in encouraging those young people to contact those who can help them to recover. Often it is the first step which is the hardest, once they have opened up to talk about eating habits going on to start treatment is often easier. EDA will go on establishing valuable links with professionals and continue to provide a comprehensive service for our young people.

- International Chapter News -

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

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

Our Chapter Institute at the 1998 SAM meeting (Society for Adolescent Medicine) Atlanta - March 4th 1998 was on the subject of *'Exploitation of Youth - An International Perspective'*
Our Youth are our resource for the future - but are we exploiting that resource? Across the world employers know that youth are a source of low waged labour, from teens working in fast food outlets to primary school children whose tiny hands can knot high quality carpets. They often work in dangerous and abusive conditions. Adolescent sexuality provides another rich area for exploitation - sexual tourism is on the increase and young prostitutes of both sexes are a prime attraction. Presentations will look at types of exploitation in differing cultures from the USA to the Far East and raise the question of where lie our responsibilities and our role in prevention?
This will be reported in full in the next journal and I am sure that those of you who were unable to attend will find the transcript informative and very wide reaching - in fact it is because we covered so much ground that there is no room for the write up in this edition.

The 1999 SAM meeting is taking place in Los Angeles on the theme of family work - we have therefore proposed the following format for an institute and hope to hear from the SAM organisers in the very near future as to whether the idea has been accepted. We would very much like to hear from anyone interested in presenting or participating.

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

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

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

Sexual Abuse and the Girl Child

Sheila Campbell-Forrester Senior Medical Officer of Health - Jamaica

Child sexual abuse especially in the girl child has been with us for centuries and has become an important Public health problem over the past decade. Sexual abuse in the girl child accounts for approximately a third of all child abuse cases. Sexual abuse is defined as the exploitation of a child through violent or non violent molestation. This includes a spectrum of behaviour ranging from violent rape to inappropriate touching of the genitals or seduction. Data from the STD Control Programme of the Ministry of Health revealed a decreasing trend in the cases of Gonorrhoea seen in the 0-14 age group between 1991 and 1992, 9.2% and 4.6% cases respectively but the trend of more females than males continues to be seen. That is 8% of cases and 4.3% in 1991 and 1992 were females. The data suggests that 80 - 90% of sexual abuse occurs in the girl child which is corroborated by data from the Child Guidance Clinics. Similar findings are also reported from the United States where 90% of sexual abuse is to the girl child.

In a study done at the University Hospital in 1984 the youngest child was 9 months of age with a mean of age of 8 years. Children in this study were seen with a range of STD's i.e.genital warts, trichomonas, herpes, all evidenced through sexual molestation. There appears to be an association between stability of home environment and sexual molestation with 60% mothers unemployed, one third having no stable residence and the highest incidence occurring during school holidays when supervision is minimal.

Characteristics of offenders vary and research has not been able to show any difference between the make up of a perpetrator and an ordinary man and sometimes sexual abuse is seen as an extension of male sexuality. A study of sexual abused cases seen at the child guidance clinic in 1987-88 showed that in 32% of cases sexual abusers were strangers, 25% were neighbours, 22% were male relatives, 11% were stepfathers and 2% fathers. A wide range of physical and behavioural consequences may occur as a result of sexual abuse in the girl child, although not confined to the girl child alone. In the study previously referred to done at the child guidance clinic the most common presentations were emotional - that of the child being sad and weepy, followed by physical problems (vaginal discharge) and then sleep disturbances, aggression, headaches and promiscuous or seductive behaviour. The history and medical evaluation is therefore of utmost importance and may be the only evidence available for the courts.

Current laws are grossly inadequate in the protection of children from sexual abuse particularly as it relates to exploitation of the young girl. The present age of consent is 14 years and should be raised to 16 years. The measure of punishment needs to be reviewed and the Justice Act needs to include proprietors of night clubs who employ girls under 17 years. Reformations of the law is

necessary and needs to be more "friendly" in enabling the justice process in sexual abuse in any child.

Child sexual abuse especially in the girl child has been with us for centuries and has become an important Public health problem. It is quite common for newspapers to print letters or to report on some aspect of child sexual abuse (eg child hookers in Ocho Rios, Daily Gleaner May 14,1995) This is probably so because more persons are becoming more willing to report child sexual abuse and to share their experiences. This is further borne out by the increase in visits to institutions allowing the Central Registry and Child Guidance Clinics to record and report invaluable information on the child abuse.

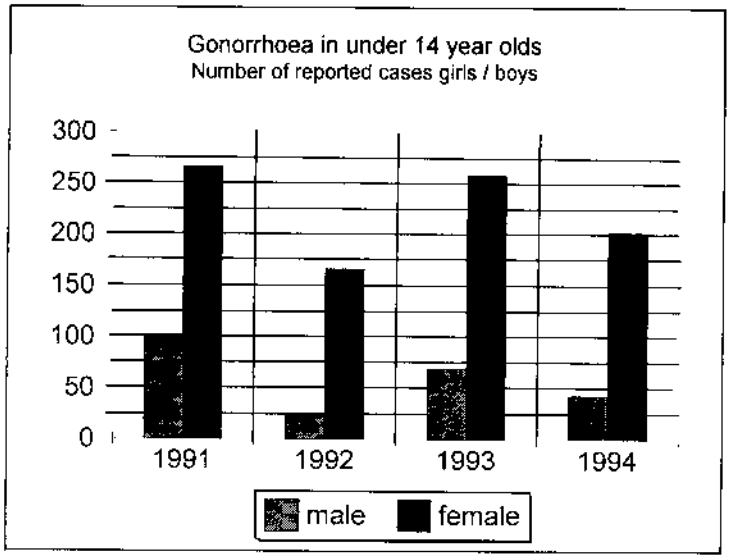
Child sexual abuse has been defined as the exploitation of a child through violent or non violent molestation. This includes a spectrum of behaviour ranging from violent rape to inappropriate touching of the genitals or seduction. (Milourn 1993 p.1) It also includes the use of the child for pornographic purposes, prostitution, exhibitionism and exposure to erotic material for the purpose of stimulation of the child and gratification of the abuser (Horsham 1989,p.4)

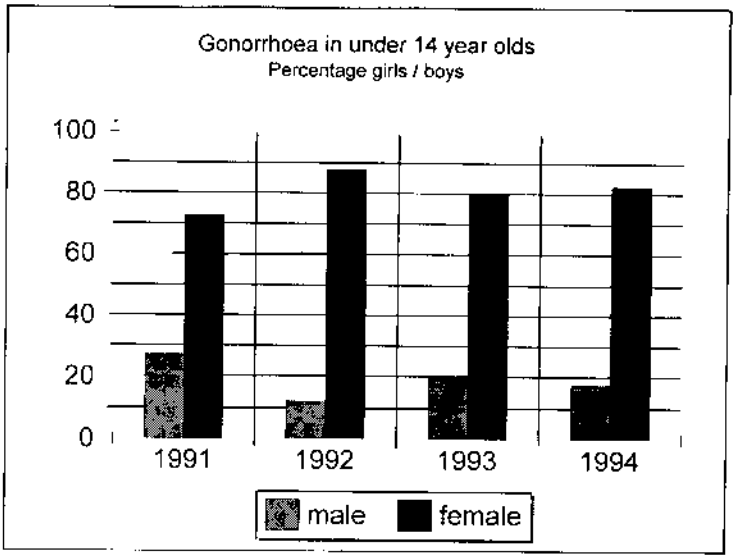
EPIDEMIOLOGY

Between 1987 and 1988 the Child Guidance Clinic at the Comprehensive Health Centre saw 55 cases of sexual abused children, 51 or 93% of which were females and 4 (7%) were males. At the child abuse clinic at the University Hospital 424 girls were seen with a vaginal discharge I 1984, 80 girls (14%) were confirmed as having gonorrhoea, which is considered to be evidence of sexual abuse. The age of youngest child was 9 months and the mean age was 8 years. Children were seen with genital warts, trichomonas, herpes, all evidence of sexual molestation (Task Force report April 1993, p.2) The 1993 data from the central registry which represents island wide data reported 243 cases of sexual abuse which was 60% of all child abuse cases. Sexual abuse was the most frequently reported type of abuse. Of the 243 cases, 237 or 97.3% were females and 6 were males which confirms the marked predominance of females in this kind of abuse. Child Guidance Clinic report 1994

Type of abuse	**No**	**%**
Sexual	243	60
Physical	120	30
Emotional	22	5
Neglect	19	5

The national data on sexually transmitted disease showed the following trend in gonorrhoea in the under fourteen age group; sexual abuse should always be considered in the girl child with an STD.Gonorrhoea cases in the girl child are therefore a sensitive indicator of sexual abuse although the data would not reflect whether or not the transmission may have been sexual or non sexual. Between 1991 and 1994 an average of 229 cases of gonorrhoea were reported in both males and females in the under 14 age group, 80% of which were females.





Of all the reported cases of gonorrhoea in females 8% were in the under 14 age group in 1991, 4.3% in 1992, 6% in 1993, and 4.4% in 1994. Less than 1% of cases in this age group were males(STD Control Programme Annual Report 1992, Data 1993/94)

The data is corroborated by that reported from the United States where it is estimated that 90% of reported cases involve girls and that only between 2% to 10% of incidents are reported (Jong 1990, p.1) The1984 university study suggested a correlation between stability of home environment and sexual molestation as 60% of mothers of these children were unemployed; over one third had no stable residence and the highest incidence were seen in January and September when it is presumed that the children were left unprotected during the school holidays (Joint Task Force Report p.3) The data of the central registry also noted a seasonal variation in sexual abuse cases with an increase of cases occurring in May and October (Child Guidance Clinic report p.8) It is, however, difficult to explain this variation. All of the perpetrators of sexual abuse were men, and this has not changed since 1987/88. It is estimated that approximately a third of perpetrators are in the age group 20-34 years old.

Sexual abuse can occur in any family at any socio-economic level, however in the Jamaican situation one has to consider such factors as the transient union situation where mothers change boyfriends frequently and usually for economic gains. Very often it is the boyfriend who is the perpetrator. Step-parenting, marital breakdown and poor supervision of children may be other factors to be considered in child sexual abuse. There are also some fathers who think it is their right to have first intercourse with their girl child and the myth still exists that the cure for gonorrhoea is to have sexual intercourse with a virgin.

The perpetrator - psychological, economic and demographic characteristics of offenders vary According to Emily Driver research has failed to find any fundamental difference between the make up of the child molester and men in general, and sexual abuse of children is seen by some as an extension of normal male sexuality. Sexual prowess is an important part of the male self image and by tradition involves conquest, domination and taking the initiative all of which are easier with children (Emily Driver 1989) In Jamaica strangers were 32% of perpetrators, relatives 25% cases and 25% of children were victimised by other individuals previously known to them(neighbours).(Millbourn 1991) In the child guidance clinic study of 1987/88 the following was found to be the profile of the sexual abuser:

Abuser	No	%
Complete stranger	18	32.7
Neighbours	14	25.4
Male relatives	12	21.8
Stepfathers	6	10.9
Not stated	3	5.4
Father	1	1.8
Stepgrandfather	1	1.8

Many perpetrators involved in repetitive abuse were usually themselves abused as children. In the case of the abusive father, he often has unfulfilled needs. Some are often wife abusers,maybe drug or alcohol abusers, unemployed or paedophilic.

Date rape or acquaintance rape situations in which a male forces or pressures a peer into sexual activity while others involve misrepresentation of power or authority to engage younger children in sexual contact. If these acts are not disclosed or reported then the perpetrator will abuse other children.

Case history: Adolescent Date Rape -15 year old Gem obese female, who has a low self esteem meets boy whom she thinks she likes. He invites her to his home. She goes, no one else is home. He tells her to take off her clothes, she refuses, he locks her in and rapes her. Afterwards he tells her to leave. Gem cannot tell mother as mother is very strict and does not allow her to go out with boys. The child guidance clinic study of 1987/88 noted that 7 teenagers were male perpetrators. Three of the group were part of gang rape attacks on three girls. This is a disturbing fact when it is recognised that there is such "disrespect and disregard for females by boys in our community" (Milbourn 1991, p.7)

The Victim -Children are taught to be obedient and obey the requests of adult without questioning. They are also vulnerable because they believe in and fear the threats of perpetrators. under 5 years of age they are not always able to distinguish between right and wrong and their emotional growth and development is hinged on love - i.e. hugging, touching and cuddling. These qualities make them vulnerable to sexual abuse and continuing abuse(Horsham 1989

The Mother In the Jamaican context it has been observed that mothers whose children have been sexually abused were seen to be passive, disconnected from their daughters and accepting the sexual abuse almost as if it were inevitable. They often bow to pressure from family and neighbours "to drop the case" and pay little attention to follow up of the child (Milbourn 1991, p.7)

Behavioural consequences and perpetrators methods - The initial and long term physical and emotional symptoms of sexual abuse vary with the trauma resulting from the abuse and the age and sex of the child. Infants and toddlers may have general irritability from oral and rectal abrasions that cannot be localised by parent or physician. Dysuria from genital trauma may suggest a urinary tract infection. Trauma resulting in laceration to the vestibule, anus or hymen should be associated with bleeding; however, an anal fissure from penetration may be misdiagnosed. Symptoms vary with age and sex of the child. Some may be overt such as fear and avoidance of the perpetrator or general and non specific.Symptoms may present in adulthood and can include medical complaints including alcoholism, sexual compulsiveness, identity and relationship confusion. The older child may be able to relate about the abuse but may be reluctant because of fear of reprisals, guilt associated with the act of acceptance of bribes or fear of dissolution of the family (Garfinkel, Carlson, Weller 1990) In the Child Guidance Study 1987-88 the presenting characteristics of sexual abuse were:

PHYSICAL& BEHAVIORAL OBSERVATIONS ASSOCIATED WITH SEXUAL ABUSE

Characteristics	No	%
Sad and weepy	23	25
Physical symptoms (vaginal discharge)	19	21.1
Sleep disturbance	13	14.1
Aggressive	9	9.7
Somatic symptoms	8	8.6
Seductive promiscuous	7	7.6
Enuresis encopresis	5	5.4
Runaway behaviour	3	3.2
Stealing	3	3.2
Suicidal thoughts and behaviour	3	3.2

(Milbourn 1991 p.16)

Powerlessness or disempowerment results because the girl child's needs and will are made subservient to the perpetrator's. The sense of powerlessness and hopelessness is associated anxiety, fear, phobias, hyper-vigilance, perception of self as victim, somatic complaints school problems, vulnerability to future abuse or becoming an abuser. Stigmatisation occurs because the child is given a message of being responsible or to blame for the abuse. This results in feelings of guilt, shame, isolation, lowered self esteem, suicidal ideation, criminal behaviour and self injuring behaviour such as drug or alcohol abuse.

Masked presentations of sexual abuse are common. These cases are characterised by initial physical or behaviour complaints other than sexual abuse. Masked presentation may make up approximately 19-60% of diagnosed sexual abuse cases. Typical masked complaints are genital symptoms, abdominal pain, constipation or rectal bleeding, straddle injury, pregnancy and other somatic and behavioural problems (De Jong 1990,p.4)

MEDICAL EVALUATION OF SEXUALLY ABUSED CHILD History of sexual abuse Sexual abuse of children usually follows a predictable sequence of events. Historical details corroborated by specific physical findings provide the strongest evidence of sexual abuse. Statements made to the physician may be particularly important in validating the allegations and may be admissable in court as an exception to the hearsay rule. The child's statements are important as they may be the only evidence that abuse has occurred and it is critical that the interview be

carried out with the same attention to detail as with collecting forensic evidence.

A sensitive, non threatening, non leading, unhurried approach is essential. It is usually painful for children to discuss their experiences and can be quite difficult for professionals to listen. Children are extremely sensitive to the reactions of those to whom they disclose the abuse. The interviewer must be open and objective and not presume that the child was psychologically damaged, embarrassed or hurt. Nor should the interviewer presuppose the child's feelings about his or her abuser; such feelings may be complex and ambivalent.

When conducting the interview, the physician should: 1. Inform the child of what will happen during the interview and physical examination. 2 Acknowledge how difficult it is for the child to talk, give support but not promise what cannot be delivered 3. Encourage the child to ask questions 4. Determine child's name for body parts and names and nicknames of family members, use these terms during the interview. 5.Obtain a medical history particularly of the gentio-urinary system or gastro-intestinal complaints 6.Reassure child that she is not to blame 7.Avoid using negative words. 8.Be non judgmental, matter of fact or casual. 9.Supplement a direct questioning approach with the use of communication aids such as drawing activity, puppets or anatomically detailed dolls.

The child is often best interviewed in the absence of the parents although this is not always possible. When taking the child's history the physical should obtain answers to the following questions. Who is the perpetrator? Is he or she a stranger or known to the child? How did the alleged perpetrator gain access to the child, have opportunity for private interaction and how were the activities presented to the child? Was this a single episode or recurrent abuse? Was there a progression of increase in intimacy of contact? How did the child describe his or her feelings during the activities? What were the circumstances surrounding the disclosure and was it accidental or purposeful? When was the last abuse? What has happened since the last episode? What type of sexual contact was attempted? (DeJong 1990,p.5-6)

SEXUALLY TRANSMITTED DISEASES - The sexually abused girl child or any other abused child is at risk of an STD. This may be the only physical evidence of sexual contact and sexual abuse. The matter of STDs has to be handled with care to determine non sexual or sexual transmission. HIV disease poses a challenge in the case of the sexually abused girl child. Testing for HIV disease is indicated in all cases especially where the perpetrator is a known case or there is no baseline knowledge about the perpetrator. In acute molestation recognition of the window period requires that baseline testing be done and the test repeated in three months. The HIV positive child in addition to facing the stresses of abuse has to face new challenges of stigmatisation and of becoming an outcast on society.

Case: Marina aged 7 was sexually abused. She tested positive for HiV and the perpetrator apprehended. Marina had to be

removed from the area in which she lived because she would not have been accepted by the community and school. Father wanted to have nothing to do with her and mother was left to support her. This is only one tragedy of an HIV infected child who has been abused.

SEXUAL ABUSE - THE GIRL CHILD AND THE LAW -The Joint Task Force on Child Abuse stated in its report that "Current laws do not appear to be adequate in the protection of children from sexual abuse, particularly from the point of view of exploitation of young girls".The present age of consent is 16 years having been changed in 1988.There is anomaly between the Incest Act which provides maximum punishment of ten years for a father who abuses his child under 12 years of age and the Offences Against the Person Act which provides a penalty of life imprisonment for carnal abuse of a young girl of the same age who is not related. The Task Force recommends equal punishment for abusers of children under 12 years whether or not they are related plus - 1.Mandatory reporting of child abuse cases. Medical practitioners, social workers and the police are required by law to report cases to the Registry 2.Mandatory counselling and psychiatric treatment for sexual abusers in a family situation. 3.Empowerment of the court to remove the child or offender from the home in the case of incest involving a girl under 17 years while trial is pending, whichever is in the best interest of the child. 4.It is also recommended that provision should be made under the Juvenile Act to prosecute a)the proprietor of a nightclub who employed a girl under 17 b)the owners of premises who knowingly rent their premises for use as a brothel where girls aged 17 are used as prostitutes. c)the persons who watch girls perform indecently or are present at such performances. Reformation of the law is necessary and needs to be more "friendly" in enabling the justice process in sexual abuse of any child. The Convention on the Rights of the Child (Art 34,1989) states that the State shall protect children from sexual exploitation and abuse, including prostitution and involvement in pornography. What should be society's vision of our children? It should be one where are children are happy, healthy, wholesome, protected, loved and cared for to enable them to achieve their full potential and certainly not abused.

Acknowledgements to Dr Pauline Milbourn, Dr Beryl Irons, Joint Task Force,Dr Alfred Braithwaite, Phylis Smikle

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A Framed Childhood Memory

Josephine Lomax-Simpson

What does one retired psycho-analyst do? Surround herself with teddy bears. Yes - whether they belong to the elderly or the young, these transitional love objects have tales to tell about their owners lives.

My latest godchild, Zoe owns Canterbury. She brought him and her feeding mug to see me on Sunday. Her father has told me I can die once I have seen his daughter married. Zoe's mother had decided to leave her with father whilst she took a day off to visit Canterbury - the first occasion for over a year. But suddenly she found herself buying a teddy bear and obviously as she was in Canterbury that was to be its name. Already Zoe has decided that Canterbury is to be a favourite toy. Will it loose an ear? - or be lost ? But there will always be the watercolour I have painted of the teddy bear in the arms of a knitted Father Christmas.

This is a story about 'continuity of concern'. As a young child psychiatrist I originally met Zoe's father age 7 years, at a Reception Centre in Blackheath. I recommended that he be transferred to a Childrens Home which I visited once a week. In due course he grew up and married with a succesful career.

Amanda's father was also someone I met in my professional role 42 years ago. His eldest daughter is another godchild and in August I was present at her wedding. The following day I painted Amanda's white polar bear embracing husband Jeff's monkey - the latter wearing a wedding carnation. A cuddly Australian custard cockatoo benevolently surveys the toys.

Paul is a very special Austrian doll more than eighty years old. He belongs to an elderly psycho-analyst with whom I have been friends for many years. She allowed me to paint him holding her grandchild's doll - a thoroughly modern doll by the name of Madelaine. Sadly Paul lost his true partner when his owner was being chased by the Nazis out of France. Perhaps when life is full of so many discontinuities, transitional love objects can give some stability for their owners - especially confidentiality. I wonder how important Madelaine will prove to be when Paul's owner eventually dies.

'Beetroot', a dark red dog with pointed ears and tail, was one of Tony's first toys at the new long term foster home in Sussex at the age of 18 months. He remained a hidden but constant companion - accompanying Tony from his foster home to a childrens home at the age of eight years. Moving to Wimbledon when he was seventeen, , Beetroot occupied space in Tony's suitcase alongside more recently acquired teddy bears. He helped provide the continuity enabling Tony to create a new life. In 1993 when his owner moved into his own flat 'Beetroot' too found his own space. Emerging from the anonymity of his past existence after 27 years he now occupies pride of place among Tony's possessions.
My painting of 'Beetroot' , complete with red tongue and sitting between his teddy bear friends 'Sgt. Lomax' and 'Reginald' hangs on the wall of the sitting room.

Most weeks Tony attends my large group when we sit together in a circle to talk.. Other members - having seen Tony's picture have brought their teddy bears to be painted. Anny's 'Freddy', Gladys's doll, Audrey's black dog, or Geoffrey's 'Thingy' alongside my very alive dog Lulu. The painter Elizabeth Blackadder has been described as "investing her pictures, even of inanimate and static forms, with energy and life". I can identify with this feeling.

Tom had always kept his dead sister's pink teddy bear . It was this bear that I placed under a 'rainbow of hoops' with a pink feather duster - recreating the same tableau which I remember my drawing mistress assembling for my drawing examination sixty years ago. Perhaps all teachers should encourage pupils to paint their teddy bears - a reminder of those immortal memories of childhood - a framed memory. Would Bion describe this as a container?

August 1996.

Enquiries into Alleged Child Abuse

Promoting Partnership with Families

A policy and Practice Guide for Elected Members, Senior Managers, First Line Managers and Practitioners

PAIN

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Enquiries into Alleged Child Abuse Promoting Partnership with Families

A Policy and Practice Guide for Elected Members, Senior Managers, First Line Managers and Practitioners

This guide has been written as part of a joint project between PAIN, NISW and NSPCC. Its recommendations stem from talking directly with children, family members and practitioners. Its aims are to:

- ★ encourage partnership between families and the agencies involved with them
- ★ avoid conflict between families and agencies
- ★ minimise distress to children and other family members
- ★ ensure the right decisions are made about whether children need protection
- ★ ensure there is as little disruption and intrusion into family life as possible

In his foreword Bob Lewis, CBE, President of the Association of Directors of Social Services writes, that the guide "reminds all of us who are part of the 'system' of the need to bear in mind that there should be a partnership with children and families, even though at times this will be very traumatic and difficult to achieve given the nature of the enquiry. PAIN, NISW and NSPCC have worked in partnership, involving a large number of stakeholders in the child protection process, to produce a guide which represents a consensus about the way forward in making enquiries. I hope that this guide will take all of us further down the road towards achieving our objectives of protecting children and young people who may have been abused whilst ensuring that all enquiries are conducted to the very highest professional standards."

This guide is essential reading for Elected Members, Senior Managers, First Line Managers and Practitioners, and all concerned with policy and practice relating to enquiries into alleged child abuse.

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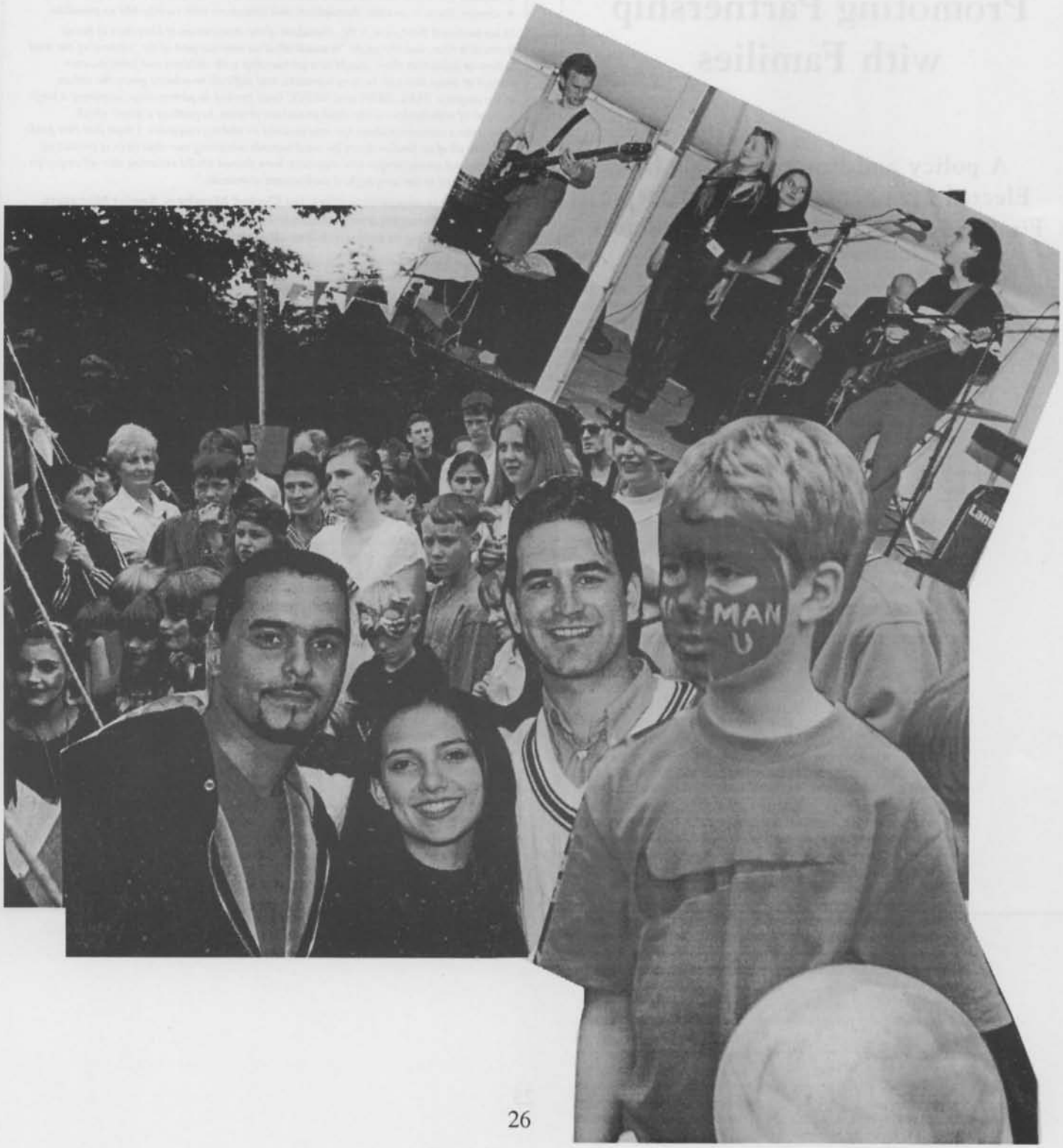
Youth Support Carnival - Sunday 24th May 1998
- Eastenders to the rescue! -

Eastender Italians - The di Marco Family came to the aid of the 'real' Italian family of Teresa (Leila Birch) in supporting young people's charity Youth Support.

The Carnival - Attended by Leila Birch (Teresa) - Louise Jameson (Rosa di Marco) - Leon Lissek (grandfather Bruno) - Michael Greco (brother Beppe) - Marc Bannerman (brother Gianni) publicised Youth Support and it's work and raised money to help run and equip 'the Bridge' and our new play therapy unit. Carnival featured costumes , beads and masks, donkey rides and pet show, games and prizes, clowns, fire eaters and limbo dancers. Music included live bands and Leila took the stage briefly to sing with her 'real' brother's band 'Scrummage'.



The Bridge - Official Opening - Performed by Leila Birch (Teresa) her screen mother (Louise Jameson) 'The Bridge' provides accommodation and aftercare in our half way house, where individuals, couples or parents with children can be offered a semi- independent lifestyle. They are able to move on to their 'own flat' with staff available for support. The ethos is generally that of an extended family - like having an aunt to call on for support and advice. Clients also have access to the services of therapy, counselling and occupational opportunities run by the charity both in Beckenham and in Penge.

Sport Sponsorship -an award was presented to a promising Basketball player to enable him to attend a special training camp in the USA. Nathaniel Henry (17) whose family originally hail from Jamaica , was recommended by the London Towers team and is set to become a basketball star - thanks to Youth Support's help. He was presented his award by screen brothers Beppe and Gianni.

EastEnders

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