DOCUMENT RESUME

ED 390 538 PS 023 759

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TITLE Helping Children through Crisis: A Special Report from the Editors of the Brown University Child Behavior and Development Letter.
INSTITUTION Brown Univ., Providence, R.I.; Manisses Communications Group, Inc., Providence, RI.
REPORT NO ISSN-0885-7261
PUB DATE 90
NOTE 50p.
PUB TYPE Guides - Non-Classroom Use (055) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Acquired Immune Deficiency Syndrome; Adolescents; Alcohol Abuse; Child Abuse; *Child Behavior; Child Development; Children; *Crisis Intervention; Depression (Psychology); Drug Abuse; Eating Disorders; *Mental Health; Pregnant Students; Prevention; Suicide; Traffic Accidents
IDENTIFIERS *Crisis Child Care

ABSTRACT

Noting that today's children face many dangers such as depression (in some cases leading to suicide), child abuse, eating disorders, accidents, alcohol and other drug abuse, and AIDS, this report, drawn from past issues of The Brown University Child Behavior and Development Letter, presents some of the most interesting and useful findings on these issues. The first chapter discusses how mental illness is the absence of mental health and focuses on positive treatments through positive behaviors and attitudes in order to promote mental health in children and young adolescents. The following chapters offer insights on several mental, emotional, and psychological problems and dangers, and may include discussions of tests, symptoms, side-effects, preventions, and other considerations. The chapter topics are: (1) depression and suicide, what is known and what to do about it; (2) child abuse, and the issues surrounding children testifying as witnesses at court trials; (3) recklessness, including treatments for dangerous behavior and early pregnancy; (4) AIDS, with information on how to deal with AIDS in children; (5) addiction, including a discussion of why teens abuse drugs and methods of preventing it; and (6) eating disorders, such as anorexia nervosa and bulimia, and their connections with alcohol use. (AP)

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Helping Children Through Crisis

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A Special Report from the Editors of THE BROWN UNIVERSITY CHILD BEHAVIOR AND DEVELOPMENT LETTER

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Helping Children Through Crisis

A special report prepared for
The Brown University Child Behavior and Development Letter

and published by

Manisses Communications Group, Inc.
Three Governor Street
P.O. Box 3357
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Providence, RI 02906-0357
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Introduction

As professionals -- and parents -- you know the many dangers facing children today -- depression (in some cases leading to suicide), child abuse, eating disorders, accidents, alcohol and other drug abuse, and AIDS. Many of these problems seem to be arising with increasing frequency, making childhood more challenging than ever before. Fortunately, new research is providing new approaches--and even answers--to many of these problems.

In this special report, drawn from past issues of *The Brown University Child Behavior and Development Letter*, we present some of the most interesting and useful findings on such issues, written by top specialists in the field today. After an introductory chapter on "Promoting Mental Health" you'll delve into such topics as:

- **Depression and Suicide** -- What we now know about it, and how to prevent it;
- **Child abuse** -- How to recognize signs of physical and/or emotional abuse, and the issues surrounding children testifying as witnesses at court trials;
- **Recklessness** -- Treatments for dangerous behavior and early pregnancy;
- **AIDS** -- How to discuss and deal with AIDS in children
- **Addiction** -- Why teens abuse drugs and methods of preventing it;
- **Eating disorders** -- Anorexia nervosa, bulimia, and connections with alcohol use;

We hope you find this report to be a valuable resource in your work. Future issues of *The Brown University Child Behavior and Development Letter* will continue to provide important and practical information on a wide variety of issues facing children and adolescents.

John P. Sulima
Executive Editor

Promoting Mental Health in Children

With improved sanitation, nutrition and medical care during the past 100 years, the threat to the development of children has shifted from physical to mental disorders. Between 10 and 20 percent of children aged 4 to 16 in developed countries have persistent and socially handicapping mental health problems, not to mention growing rates among adolescents of drug use, juvenile delinquency, accidents, sexually transmitted diseases and premature parenthood.

Most mental health problems in children and young adolescents are quite different from adult disorders. Children often show severe difficulties in one situation but not in another (for example, at school but not at home), and many problems can be seen as responses to specific situations. These characteristics indicate that children's mental health problems are linked to environmental factors in a more direct way than at any other age period. They may be best understood as deviations from normal psychosocial development resulting from disrupted or chaotic experiences in the family, at school, or in peer relationships.

As a result, interest has been growing in preventing mental health problems by promoting healthy psychosocial development in children and adolescents. Mental health traditionally has been defined almost exclusively as absence of mental illness. As a result, mental health clinicians have emphasized the diagnosis and treatment of mental illness at the expense of mental illness prevention and mental health promotion.

"Mental health," however, can also be defined in opposite terms: mental illness is the absence of mental health. If a mentally healthy person exhibits particular behaviors and attitudes that allow him to function effectively in a particular culture, mental illness might then be seen as the result of failing to develop these psychological and social resources, leading to maladaptive, problematic forms of behavior.

In children, the two most prevalent forms of psychiatric or psychological disorders are: externalizing or conduct problems, characterized by aggressive, hostile, antisocial behavior and attitudes, impulsiveness and a lack of self-control; and internalizing, or emotional problems, characterized by high levels of anxiety, depression, low self-esteem and psychosocial difficulties. B th of these general problems result from the failure of children to learn particular social and cognitive skills and attitudes.

Positive Treatment

The positive mental health perspective is consistent with current treatment for many social and emotional disorders in children and adolescents. These procedures concentrate on establishing positive behaviors and attitudes rather than reducing particular symptoms or problematic behaviors. Social skills training, assertiveness training, empathy, effective problem-solving skills, and communication skills are the major therapeutic interventions with aggressive and hyperactive children and juvenile delinquents as well as with depressed, socially withdrawn or extremely anxious children. Increasingly, therapy also involves parents and teachers.

Still, such treatment is aimed at children and teenagers already manifesting substantial social or psychological problems. Regardless of the ultimate success of therapy, the number of children with behavior disorders remains too large to be dealt with effectively by the current mental health care systems in industrialized countries and is an impossible task for developing countries where the number of professionals available to deliver therapeutic services is small. As a result, the effort to prevent mental disorders has generated substantial interest.

Health Promotion

Nevertheless, many mental health professionals have been reluctant to embrace such activities. This skepticism is based on several factors: the unrealistic expectations several decades ago of such measures as child guidance clinics or intensive psychotherapy; the inability to design effective programs to prevent severe mental disorders such as schizophrenia or affective disorders; and the view of mental health as the being the lack of mental illness.

To date, health promotion activities, including health education programs, have been concerned primarily with the promotion of physical health, such as teaching about the importance of good nutrition and physical exercise, and the detrimental effects of tobacco, alcohol and other dependence producing drugs. Little attention has been given to mental health and the promotion of healthy psychosocial development despite the repeated acknowledgement of the importance of mental health by advocates of general health promotion.

One reason why mental health promotion has lagged behind physical health promotion is the lack of empirical information regarding the attitudes, behavioral capabilities and environmental factors which are essential to healthy psychosocial development. Areas of personal competence and experience effectively prevent or deter the development of psychosocial problems.

Researchers in the emerging field of developmental psychopathology have begun to identify those behaviors, attitudes and environmental factors of young children which are most predictive of serious psychosocial and social maladjustment during later childhood, adolescence and adulthood. This has been accomplished using longitudinal studies and by comparing groups of children and adolescents who manifest psychological and social problems with other groups who show normal psychosocial functioning.

Another relatively recent strategy involves the study of so-called "resilient" or "invincible" children, i.e., children who show normal psychosocial development despite being exposed to a variety of conditions known to be risk factors for psychiatric or social difficulties. In order to understand better the paradox inherent in the fact that some persons become more easily debilitated mentally than others, with apparently comparable stressors in their lives, we have to know the answers to a wide variety of questions -- issues of nature versus nurture, subtle differences in environmental conditions, etc. While the task seems formidable, behavioral scientists have long dealt with complex antecedent-consequent relationships. Many of our theories about decision-making processes, learning phenomena, sensory integration, and cognitive reorganization involve sophisticated models on which developmental scientists should be able to rely in dealing with complicated coping mechanisms of adjustment (or maladjustment) when people fall victim to unusual stresses.

Although there is still much to be learned, at least four factors characterize resilient, mentally healthy children:

- **Social competence**: the ability to relate effectively to other members of one's society, including peers, adults and family members. Social skills begin to emerge in infancy, develop rapidly during the preschool years and become extremely important during the primary school years and adolescence. Specific characteristics of social competence include communication skills, sensitivity to the needs of others, knowing how to cooperate with others, being able to effectively resist negative influences from others, recognizing and responding effectively to various emotions in oneself and others, and assertiveness skills.
- **Cognitive problem-solving skills**: the identification of problems, systematic generation of plausible solutions, reflecting over the quality and possible consequences of various solutions, and selecting and evaluating a par-

ticular solution. These skills can be applied to both academic problems and social problems, such as peer conflict or rejection.

- **Coping with emotional stress**: recognizing stress in oneself and others, establishing and utilizing social support, employing personal coping strategies such as internal dialogue and relaxation, and developing one's individual interests, strengths, and feelings of esteem have all been identified as effective means of coping with stress.
- **A source of social support**: although this support often comes from one or both parents, it can also be provided by a teacher, another family member or a peer; in short, anyone who expresses a genuine interest in the child, someone who "really cares."

These characteristics are currently being emphasized in many treatment programs for youth who suffer from personality and conduct disorders. Consequently, social competence, problem solving, coping with stress, and social support are important concepts for mental health promotion programs which are designed to prevent psychological and social problems in children and adolescents by fostering normal psychosocial development.

Two Age Groups

Two age groups are particularly appropriate for programs that promote mental health: early school age children, aged 6-8, and young adolescents, aged 11-13.

Children aged 6 to 8 years are forming stable attitudes and patterns of behavior. Difficulties with peer relationships at this age strongly predict later social and psychological maladjustment. At a young age children have begun the important task of learning social competence. Also, children begin to form concepts about themselves and the world, including feelings of personal competence in school, with friends and in coping with stress.

Young adolescents are undergoing rapid physical, psychological and social changes and are beginning the transition from childhood to adulthood. It is particularly important that healthy psychosocial functioning be encouraged during this period, for it is a time when many social and psychological problems being to manifest themselves, particularly delinquency, substance abuse and emotional disorders. Most are still in school, where programs can be implemented that reach a large percentage of youth.

Prevention programs for the younger group should focus on conduct disorders, specifically aggressive behavior and attitudes, hyperactivity and impulsivity, and on emotional disorders, such as social withdrawal, anxiety and feelings of inadequacy. For the adolescents, the major problem areas are conduct disorders manifested in antisocial and delinquent behavior and attitudes; emotional disorders usually seen as depression, anxiety, low self-esteem and social withdrawal; and substance abuse, involving alcohol, marijuana, or other drugs.

Well-adjusted, resilient children typically have good social coping skills, approach different problems systematically and flexibly, and see themselves as having a social support person or network. Youth with personality or conduct disorders seem to benefit from treatment programs leading to these attributes. Fostering normal psychosocial development involves helping the child or adolescent to develop special skills for coping with stress, so that the achievement of real competence and the feeling of competence becomes possible.

Depression and Suicide

The Search for Childhood Depression

Strides have been made in recent years in identifying and treating depression among adults. Unfortunately, progress in identifying and treating mood disorders among children has not been as great.

Recent investigations of depression have suggested the existence of at least two distinct subtypes; there may be more. Those identified as clear and distinct are:

- **Bipolar**, in which the condition is cyclical. The subject's mood may cycle over time between elation and depression, or discrete episodes of elation or depression may occur periodically.
- **Unipolar**, in which the person feels depressed without periods of elation.

There is good evidence for an inherited factor in these disorders. Pedigree studies have demonstrated a high incidence of mood disorders and alcoholism in certain families. In studies comparing incidence in genetically identical twins versus non-identical twins, it has been shown that concordance for affective disorder is significantly higher among identical twins. Some studies have suggested a stronger genetic link for the bipolar subtype than for the unipolar subtype.

What About Children?

These interesting findings have prompted research in child psychiatry. Do some children suffer from an early equivalent of melancholia? If so, what is the biochemistry of the disorder, and can it be reversed with antidepressants or lithium?

The misery of many unfortunate children is not in question. Dickens described it eloquently. The essential question is whether children ever develop the peculiar syndrome of agitated depression, thought disorder, listlessness and insomnia which is characteristic of adult melancholia. Putting the matter simply, is it possible to distinguish depression from everyday unhappiness in children?

Up to this time, both genetic and biochemical studies for the most part have involved only adults. It is difficult, for example, to find large enough samples of children who are twins or to identify mood disorders during childhood. Biochemical studies involving children raise the serious ethical concerns of drawing blood and injecting chemicals when no clear benefit is gained for the child. But while the few studies completed have involved only small samples, they are consistent with adult biochemical findings.

The Effects of Separation

During the last 40 years, there have been several celebrated studies of the effect of separation and emotional neglect on children.

Shortly after World War II, Rene Spitz described the physical and mental stunting of neglected babies, while John Bowlby reported the rage, desolation, and ultimate apathy of young children separated from their parents. Could these reactive conditions be compared with melancholia? Do older children have sufficient mental maturity to experience the guilty self-recrimination so characteristic of the adult disorder?

Although these studies have been criticized recently from a scientific point of view, primarily because of the inadequate reporting of data, Spitz's conclusions were probably correct, even if he did exaggerate some of the effects.

Spitz and Bowlby's studies have been extremely influential in the study of attachment motivation. Other studies have suggested that attachment to infants by their parents has evolved as a means to promote survival among social species. Distressed infants of many species cry, for example, sending signals to attract the parent. The parent has reciprocal responses, a mother being unable to resist the cries of her child. When attachment is disrupted, the child undergoes a profound physiological and psychological reaction. If separation persists, the child enters a mourning period, the purpose of which is to attenuate attachment bonds and re-attach to someone else.

Is there an overlap between normal mourning and melancholia? Freud saw melancholia as a distorted form of mourning, the melancholic demonstrating a pathologically intense and persistent mourning response. Spitz's and Bowlby's studies have suggested why some persons later are vulnerable to mood disorders. Subsequently, a number of studies have sought to find whether pathological separation during childhood predisposes adults to mood disorders. So far, there has been no clear answer. Retrospective studies are unreliable; for example, melancholic adults may have a different perspective on their childhood than normal adults. But longitudinal studies of individuals require long periods of observation.

Misery or Melancholia?

In the 1960s, a number of psychiatrists referred to the running away, stealing, sexual escapades and irritability of troubled youngsters as "depressive equivalents" or "masked depression." The child was thought to be warding off intolerable sadness with eruptions of impulsive activity. Recent studies have suggested, however, that overt disorder of mood can be determined in many of these patients if the pertinent questions are asked. Do they feel sad, unlovable, unwanted, ugly, bad or as though life were not worthwhile?

But how can common misery be distinguished from melancholia? Is it likely that the adult syndrome of melancholia would be replicated in children? Recent surveys have shown that many normal youngsters experience sadness, low self-esteem and hopelessness from time to time. However, psychologically disturbed children are even more likely to harbor such feelings. Do these feelings indicate a depressive disorder or are they nonspecific concomitants of emotional distress? Delinquent, school-phobic and learning disordered children alike express their unhappiness in these terms. Furthermore, it is difficult to evaluate the answers of children to direct and persistent clinical inquiry. There is no guarantee that children's emotional responses have the same meaning, or the same reliability, as those of adults. But, until recently, the children weren't even being asked such questions. Whatever the reliability and meaning of their responses, the matter cannot be lightly dismissed.

Biochemical Testing

If there were a reliable biochemical test for melancholia, the puzzle would be easier to crack. A breakthrough was thought to have occurred when Dr. Bernard Carroll, now chairman of the psychiatry department at Duke University, introduced the Dexamethasone Suppression Test (DST). Based on the known effects of dexamethasone on cortisol sensation, the synthetic drug is injected and levels of cortisol in the blood measured over 24 hours. If the levels are not suppressed significantly, the patient is thought to be suffering from depressive disorder.

Recent studies, however, have cast doubt upon the sensitivity of this laboratory procedure. If the results are positive, the practitioner can be fairly certain the patient has a mood disorder. A negative result, however, is not nearly so conclusive. The practical utility of the test has recently been questioned, particularly in children.

There have been few acceptable scientific studies of the efficacy of antidepressant medication in children thought to be melancholic. No definite conclusions can be drawn, although it appears that psychosocial therapy is no less effective than medication in helping most children thought to be depressed. The current widespread use of antidepressants in such cases does not have firm scientific foundation. Psychiatric enthusiasm for the medication is premature.

Severe Side-Effects

Higher doses of these medications can have severe side-effects, especially on the rhythm of the heart. In fact, there has been one death caused by excessive dosage of antidepressant medication in one case when the drug was prescribed (for reasons other than a mood disorder). Antidepressants can also be quite lethal if used for suicidal effect, a point to keep in mind in the case of adolescents.

What does the future hold? Further elucidation of the biochemistry of melancholia may lead to the development of reliable laboratory tests for the disorder. These tests will be applied to children to determine whether the behavioral mood syndrome has any validity. Controlled studies will determine which children, if any, are helped by antidepressants. Psychological therapies will be further developed to reverse the chronic pessimism which renders some youngsters vulnerable to loss or disappointment. Finally, the association between psychological predisposition, social stress, depressive feelings and adolescent suicide will be more intensively researched.

As we have seen, while much has been learned about depression, we are only at the beginning of studying mood disorders in children.

Birth Stress and Adolescent Suicide

It's no secret that adolescent suicide is on the upswing; newspapers and television have given great attention to the problem. In fact, during the past three decades, the rate of suicide among teenagers has risen four-fold with no corresponding increase among the population as a whole.

While the questions raised by that statistic are far from settled, a study conducted at the Brown University Child Study Center sheds another small beam of light on a problem that continues to baffle experts in all of the relevant disciplines.

The study, published in a recent issue of the British medical journal *Lancet*, showed that teenagers committing suicide were more apt to have experienced stresses before and during birth than those who don't. That's not to say that all or even a moderate number of at-risk babies go on to take their own lives; they still form a very small proportion. But recognizing that seemingly minor birth stresses can escalate into suicide may give us clues as to how to reduce those numbers even further.

Clinical Observations

The study was prompted by the author of the article, Dr. Lee Salk, a child psychologist at Cornell University Medical College's psychiatry department in New York City. He had noted that parents of adolescents attempting suicide often told him that their children had been born at risk.

The idea was not without precedent. Other studies had found links between birth stress and later problems. The Child Study Center, for example, found several years ago that babies who suffered crib death had experienced more adverse life events during their mother's pregnancies or during their own birth, than control infants of the same sex and race who had been born in the same hospital at about the same time. Before this,

a noted forensic pathologist in Sheffield, England and his biostatistician collaborator had made a similar finding. In Finland, a group of medical researchers have also shown that schizophrenics have a higher-than-usual incidence of perinatal and early developmental risks in their medical histories. One can only speculate as to how such early conditions of jeopardy may impose themselves upon other aspects of an individual's life outcome.

In the Brown study, ten risk factors were found to be more frequent in the histories of the suicide victims and their families than in the control groups. These included previous premature births, bleeding during pregnancy, and duration of labor. Objective statistical methods, however, turned up three factors that were especially pronounced in the suicide group compared with controls. They were:

- Respiratory distress of the child for longer than one hour after birth;
- Chronic disease in the mother, and
- No prenatal care prior to the 20th week of pregnancy.

Interestingly, these three events were not related to each other. The events were most often present as a single factor of jeopardy in the individuals eventually committing suicide.

What It Means

For the first time, there is evidence that a connection exists between perinatal stress and adolescent suicide. For practitioners, it provides another factor -- but not the only one -- to look for when evaluating an adolescent who seems bent on committing suicide. Other factors to include are:

- **Depression**. About one-quarter of all teenagers in the U.S. experience some crisis that leads to depression, although only a small proportion actually attempt suicide. About two-thirds of those who do, however, show signs of depression such as changes in appetite, sleep, or school performance; changes in personality, such as increased moodiness, withdrawal, or aggression.
- **Loss**. A breakup of a relationship, perceived or actual failure in school, or a conflict with parents sometimes can set off depression leading to suicide.
- **Self-destructiveness**, including use of alcohol or other drug abuse.
- **Poor problem-solving skills**. Often, suicidal teenagers, while bright, are underachievers because of developing psychological problems or a situation that exacerbates conflict with parents.
- **Family problems**. Suicidal teenagers more often have parents with marital, drug, or alcohol problems, or who may be depressed themselves.
- **Preoccupation with death.** Teenagers contemplating suicide often fantasize killing themselves in their writing or art.
- **Previous suicide attempts.**

If teenagers exhibit some of these symptoms and have also been found to have experienced perinatal stress, then this study warrants the practitioner to keep an even closer eye on the teenager and begin or intensify psychological or social counseling for the individual and his or her family. Common sense also dictates that prescription medications and firearms -- the two means most commonly used by suicidal adolescents -- be kept under control.

Some Considerations

There is a danger, as some have pointed out since the study was published, in inferring that all or most at-risk births result in suicidal teenagers, which is clearly not the case. We must consider that only a retrospective study could have easily established these risk conditions as having some effect on outcome. If one started with a group of infants who had been resuscitated at birth, or a group of infants whose mothers did not seek medical help until after the 20th week of pregnancy, most of the surviving babies

would have been indistinguishable by 12 years of age from a general population of babies not born under such conditions of risk. Thus, we are talking about "minimal jeopardy" set up by these risk factors.

Others have expressed concern that these findings will be misinterpreted, particularly by parents of adolescents who have committed suicide. Critics have said that these parents, who already have an enormous burden of guilt to bear, should not have to assume that perhaps some preventable condition of fetal development or birth might have obviated the suicide. The fact is that most of the perinatal stresses associated with suicide later on could not have been prevented, such as the chronic disease in the mother or the need for resuscitation at birth. If anything, knowledge of the essential conspiracy of perinatal factors that constituted risk should help alleviate parental self-blame.

Most parents today are quite well-informed about numerous factors of fetal life that may contribute to eventual developmental deficits. For example, some taverns have signs warning pregnant women that excessive drinking may damage their offspring. Admittedly, there are ethical issues involving how much information is given and when. Our society, however, like most Western societies, seems to have decided that the public should be informed about the possible deleterious effects of smoking, drinking, pollution, and even anesthesia on developmental outcome. The study of adverse prenatal conditions, and the revelation that these might be related to adolescent suicide as well as to other unfortunate developmental outcomes such as schizophrenia and cerebral palsy, is just one further step along the way to becoming a well-informed society. The ultimate prevention of such outcomes will depend on work of this sort.

The Roots of Suicide May Be Both Biological and Imitative

Suicide may have both biological and imitative roots, according to recent but separate reports.

The first of these reports suggests that some congenital brain abnormality may lie behind suicidal impulses, and that this abnormality might be counteracted by drug treatment. The brain characteristic -- an unusually low level of serotonin, a neurotransmitter--was found in 30 Swedish patients hospitalized for suicide attempts. Within a year, 20% had succeeded in taking their lives.

In related findings, presented at a New York Academy of Sciences meeting in 1985 and published in 1986, many experts argued the view that some biological vulnerability exists in suicidal persons. Suicide prediction has always been a weak enterprise; so many apparently vulnerable persons do manage to withstand the stresses of life, while others who have not seemed suicidal surprised their closest friends and relatives by killing themselves. Any effective biological marker, hereditary or otherwise, could help forestall suicide by providing a signal for intervention.

Another view suggests that suicide, as well as other forms of violence, may be contagious. Sociologist David P. Phillips of the University of California at San Diego has drawn together a great deal of evidence (published in the July/August 1985 issue of The Sciences) to show there may be a very heavy "contagion effect" in suicide. Because suicide is undoubtedly multi-determined, this view does not necessarily run counter to the possibility of a biological marker. Suicide, after all, may occur more often in people hereditarily or constitutionally disposed to commit suicide, and at the same time the act may be triggered by psychosocial circumstances additional to the biological conditions.

Professor Phillips makes a convincing argument for a sort of epidemic of imitative self-destructive behavior often following the suicides of celebrities. In 1774, J.W. von Goethe wrote a novel, *The Sorrows of Young Werther*, which documentably "drove to sui-

cide" numerous young readers seeking to imitate the hero; the book was banned, therefore, throughout Denmark, Germany, and Italy.

Dr. Phillips examined the effects of a more modern suicide: Marilyn Monroe's in August 1962. Using *The New York Times* as his detector of celebrated suicide events, he noted the incidence of suicide in other Augusts and compared them for the entire period from 1947 to 1968, and then looked at the suicide rates throughout the U.S. at the tagged time periods. There was a definite relationship. For example, in the month after the Monroe suicide, there were 197 more suicides than there would have been otherwise expected--an increase of 12%. It also turns out that highly publicized single car accidents (the drivers in such instances are often suspect for suicide) are followed by a significant rise in other such accidents.

Finally, there is an age-congruity phenomenon associated with all of this. The "model" seems to attract greater incidence of suicide in like-aged persons. Thus, it goes without saying that prevention of one suicide may actually have a deterrent effect upon numerous other "follower suicides."

Child Abuse

Preventing Sexual Abuse of Children

Few prospects are as frightening to parents as the sexual abuse of children. According to statistics, nearly one in every four children in America will be sexually abused by the age of 18. Sexual molestation ranges from exhibitionism and pornography to fondling and intercourse. At least 10 percent of these children are less than 5 years old when they are first attacked.

Today a child is more likely to be sexually abused than hit by a car. Yet parents generally find it easier to teach their children the rules of the road than how to face their sexuality. It is time for child care professionals to encourage parents to put lessons about sexuality and sexual abuse warnings in the same context as other information children need for their safety and survival.

As professionals, we are one step removed from preventing sexual abuse. We can, however, counsel parents in what they can do to protect their children.

Be Open

The first step for parents is to deal with their own sexuality in a realistic and open way. Children need and deserve correct information about their bodies and their rights to privacy. If parents hesitate to give it to them, they put their children at a disadvantage. Studies are beginning to show that children are less likely to be sexually abused if their parents give them correct information. They are also more sexually responsible later in life.

Sexual assault results from an imbalance of power between the victim and the offender. Children become less vulnerable to these pernicious acts when we teach them how their anatomy works, how to refuse improper advances and how to get help.

Starting around age three, as children become more independent, they begin to ask their parents questions about sexuality. During the preschool years, they will ask more of these questions than any other time in their lives.

If parents ignore or postpone questions about sexual matters, they lose the opportunity to share their own feelings about sexuality. Although the basic information is always the same, the way in which they share it and the values or restrictions they place on it are solely theirs as parents and teachers.

Helping children feel good about themselves, their bodies, and their relationships with others is as important as giving factual information. Talking about love is a major part of sexuality education. Since children often learn by watching, they ways parents express affection and interact with others also reveal a great deal.

Facts of Life

Urge parents to minimize any embarrassment or fear when it's time for them to discuss the facts of life with their children. They should emphasize open communication and self-reliance on the child's part. They must remember that preschoolers need to know how their feelings can help them make decisions.

If the child asks a question about the difference between boys and girls or the start of life, parents should give themselves a moment to think before answering. They can find out how much their child already knows, including any misconceptions, by ask-

ing, "What do you think?" Answers should be short, simple, and honest, using language the child can understand, but correctly naming body parts and functions.

Dr. Sally Koblinsky, a San Diego State University educator, suggests the following guidelines for parents of preschool children:

- They should clarify their sexual values with their spouse and rehearse how they will respond to their child's questions.
- Children's books on the subject are helpful in explaining sexuality.
- Parents should answer questions as they come up. If they don't know the answer, they should admit it, find the information, and get back to their child.
- If the parents feel uncomfortable, they might try saying "This is hard for me, but I want to talk to you about it anyway."
- Remember, children will stop listening when they are no longer interested.
- If a child hasn't asked any questions by age 5, parents shouldn't assume a lack of curiosity and bring the subject up themselves.

Often children not only ask questions but explore each other's bodies. If parents scold or punish their child for engaging in sex play, they may make the behavior seem more exciting. They may also increase its frequency or give the idea that certain parts of the body are "bad."

If parents find children playing this way, they should acknowledge their curiosity, saying, "It looks as if you're curious how boys and girls are different. Put your clothes back on and let's look at a book that shows us these differences."

As children mature, they will need specific information not only about differences between the sexes, but also about the process of reproduction, menstruation, pregnancy, and birth. They need to know that masturbation is a natural response that feels good and that two people "make love because they care deeply for each other, find it enjoyable, and both want to do it."

Protecting Children

As parents teach their children about sexuality, they must also tell them how to protect themselves against sexual abuse. Parents should not worry that discussing sexual assault will cause their children to grow up suspicious or fearful of everyone. After all, we don't worry that we'll frighten our children or harm them when we repeatedly warn, "Don't run out in front of cars," or "Don't pet strange animals." Children should be told their bodies are private and no one has the right to touch their private parts. They should understand this rule applies to family members and close friends, as well as outsiders. Only a physician examining them or a parent or caregiver bathing them or applying medicine qualify as exceptions.

Sexual abuse, however, should in no way be confused with loving, physical contact between adults and children, which all youngsters need to thrive and grow. Responsible adults automatically limit their physical affections with children. They respect the child's person as part of a warm, healthy, relationship.

Parents should talk to their children about good touches like tickling and hugging, bad touches like being tickled so much it hurts, and confusing touches, perhaps when someone sneaks up on you. Children should not be forced to touch other people or be touched by them. If they don't want to kiss a relative, they can shake his or her hand. Parents should always back up their child's feelings.

Children should be told what sexual assault means. It is a "touch that doesn't feel good." Someone might try "putting his hand down your pants, rubbing up against you,

telling you to touch her, making you look at him or asking you to keep a secret," parents may explain.

Youngsters usually think: "Yuck! Who would do that?" They need to know that it could be a stranger or someone they know. If a stranger approaches them, they can say, "I'm not allowed to talk to strangers." Then, if necessary, they can run away. Children must also realize who a stranger is.

Parents can also explain that "even nice people may not realize how mean they are," or that "everyone makes mistakes."

Saying "No"

From research, we know that most common sexual assaults are fondling and exhibitionism. We also know that the majority of sexually abusive situations develop gradually over time, which gives children a chance to act. Since bribes and threats rather than extreme physical force usually are used to make youngsters comply, children should know how to respond to such blackmail.

Children must be told to refuse when someone says, "I'll let you feed the rabbits if you undress for me," "Don't tell or I'll go to jail," "I'll let you watch TV if you let me touch you," or "Don't tell our secret or I won't like you anymore."

Children should not be taught to blindly respect or obey adults. They must learn to say no. They can say, "My mom told me not to," or "I'm going to tell my dad," or "Don't do that!" Children should be told:

- If someone wants to hug you and you don't want them to do it, say "No, thank you."
- If someone pats you on the bottom, tell him not to.
- If someone grabs you through your clothes, say, "Stop, I don't like that!"

Children should have a chance to rehearse "what if" situations. They need time to plan out what they should do if they get separated from parents in a grocery store, a babysitter wants to take a bath with them, someone they love wants to put his hands down their pants, or a neighbor whose flowers they've picked says he won't tell if they will play a secret game with him.

Parents must make sure they give their child a firm set of rules to fall back on if a potentially abusive situation arises.

Watching Out

Parents must properly screen babysitters and day-care providers and review for them the family rules. They must always let a substitute caregiver know that their family doesn't keep secrets. Parents can say that they want to know if anything goes wrong and that their children have their permission to say "no" if they don't understand a request. They should follow up by asking both the sitter and their child how they feel about their time together.

Children need to be told more than "mind the babysitter." They need to know the rules they are expected to obey and that they can refuse babysitters who threaten them or offer special treats for doing something they don't understand.

Tell parents to watch if their child appears uncomfortable for any reason and act on any suspicion. They must be wary of someone who won't listen to their child's attempts to set limits, an adult who continually entices children into his or her home, or a certain friend that their child suddenly avoids.

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Children should be encouraged to tell parents or other responsible adults, such as teachers, if anyone touches their body or asks them to do the touching. If a child comes to you, as a child care professional, listen, believe what is said, and support him or her.

Be ready--and urge parents as well--to call the police and the department of social services if you find that a child has been abused. Don't confront the offender in the child's presence. Keep cool, and remember it isn't the child's fault.

Our children need to know that they can come to us if something happens to them that feels uncomfortable or that they don't understand. They have a right to ask us about puzzling adult behavior. They also have a right to control who touches them, and how.

What Is Psychological Maltreatment?

Each morning a mother threatens her 4-year-old son with abandonment: "Maybe today is the day I go away and leave you alone. You'd better be good or you'll never see me again." A father restricts his 7-year-old daughter to her room every day after school: "I don't want you involved with other kids; they're not good enough for you." A man suspects he is not his 3-year-old son's father, that the boy's mother had an affair while he was away on business. Now he refuses to speak with the boy: "He's not mine; I don't want anything to do with him."

These parents are psychologically maltreating their children. What they are doing and saying jeopardizes the development of self-esteem, social competence, the capacity for intimacy, and positive and healthy interpersonal relationships.

But what exactly is the problem? How do we relate these cases of severe psychological maltreatment to the broader range of behaviors that pose a threat to the emotional and intellectual development of the child?

We can start with efforts to zero in on a cluster of behaviors that exemplify psychological battering. Lenore Walker, in her work on spousal abuse, says "psychological torture" includes "violence correlates" such as physical attacks on the victim's possessions -- pets, plants, and loved ones -- as well as isolation, sleep and food deprivation, monopolizing of perceptions, verbal degradation (name-calling or humiliation), threats to kill, and drugs, all mixed occasionally with indulgences.

2.2 per 1,000 Abused

In 1978, the National Center on Child Abuse and Neglect defined emotional abuse as verbal or emotional assault, close confinement, or threatened harm. Emotional neglect included inadequate nurturance or affection, knowingly permitting maladaptive behavior such as delinquency, and other refusal to provide essential care. Using these definitions, the federally funded National Incidence Study found that 2.2 per 1,000 children in the U.S. were subjected to emotional abuse and that 1.0 per 1,000 children were victims of emotional neglect.

Any observation of psychological maltreatment depends heavily on the social and cultural context. Psychologically abusive behavior conveys a culture-specific message of rejection or impairs a culturally valued psychological process, such as the development of a coherent positive self-concept. Stuart Hart speaks of acts or omissions that "aim directly at the heart, at the self, that torpedo the ego." When families or societies sabotage this process of establishing a strong ego, when they send destructive messages to children, we enter the realm of psychological maltreatment.

Factors in Child Abuse

We cannot understand these messages without the perceptual filter of culture. We must accommodate cultural and ethnic differences when defining such maltreatment. For example, in some cultures it is normal for children to sleep with parents. In others, such arrangements verge on the pathological. Conversely, some cultures consider it abusive to require that infants sleep apart from parents. Some such differences are simply a matter of style; others reflect alternative but equivalent socialization goals. Still others reflect real pathology because they violate a set of categories general enough to reflect the universals of human nature.

Culture is not the only accommodation, however. If we are to move to an operational definition of psychological maltreatment, we must take into account a developmental perspective on the meaning and significance of behavior. Clearly, what psychological maltreatment is for young children may not be for adolescents and vice versa. For example, scaring with tales of ghosts and monsters is a genuine threat to most young children but to very few adolescents. Teenagers are sensitive to peer humiliation while infants are not.

Developmental Issues

We may need age- or stage-specific definitions to the same extent that we do in assessing social competence and other developmental phenomena. Are developmentally advanced children more resistant to some forms of psychological maltreatment but more vulnerable to others? Are cognitively sophisticated children more vulnerable to subtle insult than unsophisticated children? Are infants more vulnerable to being ignored than adolescents? We must work out these questions.

We must also approach this issue developmentally. The vulnerability of children shifts as cognitive, linguistic, and affective capacities emerge. The infant's pre-programmed need for developing attachment makes the aloof parent a serious threat while the adolescent's impulse to conformity makes threats of public humiliation particularly powerful as a form of abuse.

Central Issue

Rather than casting psychological maltreatment as an ancillary issue, subordinate to other forms of abuse and neglect, we should place it as the centerpiece of efforts to understand family functioning and to protect children. In almost all cases, the psychological consequences of an act define that act as abusive. This is true of physical abuse, too -- an injury inflicted by a parent in rage is different from the same "injury" inflicted by accident in the course of an athletic event. It is also true of sexual abuse, since sexual acts have little or no intrinsic meaning apart from their social psychological connotations - as the incredible variety of norms regarding sexual activity in childhood and adolescence across cultures suggests. Rarely, if ever, does a child experience physical abuse or neglect, or sexual assault or exploitation in a relationship that is positive and nurturing. Indeed, even to pose the matter in such terms seems ridiculous.

Psychological maltreatment, then, is a concerted attack by an adult on a child's development of self and social competence, taking five forms:

- **Rejection**: the adult refuses to acknowledge the child's worth and the legitimacy of the child's needs.
- **Isolation**: the adult cuts off normal social experiences, prevents the child from forming friendships, and makes the child believe that he or she is alone in the world.
- **Neglect**: the adult is psychologically unavailable, being physically present, perhaps, but not responsive to the child's need for interaction.

- **Terror**: the adult assaults the child with words, creates a climate of fear, bullies and frightens the child, and makes the child believe that the world is capricious and hostile.
- **Corruption**: the adult "mis-socializes" the child, stimulates the child to engage in destructive behavior, reinforces that deviance, and makes the child unfit for normal social experience.

These behaviors are basic threats to human development. Psychological maltreatment is the core issue in the broader picture of abuse and neglect. It provides the unifying theme and is the critical aspect in the overwhelming majority of what appear as physical and sexual maltreatment cases.

Must Compensate

When children are rejected, terrorized, ignored, corrupted, or isolated from sources of social support, they are vulnerable to negative influences in the broader social environment. Accordingly, the key to stress resistance is the absence of psychological maltreatment. Threat, trauma, or deprivation in one domain of a child's life increases vulnerability to the effects of threat, trauma or deprivation in another. For example, children who are emotionally deprived at home are more vulnerable to negative experiences in day care than children whose home life is enriching.

Whereas children can absorb and overcome the experience of physical assault and sexual misuse if they are psychologically strengthened, they rarely do so if they are psychologically mistreated as part of the experience. Mounting evidence on the beneficial impact of treatment of sexual abuse victims seems to verify this proposition. Similarly, emotional support in the process of disclosure and investigation can go far in reducing adverse consequences.

The concept of psychological maltreatment offers a vehicle for unifying and illuminating the broader topic of abuse and neglect. Such a conception anchors efforts to identify, diagnose, and intervene where they belong, in the child's emergent map of the world and his or her place in it.

Background Factors in Child Abuse and Neglect

Little is known about which treatment approaches are most effective with cases of child abuse or neglect. This is due, in part, to the fact that the characteristics of families of abused and neglected children are so diverse.

In order to discover which approaches seem most successful in averting abusive/neglectful interactions, Thomas Kochanek, Ph.D. of Rhode Island College and his research team carefully examined the attributes of families in which child abuse/neglect had been substantiated and also looked at the services provided by Protective Service Treatment Programs (PSTP) in a New England state. Here is what they found:

Child Characteristics

Information about children and adults who receive treatment yields a profile of individuals with multiple risk factors or disposing conditions.

Abused children tend to be less competent, academically, interpersonally, and emotionally. They also have current histories characterized by persistent behavioral, physical, and medical problems. Females have a greater probability of being abused.

Of great interest and importance is the marked contrast between the functioning levels for victims and non-abused children. While 95% of the non-reported children were

socially and academically "fair" to "superior," using professional criteria of assessment (DSM III), 66% of the victims were at the opposite end of the continuum - "fair" to "grossly impaired."
This suggests that the child's level of functioning may be a primary determinant in abusive interaction between adults and children. This type of assessment may be also a very convenient method of identifying youngsters at substantial risk for abuse/neglect. The finding itself is corroborated by other investigations in which the child's behavior is cited as an immediate precipitating factor in the majority of cases treated.

Of further interest is the fact that 18% of the victims are graduates of early intervention programs, and 64% have been or are now involved in outpatient mental health programs. The data also indicate that, at program entry, 31% of the victims have physical/medical problems, and 78% show social or emotional maladjustment.

The perpetrators themselves report having been victimized as children. Nearly 80% reported being emotionally abused or neglected, and 40% said they had been sexually assaulted. Consistent with these historical data, 97% do present serious emotional/social disorders, while 64% have had serious problems with substance abuse or dependence.

Adult Characteristics

Data on the adult abusers show that males and females are equally likely to be involved. The circumstances of abuse or neglect may be quite different, however. Females are more likely to engage in covert abuse such as emotional and physical neglect, while males engage in more overt and severe assaults.

Most adult abusers are of low educational attainment. They typically have serious social/emotional problems, and are usually moderately to severely impaired in their occupations.

Not all abusers are parents of the victims, of course. The majority of adult perpetrators are related to their victims (78% are the natural parent, sibling, grandparent, or other relative). The next largest group (17%) are either adoptive or step-parents. About 25% of the adult perpetrators have been treated as in-patients in psychiatric or correctional facilities, and the majority (81%) have received outpatient mental health services.

Prevention and Treatment

Many studies, including Kochanek's, indicate increases in reported abuse and neglect cases in the past two years. To implement effective preventive and treatment programs, it is useful to know the course of development of abusive interactions. In this way preventive measures may be taken prior to the seemingly inevitable escalation of abuse into its more serious forms.

Data indicates that emotional abuse and neglect are more prevalent than physical assaults and sexual abuse. Thus it appears reasonable to attempt treatment of families in the less serious categories of abuse prior to escalation. In contrasting families who continue in or complete treatment with those who withdraw from or reject therapy, our data indicate that the motivation to continue revolves around several factors:

- The treatment was court-mandated;
- Both the children and the adults in the case are functioning at higher levels of adjustment or adaptation; and
- Low levels of abuse interactions are occurring at time of entry into the program.

Of those families that prematurely withdraw from treatment, only 15% have been directed into treatment by the court. The courts are thus highly influential in a family's continuation and completion of treatment. To the extent that treatment does indeed lower the future abuse rate, this should prove a powerful finding in terms of public policy.

Treatment Outcomes

Kochanek's findings indicate that some change occurs in families after one year of treatment. Much more pronounced reduction of abuse occurs after two years of intervention, particularly in physical and sexual abuse.

Factors which statistically relate to these reductions include (again) court mandates, child and adult competency-levels, and total hours of therapeutic services provided. The presence of a court order into treatment accounts for approximately 50% of the variance in outcome with respect to physical abuse. Overt physical assaults are definitely modulated by treatment.

The findings thus far are so striking as to merit some preliminary attention, particularly since the phenomenon of child abuse seems still to be on the increase, and because some of our findings so clearly point to steps that might be taken to abate the problem.

Kochanek's data suggest that optimal conditions for effective response to treatment include a condition of therapeutic receptivity best indicated by competent levels of functioning in other aspects of the lives of the children and their victimizers. This stability, coupled with court-ordered treatment, seems to bode well for eventual improvement of the family condition.

Conversely, dismal prognosis exists for families in which all parties to the abuse condition are functioning at a low level, where the perpetrator of the abuse is living within the household, and where no court order for treatment exists.

Finally, and contrary to beliefs held by many, such analyses suggest that severe cases of physical and sexual abuse are often especially responsive to therapeutic intervention.

Identifying Child Abuse

Personal bias is always present in evaluating the care and discipline of a child, but the laws set forth specifics which are unalterable:

- Any physical punishment which results in bruising or injury is physical abuse.
- Emotional deprivation or verbal assaults which significantly interfere with a child's ability to develop normally is emotional abuse.
- Sexually stimulating behavior or sexual interactions involving a child as an object exploited for another's sexual gratification is sexual abuse.
- Failure to provide a safe environment, adequate supervision, adequate nutrition, and to meet the normal needs of a child is neglect.

Today, we have a good base of information about the abused child and abusive parents.

- Abuse and neglect affect at least 1,000,000 children annually in the United States.
- Families involved come from all socioeconomic groups.
- Abusive parents were most often themselves abused or neglected as children.

- Abusive parents usually express that they love their children and want to be good parents.
- Abusive parents usually have high, self-oriented, inappropriate expectations which the child cannot fulfill.
- Many serious injuries to children occur during times of stress.
- At least one in four girls and one in ten boys are sexually abused by age 18.
- Sexually aggressive behaviors may begin in early childhood.

The Child as Witness

The increased reporting of sexual abuse of children has created new challenges for the nation's judicial system. Having to balance the rights of the victim with those of the accused, courts have depended increasingly on the services of clinicians.

The difficulty lies in the fact that child victims of sexual abuse usually are the only witnesses to the crime. As a result, a child's testimony may be the main evidence against the accused.

The plight of the child sexual abuse victim in the courtroom has been well-described by researchers. Most likely, the child is already psychologically disturbed as a result of emotional deprivation in a disturbed home, the trauma of sexual molestation, and guilt about the victim's own part in the offense. Before the trial, the victim is expected to recount the details of the alleged offense, again and again, to strangers. Repeated court appearances will be required.

In court, the child will be confronted eventually by the accused. In contrast to the accused, the victim has no advocate. Testimony is open to direct challenge on the grounds of incompetence, confabulation or fabrication. These considerations deter victims from reporting offenses and testifying against offenders, lead to false retractions, and erode the apparent credibility of honest witnesses.

A Biopsychosocial Syndrome?

Children who have been sexually molested commonly exhibit a number of symptoms and signs. Following a single incident of molestation, a child will suffer an emotional disorder similar to that often observed in adult victims. The child exhibits generalized anxiety, nightmares, emotional instability and phobias. Younger children regress, with separation fears and infantile clinging. Depression and suicidal ideation may be encountered in adolescents. Female victims may question their own responsibility for the event. Male victims may describe a compulsion to perpetrate the same offense on other boys.

Victims of incest are also likely to exhibit a number of symptoms. Physical complaints include bed-wetting, soiling, and urogenital irritation or infection. The child may present other somatic symptoms, especially abdominal pain, fatigue, and headache. Teachers or foster parents may note anxiety, depression and episodes of mental abstraction. The child may be petulant, manipulative, and withdrawn at different times and show an excessive interest in, and unusual knowledge of, sexual matters during play or in drawings. Frequent masturbation, indiscriminate seductive behavior, and gender role confusion have also been described.

The child sometimes demonstrates maternal role reversal. Older victims commonly exhibit shame, guilt, hostility to both parents, and social withdrawal. Anxiety, nightmares, phobias, feelings of helplessness, fear of sexuality and a sense of inner badness are typical. As they become adults, sexual promiscuity, prostitution and marital maladjustment are frequent.

Competency and Credibility

Another hurdle to a child's testifying is his or her competency and credibility. The testimonial competency of a witness refers to the capacity to provide reliable testimony. A witness's credibility refers to the extent to which the judge and jury believe the witness is providing honest and accurate testimony. Though competency and credibility are interwoven, it helps to consider them separately.

In some states, children under 10 are presumed to be incompetent to testify unless the judge is convinced to the contrary. In other states, case law puts the age of competency at 14 years. In fact, however, children as young as three years of age have been qualified as witnesses.

The rules of evidence are customarily relaxed to accommodate qualified minors: leading questions are permitted and, in some circumstances, hearsay evidence is admissible. For example, another witness may be allowed to testify concerning the child's excited utterances shortly after a traumatic event. The event is thus regarded as "speaking through the child" (*rea gesta*).

However, the law is skeptical of the capacity of children to observe and recall events accurately, to appreciate the need to tell the truth, and to resist the influence of other people. Children are commonly thought to have great difficulty distinguishing fantasy from reality, and to be readily confused by an exaggerated curiosity about sexuality. Although it is suggested that false accusations of sexual molestation are prevalent, it is also said that fact-finders tend to be biased against adult defendants in favor of female or child witnesses. For these reasons, the judge will commonly assess the testimonial competency of the prospective child witness before the trial begins. The child does not need to understand the full legal implications of taking an oath, but the judge must ascertain that the child has the capacity to register, recall and describe events reliably, to distinguish truth from falsehood, and to appreciate his or her obligation to tell the truth.

Competency and credibility interact and are related to the psychology of memory, suggestibility, fabrication and moral development. A review of recent psychological research throws light on these contentious issues.

Children under nine years of age have less capacity than older children to recall past events without prompting. There is also evidence that younger children are somewhat more likely than older children, adolescents, and adults to be influenced by suggestive questions, though research has been inconsistent on this point. Nevertheless, if prompted, children as young as three years of age can recall past events quite well, although they will have difficulty under 10 years of age dating the events or attributing the appropriate motivation and intention to other people.

Despite conventional wisdom, there is no evidence that children are more prone to lie than adults, and no evidence that they are more prone to fabricate complex allegations. There has been little research into how susceptible children are to adult influence; indeed, a child's level of moral judgment may be more important than his or her age in this regard. The possibility of parental indoctrination should be considered, however, in all cases involving disputed custody or visitation rights.

Unfortunately, little is known about the effect of high emotional arousal on a child's memory of personal experiences, a matter of great importance in the context of traumatic sexual molestation and potentially disturbing courtroom confrontations.

Let the Jury Decide

Given these research findings and the dubious validity of judicial evaluations of children's competence, children should be allowed to testify, leaving it to the jury to determine competency and credibility.

This more liberal attitude to the juvenile witness seems appropriate to children older than 8 years of age. However, since the rules of evidence are relaxed for minors, who consequently will be posed many direct or leading questions, younger children should be clinically evaluated for competency before trial.

The clinician may also be asked to examine the child before legal action is taken, in order to determine whether the child is credible and psychologically robust enough to cope with repeated appearances in court, whether psychological preparation would enable the child to give evidence, and whether psychiatric treatment would prevent further emotional trauma as a consequence of the legal process.

It is important to follow a logical pathway when evaluating a child's potential credibility as a witness, first excluding mental incapacity, misinterpretation and delusion, and then probing for fabrication or indoctrination. Verbatim recordings of such interviews can provide telling evidence, in court.

Although many children exposed to sexual abuse exhibit emotional disturbance, the symptoms which have been described as characteristic are largely nonspecific. It is doubtful that a true "sexual abuse syndrome" can be supported. Although it has been suggested that expert opinion about the presence of the hypothetical syndrome could be used strategically in court to shift the burden of proof onto the accused, this maneuver does not seem legitimate clinically or legally. The pattern of symptoms and signs associated with sexual abuse must be regarded as consistent with, not pathognomonic of, sexual abuse.

Videotape Considered

In recent years, greater awareness of the plight of the child victim and of the danger of "legal process trauma" has suggested modification of courtroom procedures. Audiotape or videotape recordings have been proposed as substitutes for adversarial confrontation.

For example, D. Libai (1969) recommended the use of a special courtroom for the hearing of child witnesses, a practice which has been adopted in Israel. Libai also discusses the training of special police interrogators for children, the admission into evidence of pretrial testimony, the scheduling of special sessions if the case is unduly protracted, and limitations on the size of the audience in the courtroom.

A number of states have already adopted the procedure of videotaping the testimony of the child victim in a special court from which all people have been excluded other than the judge and the opposing counsel. It is not clear whether the use of the special child courtroom would withstand appeal to higher courts. The right to a public trial and the right to be present throughout one's trial in order to confront one's accuser and consult counsel are protected by the 6th and 14th Amendments to the U.S. Constitution. The flexibility of these constitutional safeguards has not yet been tested.

Reckless Behavior

Researcher Outlines Treatments of Antisocial Behavior

Antisocial behavior -- which may include a wide variety of aggressive acts such as theft, vandalism, fire-setting, lying, truancy and running away -- represents a major psychological problem, especially since children with antisocial tendencies often grow up to be maladjusted adults.

Psychiatrist Alan E. Kazdin of the University of Pittsburgh School of Medicine, writing in the *Psychological Bulletin* (102:187-203, 1987), outlined four of the most promising approaches to treatment.

Parental Management Training (PMT) is a method of therapy based on the idea that "problem behavior is ... developed and sustained in the home by maladaptive parent-child interactions." Aggressive acts are often inadvertently reinforced when parents comply with a child's demands in the short run, increasing the likelihood that the negative behavior will recur. PMT trains parents to identify, define and observe the behavior of their children in new ways. Parents learn and practice a number of specific techniques, including positive reinforcement, mild punishment, negotiation and compromise. Overall, studies have confirmed that PMT is effective, Kazdin says. It is unlikely, however, that it can be successfully applied to families where the parents themselves suffer from behavioral dysfunctions, or from severe economic hardship.

Functional Family Therapy (FFT) is based on the idea that "the problem behavior evident in the child is the only way that some interpersonal functions (e.g. intimacy, distancing, and support) can be met among family members." According to Kazdin, "maladaptive processes within the family are considered to preclude a more direct means of fulfilling these functions." In FFT, therapists work one-on-one with parents and children in order to establish more positive patterns of interaction and communication. Studies have shown that FFT greatly improves familial interaction on a day-to-day basis. It may not focus enough on the actual, psychological problems of the individual antisocial child, however.

Cognitive Problem Solving Skills Training (PSST) assumes that "aggression is not triggered merely by environmental events, but rather through the ways in which these events are perceived and processed" cognitively. For instance, antisocial children are more likely than normal children to attribute hostile intent to their peers and are often unable to imaginatively empathize with other people. Previous studies have also shown that disturbed children "tend to generate fewer alternative solutions to interpersonal problems, to focus on ends or goals rather than the intermediate steps to obtain them, to see fewer consequences associated with their behavior, to fail to recognize the causes of other people's behavior, and to be less sensitive to interpersonal conflict."

PSST therapists use games, academic activities, stories, role-playing, and positive feedback in order to make antisocial patients aware of the cognitive processes that underlie social actions. Overall, PSST had not been an effective treatment for antisocial children, although it often does bring about specific improvements in behavior both in the home and at school. Kazdin points out that this theory fails to take into account developmental differences in children's cognitive skills. Mental processes that adults employ frequently may not yet be present in the mind of a child.

Proponents of **Community-Based Intervention** believe that therapy should be conducted within the context of the community, drawing on resources such as youth centers and recreational programs. In community rehabilitation programs, young people engage in a wide variety of group activities, including sports, arts and crafts, fund-raising

and discussion. Youths involved in this type of therapy often do exhibit reductions in antisocial behavior. The effectiveness of such programs seems to depend a great deal on the experience and training of the group leaders, however.

How might the existing methods of therapy be employed more successfully? Kazdin suggests that therapists experiment with increasing the intensity of the various treatments mentioned. He also recommends that therapists spend more time evaluating the family situations of antisocial children, in order to determine which types of treatment are likely to be most effective for particular families. Finally, he urges therapists to creatively combine the various treatment procedures mentioned above, perhaps in conjunction with additional measures such as psychotherapy or medical intervention.

Misperception of Risk Increases Accidents

Both environmental factors like changes in illumination and personal factors, such as failure to perceive and respond appropriately to danger, are important elements in causing serious automobile accidents, according to a noted visual scientist.

At a recent conference on self-regulatory behavior and risk-taking sponsored by the National Institute of Mental Health in Maryland, Prof. Herschel H. Leibowitz, a Pennsylvania State University psychologist, explained that the source of misperceived risk lies in a "mismatch" between our sensory and perceptual capabilities and the demands of our modern technological culture.

Until the present century, he said, our sensory-perceptual systems were adequate for self-locomoting or for passive transportation in slow-moving vehicles. New technology, however, has resulted in spectacular increases in the task demands on the human operator. The cost of our ineptitude in driving, and of our failure to fully appreciate and act on the hazards of automobile transportation, are reflected in the fact that more than 50,000 deaths occur annually in the U.S. due to driving accidents. Automobile accidents are the leading cause of death for people between the ages of 1 and 39.

Dr. Leibowitz believes there is insufficient public awareness of the three-fold or four-fold increase in danger when driving at night. He and his colleague, Dr. D. A. Owens, have attributed the night-time driving dangers to what they call selective degradation of recognition and guidance vision. "Recognition vision" is the most familiar type. Involves the ability to read and recognize objects. Recognition ability is reduced by poor illumination or blurring of the optical image. Interestingly, our "guidance vision" is much less affected by lowered illumination or optical blurring. One can locomote quite well in a dimly lit strange area. Both kinds of talent are involved in driving. But steering is much less demanding than recognizing objects, signs and, in general, hazards.

Further compounding the visual-risk problem is the fact that recognition is carried out at a higher level of awareness than guidance tasks. Thus, says Professor Leibowitz, "Drivers remain confident about their ability to steer the vehicle but are not aware of the severe impairment of recognition vision." The impaired person -- one who has become tired or has been drinking, for example -- will be unprepared for the rare occasion involving critical recognition of a hazardous situation. About 25% of drivers who hit a pedestrian claim they were not aware of an impending danger until they actually heard the sound of the impact. Leibowitz points out that driving speed is an optional or judgmental matter. It is, and therefore the accident is, under psychological control.

As preventative measures, Dr. Leibowitz proposes: (1) educating drivers to the special hazards of night driving, and about the dual vision system of recognition and guidance; (2) adopting different speed limits for day and night driving; and (3) acknowledging the considerable effect of age on optical transmissivity (an 80-year-old typically has 16 times less light transmitted than a 20-year-old).

It may be noted that a special hazard not exclusive to the young but more frequent in young people is the tendency to drive while affected by alcohol ingestion or other drug use. This has the effect of lowering one's awareness of hazards, and often increases the bravado associated with youthful risk-taking. Education about the two-track visual system that Leibowitz and his colleagues have documented might help teenagers to better appreciate both the hazard associated with night driving and the critical effect that intoxication can have on visual processes.

Teenagers Found Unable to Calculate Risk of Pregnancy

Can the average teenage girl accurately assess her risk of pregnancy? Is there a high correlation between perceived pregnancy risk and contraceptive use? Addressing these questions, Pearila B. Namerow, Amelia I. Lawton and Susan G. Philliber found that most sexually active adolescents are inadequately informed about the mechanics of the menstrual cycle and the timing of ovulation.

The subjects of this study were 425 female teenagers who frequented "The Door," a youth center in New York City that offers a variety of recreational, educational, health and counseling services. These young women - who represented a variety of ethnic and socio-economic backgrounds - were between 13 and 19 years of age, unmarried, and sexually active. Their "subjective" knowledge about the probability of pregnancy was gauged by their answers to the question "If you hadn't used contraception, how likely would it have been that you would have gotten pregnant the last time you had sex?" Women who had engaged in sex either 12 to 18 days after or 11 to 17 days before their last menstrual period were counted as being objectively at high risk, along with those women who indicated that they experienced irregular menstrual cycles.

A variety of background information was also considered in order to more precisely determine the likelihood of each individual becoming pregnant. This additional data took into account pattern of contraceptive use, social and demographic variables, sexual history, degree of support received from significant others regarding birth control, psychological stability, and general knowledge of pregnancy.

Approximately one-third of those surveyed judged that pregnancy was a "virtual certainty" for them. Since only one-fourth were found to be this much at risk by more scientific measures, the researchers concluded that personal and objective assessments of risk do not tend to be well correlated. In addition, the young women who were well informed about the nature of their menstrual cycles were not found to be significantly more skilled at calculating their individual risk than their less well-informed peers. In fact, those at high risk were slightly less likely to use contraceptives than those at low risk.

It seems fortunate that more subjects thought themselves at risk than actually were. Nevertheless, it is disconcerting that overall fewer than half proved able to accurately estimate the extent of their risk. The researchers recommend that future efforts to sexually educate teenagers place more emphasis on both the mechanics and the importance of monitoring one's own menstrual cycle (while continuing to point out that there really is no "safe period" for intercourse). They also cite a need for "additional research directed explicitly at outlining some of the important determinants of perceived probability of pregnancy."

Facts About Teenage Pregnancy

In a recent issue of the American Journal of Obstetrics and Gynecology, D.R. Hollingsworth and colleagues have provided some factual updates on teenage pregnancy, some of which support current suppositions and some of which do not:

1. Premarital sex activity increased in young females from 28% to 42% in the years from 1971 to 1982. That increase is attributable largely to a sharp rise in early sexual activity on the part of white adolescents.
2. The increase in sexual activity has resulted in enhanced risks of pregnancy in this age group.
3. The U.S. has the highest pregnancy rate of all western nations, Great Britain and Canada being second and third.
4. Teenage pregnancy in the U.S. affects all geographic areas and racial groupings. Some popular belief to the contrary, teenage pregnancy is not solely or even principally a problem for the black community.
5. Interestingly, the total number of births to adolescent mothers has declined 15% in the years from 1960 to 1983. This statistic is definitely age-related, however, for the number of adolescent pregnancies has increased in the age group from 15 years and younger. (The implication, clearly, is that older teenagers are availing themselves of opportunities to remain pregnancy-free -- through education and changes in their behavior, through using condoms, etc. -- while the youngest teenagers are apparently not getting, or acting on, the appropriate messages.)
6. The teenage birth rate has declined, and the trend continues.

Reforming Teen Pregnancy Prevention Classes

A top mental health official in the country says U.S. sex education programs are failing to curb the epidemic of adolescent pregnancy. He proposes two program models as being more effective.

Writing in a recent issue of *Public Health Reports*, Donald Ian Macdonald, M.D., a pediatrician and former head of the federal Alcohol, Drug Abuse and Mental Health Administration, said that current curricula emphasize the provision of data to youth, ignoring the fact that parental guidance and direction are more often helpful than data and options.

Macdonald said the family -- traditionally the child's principal support -- has been transformed radically in recent decades because of factors such as rising divorce rates, working mothers, changing attitudes towards sex, and increased mobility. He also cited "anti-squeal" rules "based on the false assumption that teenagers identified as having problems could best manage their lives without parental involvement or that occasional visits by social agency staff could replace daily family contact." Finally, he said, "the role of parenting and the competence of parents have been downplayed."

These factors have resulted in teenagers lacking support, guidance and protection "as they are presented with myriad unhealthy choices during their developmental years."

The result has been an increase in drug use by teenagers and increased sexual activity, which, he said, are closely related. Alcohol and other drugs overcome shyness, anxiety and discomfort in social situations and reduces inhibitions. Furthermore, he said, studies have shown that the predictors of sexual promiscuity and drug and alcohol use are often the same. "Positive self-image, good problem-solving skills, healthy family relationships, and an ability to communicate well are all characteristic of children who are least susceptible to either problem.

Macdonald suggested two models for adolescent pregnancy prevention: "Just Say Later" and "The Support Model."

"Just Say Later"

Most parents want their children to abstain from sex, "yet we often give ambivalent and confusing messages, as does a father who, while insisting that his daughter not engage in sex, urges her to use precautions if she must be active."

"Uncertainty as to whether the message ought to be targeted to those adolescents who are likely to be abstinent or those who are not may result, in effect, in abandoning these youngsters who waver between choosing abstinence and sexual activity," he said, adding that no single message is likely to be effective for all.

Concentrating on messages about "safe" sex -- assuming most teenagers are or soon will be sexually active -- is wrong, too, he says, because it assumes that "the battle for abstinence" has been lost and that these messages are effective in reducing teen pregnancy. Both assumptions are unproven, he believes.

Rather, he suggests a variation on the Just Say No campaign against drug use, called "Just Say Later." This will be most effective, he said, for the group who are still undecided about sexual activity. Those who are committed to abstinence or to being sexually active have already made up their minds and aren't easily reached by any message, Macdonald says. A "Just Say Later" campaign could reach the 16% of adolescents who, he believes, are undecided about whether to have sex.

"For the majority of teenagers who are not sexually active, reinforcing the choice of abstinence may have immediate benefits. Teenagers want to belong and be accepted. When the prevailing assumption holds that most teens are sexually active, the abstainer may feel socially deviant ... The abstinence model gives permission to say "no" and feel comfortable with that decision ... Approaches that strengthen the peer community and give teen leaders support in their message of abstinence could bring tremendous results."

The Support Model

The second strategy that he proposes would re-involve parents. In the 1960s and 1970s, we assumed that schools "could do it alone" in preventing teenage pregnancy and other behavioral problems. Yet, along with burdening schools with that responsibility, society told them that "they could no longer teach ethics, values, and morality...Teenagers were provided with data and asked to make decisions on their own as to what was appropriate and responsible behavior," Macdonald said.

Since by nature schools cannot impart moral and ethical values because they might conflict with those of their parents, Macdonald suggested that information regarding sexual activity be directed toward parents and others "who are more mature and thus better able to deal effectively with difficult decisions. That is, we should place more emphasis on the information needs of the individuals and social institutions that are charged with overseeing the welfare and education of our children -- parents, churches and others in the community."

To implement the models, Macdonald said:

- "Parents must acknowledge that teaching their children the importance of goals and ideals is no less critical than providing food, shelter, and education opportunities." Parents must be helped to understand that children are less likely to be involved in self-destructive behavior where there is strong family bonding.
- "Schools and educators must be encouraged, and directed when necessary, to work with rather than in place of parents." Schools should alert youths to peer and societal pressures and train youths to resist such pressures, he said.

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- Media should be encouraged to support abstinence through editorials and articles.
- Health care providers must be given information "which they can use in speaking to their children about sexual attitudes and behaviors," particularly the relationship of alcohol and other drugs to premature sex and pregnancy.

AIDS

Pediatric AIDS: Psychosocial and Educational Needs Are Growing

As the medical needs of children with AIDS or AIDS-related Complex (ARC) have been addressed during the past several years in clinics and hospitals in areas of high incidence, it has become apparent that a host of psychosocial and educational needs of the families also need to be dealt with.

The cities with the highest concentration of pediatric cases -- New York City, Newark, Miami and Los Angeles -- are developing models for psychosocial and educational services delivery to the families of these children. There are some major differences among the cities in the nature of the populations served: in New York and Newark, children with AIDS are born to IV-drug-using women with the disease; Miami has a large percentage of heterosexual transmission cases among recent Caribbean island immigrants; and Los Angeles includes a mix of IV-drug-related and blood transfusion related cases. Nevertheless, there are enough similarities to make some general statements about the needs that influence the kind of models being developed.

In these geographic areas, the overwhelming majority of cases involve perinatal transmission. This means that not only the child but also the mother and perhaps the father and other siblings are infected with the AIDS virus. This fact alone complicates the intervention picture dramatically because at least two members of the family system are at very high risk for a fatal disease. Most families are poor, lacking in housing, food, transportation and financial support. Many families are single-parent or unmarried couples. They have little schooling, and communication is further complicated in many cases by cultural and linguistic differences.

Diagnosis: First Stressor

The initial stressor on the family usually comes with the diagnosis of the child with AIDS, ARC, or HIV infection. Often, this is the indication that anyone in the family is infected. This knowledge triggers a wide range of reactions in the parent(s) including denial, guilt, fear, blame, anger, and extreme distress. Since the parents and other members of the family are encouraged by the clinic to be screened for infection with the AIDS virus, issues of confidentiality about the diagnosis become paramount. For many of the families, already disadvantaged and discriminated against, the diagnosis considerably exacerbates their situation. Their own employment may be jeopardized if the diagnosis becomes known. Family, friends and neighbors may begin to shun them.

In all four cities, social workers act in conjunction with physicians to provide counseling and support to deal with the family's reactions to the diagnosis. Working through these initial reactions can be critical for the success of later intervention efforts. If the reactions are severe, referral for appropriate outside counseling and therapy may be made. The social worker also assesses basic needs and assists the families in obtaining needed social services.

Ongoing Support Needed

The need for counseling and emotional support for the families is ongoing, as many parents must deal with a chronic, terminal illness not only in one or more of their children, but in themselves and/or their partners as well. However, it should also be noted that HIV infection does not always lead to AIDS; many infected individuals are asymptomatic or experience only mild symptoms such as lymphadenopathy. Although published figures are not currently available on the proportion of pediatric cases at dif-

ferent levels of disease reaction to the virus, ongoing research will be generating this information. For most families, the threat of AIDS hangs above them like a sword of Damocles, greatly affecting all of their decisions about current and future life plans.

At most of the sites, a nurse educator works with the families to assist them in understanding the diagnosis and all of its implications, the basic facts about AIDS and HIV infection, what kind of measures can be taken to prevent further transmission of the virus to sexual partners, and how to avoid additional pregnancies. The nurse educator also focuses on knowledge and practices related to health promotion, nutrition and infection control. Some educational materials have been developed or are being developed to supplement these training efforts, but the process is complicated by cultural and linguistic differences. In many cases, written materials are inappropriate and ineffective, and alternative approaches using audiovisual and graphic materials are being developed.

Developmental Delays

The evidence is mounting that developmental delays and neurological impairment are associated with HIV infection. There are also some tentative data suggestive of a dysmorphic embryopathy, including microcephaly and cranio-facial abnormalities, resulting from infection in utero. Lack of stimulation from repeated hospitalizations and isolation may also be contributing to some of the delays observed. Data are currently being gathered in ongoing prospective longitudinal studies to determine the range and the degree of the associated disabilities and the proportion of children affected. Many of these children qualify for placement in early intervention programs and special education tracks at school age. Dealing with the fears and concerns of educators is an important prerequisite to integrating these children into the school system.

Finding baby-sitters or day-care placements for many children is a problem because confidentiality is a concern, and yet it is recommended that those who may be handling the child's bodily fluids (diapering, etc.) be informed so that they can take precautions. Day care programs serving only HIV-infected children are being explored as an alternative, and are being developed at the various sites. The potential for spread of other infections in group care settings is being carefully monitored at the centers by the nursing staff.

Child Care Problems

For some children, residential or foster care placement becomes a need, either as a result of abandonment by the family or because of the death of one or both parents and the lack of alternative placements with willing or available relatives. The problem of abandonment is greatest where the parents are IV-drug users. Because of the major fears associated with the disease, finding appropriate residential placements has been difficult, and will become a serious problem as the number of cases increases.

The needs of these families are extensive and complex. The models evolving at the different sites are all interdisciplinary in nature, with the number of disciplines involved increasing as additional needs are identified. What began as a concern primarily of pediatric medicine has expanded to include input from social work, nursing, psychology, neurology, education and speech, physical and occupational therapies. Fortunately, there are many parallels with other medical and social problems (e.g., chronic and terminal childhood illness, handicapped children, disadvantaged families) that can guide these model development efforts. Yet there are many aspects of the pediatric AIDS program that will continue to present their own unique challenges to the service delivery system, until widespread community education efforts on AIDS are more successful and until a vaccine and a cure are found.

AIDS Education Should Be Geared to the Age of the Child

As the cure for AIDS and a vaccine against it remain elusive, virtually everyone from the Surgeon General to grassroots health practitioners agrees that education is the key to stemming the tide of this fatal disease. Prime targets for this effort are our nation's children, who, as a result of their risk-taking nature, are at risk for sexual and drug experimentation.

What makes for good AIDS education? First of all, it should be more than that. AIDS education is best integrated as a dimension of education in the physical, emotional and spiritual implications of human sexuality. It must avoid the negative "thou-shalt-not" hygiene mentality of past health teaching. It must be honest, pro-active, relevant, and comprehensive, and must strive to motivate its recipients to make healthy lifestyle choices.

Up to now, however, we have failed as a society to meet the challenge of sex education as evidenced by the 1.2 million adolescents who get pregnant each year and the 2.5 million who acquire sexually transmitted diseases. The specter of AIDS makes improvements in sex education even more urgent.

AIDS and sex education must be conducted on three separate, but united, fronts:

1. Parents must re-assert their role as the primary sex educators of their children. They should provide not only the facts about AIDS and human sexuality, but the values and morals which traditionally have been their purview. Parents need to be helped to understand normal child growth and development and to acknowledge developing sexuality in their children.
2. Health care professionals must integrate preventative sex education into their professional practice with as much fervor as they promote immunizations to curb the spread of infectious disease. Physicians and nurses need to acknowledge sexual development in children and provide both direct education to children as well as information and resources to parents. For too long, health care providers have focused their energies on picking up the pieces of adolescents who are suffering the effects of ill-informed, irresponsible sexual behavior.
3. Educators must work to develop human sexual curricula that are relevant, age-appropriate and comprehensive. To be most effective and to help ensure community acceptance, educators should invite and encourage parent and community involvement in program development. Persons who are selected to teach sex and AIDS education must be comfortable with the topic, have good communication skills, and have solid technical expertise in the area. Teachers should have access to comprehensive training programs for sexuality and AIDS education, followed by periodic in-service programs to help teachers stay current in their knowledge and teaching methods.

What do children need to know about sexuality and AIDS and when do they need to know it? While it is difficult to generalize a standard appropriate to all children, it is possible to establish age-specific guidelines to the needs of children and adolescents for sexuality and AIDS education.

Birth to Age 4

During the first four years, health and sexuality education are centered within the family. Pre-schoolers learn as much from the non-verbal behavior of adults as from their words. Little children are interested in their bodies, bodily functions and life in general. Education at this age is very basic. Adults should model good health behaviors and teach children that they must begin to develop responsibility for their personal health and safety.

Children should learn the correct terms for body parts. Parents should be encouraged to use the words penis, scrotum, vagina and breasts. Substituting silly nicknames conveys that there is something inherently embarrassing about sexual organs.

Parents should answer all questions about the body, sex, and health as openly and honestly as possible. This is an age group in which adults may take cues of what the child is ready to know from the child's questions. How a child's questions are answered at this early age may well set the stage for more involved discussions as the child gets older. Parents and adults working with pre-school children need to remember that young children are not ready for long, detailed discussions of any subject, including sex. Be sure to listen to the child's questions and phrase the response as simply, briefly, and positively as possible. If the child needs more information, he or she will almost always ask further questions.

Ages 5 to 8

Children at this age are curious about many things and are usually not yet embarrassed to ask questions about sex. Often they ask questions about how babies are conceived and how they are born. Giving these youngsters gradually more detailed information about the reproductive function of human sexuality provides an excellent foundation for discussion about other aspects of sexual behavior when the child is older.

Young children have heard about AIDS and may be curious and worried about the disease. This is an age of fears and children might worry that they themselves or Mommy or Daddy will develop AIDS and die. Young children need to be reassured that AIDS does not spread as easily as most other viruses and that AIDS is transmitted from one person who has the virus to another person who is healthy only if these people have intimate sexual contact or share dirty needles while using IV drugs. A young child can also understand that a mother who has AIDS can pass the disease to her baby before birth.

They should be taught that everyday activities like going to school, playing in the park, and using public restrooms do not expose children to the virus that causes AIDS. They should also know that it is safe to play with a child who has AIDS.

Young children should be told that the needle used by a doctor or dentist in giving a "shot" does not spread AIDS because it is clean. Only dirty needles can be contaminated with the virus.

Talking about AIDS to a 5- to 8-year-old is a good opportunity to teach that people make choices about their behaviors and lifestyles. These behaviors may be either healthy or harmful to their well-being. Emphasize that they should try to choose healthy behaviors and that parents and other caring adults will help them take good care of their health. Children should be reassured that if they assume responsibility for their health and avoid the behaviors that expose them to the AIDS virus, they need not worry about catching the disease.

Ages 9 to 12

These children are beginning to experience puberty. As their bodies grow into reproductive maturity, they need love and support. They also need clear and specific information about all aspects of human sexuality. Pre-teens learn a great deal from a sexually explicit world -- some of it false -- and certainly have a great interest in sex.

To avoid being candid and factual with pre-teens is to leave their sex education to their peers, television, rock music and the world in general. Unfortunately, pre-adoles-

cents will rarely ask questions; they have learned to be embarrassed about sex. As adults working with children, we must volunteer the information we know they need.

Pre-teens need to fully understand:

- The possible consequences of sexual intercourse, including pregnancy and sexually transmitted diseases, one of which is AIDS.
- Accurate information about sexual intercourse and other forms of human sexual expression.
- That the risk of AIDS increases with each sexual contact and that a person may look and feel perfectly healthy but still carry and be able to transmit the AIDS virus.
- The many harmful effects that can come from drug abuse.

Children in this age group should be helped to feel they have control over their own bodies, that they choose their behaviors and, therefore, can avoid placing themselves at risk for AIDS. A clear message to be conveyed to pre-teens is that abstinence from sexual activity involving the exchange of body fluids and abstinence from drug use can virtually assure an individual safety from acquiring AIDS.

Ages 13 to 18

The characteristics of the teen years -- the feeling of invulnerability and the desperate search for independence -- explain why teenagers are frequently involved in sexual risk-taking behavior.

We must acknowledge teenagers as sexually maturing human beings with personal control over their decisions regarding sexual behavior. Parents need to communicate their values regarding sexual morality to their children while acknowledging that they may choose to reject family and societal values. Teenagers must be helped to understand the scope, extent and seriousness of the AIDS epidemic. They need to fully understand the modes of transmission as well as the sexual and personal behaviors which increase the risk of exposure to HIV.

It should be emphasized throughout the teen years that abstinence from intimate sexual contact and IV drug use virtually assures a person safety from contracting AIDS - as well as safety from pregnancy, other STDs and possible emotional consequence of an intimate sexual relationship which a teenager may not be ready to handle. Teenagers also need to know that if they choose to be sexually active, there are certain facts that can reduce the risk of contracting AIDS:

- The only safe sex is monogamous sex between two people who are free from the AIDS virus. It is also important to know about a partner's past sexual history since the AIDS virus may live in a person's body for many years without symptoms.
- Older teenagers must know the chance of contracting AIDS and other sexually transmitted diseases increases with each sexual contact.
- In other than a monogamous sexual relationship, persons should avoid the exchange of bodily fluids, including semen, vaginal secretions, blood, urine and feces. Proper use of condoms reduces the chance of exchange of fluids and lessens the risk of transmitting AIDS. Spermicidal foams, creams and jelly containing the ingredient "non-oxynol 9" have been effective in laboratory tests in killing the AIDS virus and are recommended for use in combination with condoms.
- Sexual practices that injure body tissues (anal intercourse, for example) should be avoided. Such activity increases the likelihood of transmission of infection through the bloodstream.
- Using intravenous drugs and sharing needles is extremely dangerous and transmits many diseases, including AIDS.

- Mixing alcohol and other drugs with sexual encounters affects judgment and leads to irresponsible sexual behavior.

With all age groups, the challenge in AIDS educatic is to provide the information young people need while avoiding the fear and hysteria that can accompany talking about the disease. We must emphasize that the AIDS epidemic is no one's fault and that it is not who you are but what you do that puts a person at risk for AIDS.

Children deserve a rational approach to AIDS education; they need to know about the disease and how they can protect themselves from it. But we also must convey to children a sense of the goodness and beauty of human sexual expression.

Don't Over-Restrict Children with AIDS

Of the thousands of cases of Americans with Acquired Immune Deficiency Syndrome (AIDS), none are so tragic as the hundreds who are children. Not only are they suffering from a serious disease, they are also at the center of a storm of debate over whether they should be allowed to attend school with their healthier peers.

It is important to remember, however, that we have learned much about AIDS and that all of the available evidence--some of it quite strong--indicates that the virus cannot be spread through casual contact, even in the rough-and-tumble world of a school playground.

Sexual Contacts

As serious as AIDS is, it is important to remember that it is not a highly contagious disease. Despite the detection of the virus in tears and saliva, all of the considerable evidence to date shows that it is spread only through intimate sexual contact, shared intravenous needles among drug abusers; and, until recently, through blood or blood product transfusions. Careful screening of the nation's blood supply since the outbreak of AIDS has made transmission through transfusions virtually impossible.

As a result, most of the AIDS cases are limited to the well-known high risk groups: homosexuals and bisexuals and their heterosexual partners, and heroin addicts and other drug abusers who share IV needles (and sexual partners). The AIDS virus is estimated to have infected about 30% of the gay population in Boston, 50% of New York City's homosexual community, and about two-thirds of San Francisco's gays, according to data collected in city sexually transmitted disease clinics.

Yet, as opponents of AIDS patients being allowed in schools often point out, 5% to 6% of those with AIDS are not in high risk categories, and they include children. How then, do they get infected with the virus?

In all the cases in children, the virus was spread in one of three ways:

- Transfusions of blood or blood products infected with HIV, usually to hemophiliacs;
- The child was infected with the virus in utero or at birth from an infected mother;
- A nursing mother infected with the virus may pass it on to her infant through her milk.

It is highly unlikely that the disease can be spread through means other than blood-to-blood, semen-to-blood, or parenteral contact, and here's why:

- No cases have been reported in which the virus was spread by casual contact through play.

- In none of the cases in which children have AIDS has any family member contracted AIDS from them.

If AIDS has not been spread through such means, then the danger of it spreading in school is extremely low.

Exceptions

Medical prudence dictates that in some limited cases a child with AIDS should be in more restricted settings than a general school population. According the Centers of Disease Control, "For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of the acquiring potentially harmful infections in the setting and the apparent non-existent risk of transmission...For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behavior such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with [the virus] should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.

Simply put, children should not be prevented from attending school with a child who has AIDS.

Other Concerns

The CDC has made several other recommendations both to prevent the spread of the AIDS virus and to protect the young AIDS patient. They include:

- Feeding and diaper changing should be done with care by a person aware of the child's HIV infection. Caretakers should always wash their hands afterwards and wear gloves if they have open sores or lesions. Lesions on the child should also be covered.
- Soiled surfaces on schools or day care centers should be promptly cleaned with disinfectants, such as household bleach (diluted 1 part bleach to ten parts water). Disposable towels should be used and mops rinsed with disinfectant.
- Physicians caring for children of HIV-infected or high risk parents should consider testing children for the virus. One reason for this is that vaccination of infected children with live virus vaccines such as the measles-mumps-rubella vaccine (MMB) may be hazardous.
- Adoption and foster-care agencies should consider adding HIV screening to their routine medical evaluations of children before placement. Mandatory screening, however, is not warranted.
- Persons caring for or teaching infected children should respect their right to privacy, including maintaining confidentiality records. Only those with a need to know in order to care for the child should be told of the child's condition.
- Finally, all educational and public health departments "are strongly encouraged to inform parents, children, and educators regarding the AIDS virus and its transmission."

We should remember that while even medical personnel may be apprehensive, AIDS patients need to be cared for, attended to, and not rejected by society. We are dealing with human beings who are sick. We can help them, and as health care providers have an obligation to do so.

Alcohol and Other Drug Abuse

When It Comes to Treatment, Teens Are Different Than Adults

Most professionals who deal with children and adolescents understand the marked behavioral differences they have with adults. Yet, in some emerging fields, those differences are not being taken into account in treatment. A good example is alcohol and drug dependency treatment, in which expertise gained in counseling adults is almost automatically applied to adolescents, often with disappointing results.

Martin N. Buxton M.D., F.A.A.C.P., program director of the adolescent chemical dependency program and coordinator of medical training and research at Charter Westbrook Hospital of Richmond, Virginia, has identified five particular ways professionals should recognize the differences in treating the teen drug or alcohol abuser. His suggestions may jog the thinking of other professionals with different specializations who deal with teenagers.

1. Don't allow the adolescent to convince you he or she is like an adult. This may seem obvious, but the point needs elaboration: Nearly all of the adolescents entering Dr. Buxton's treatment program are co-dependent, that is having at least one parent who is either chemically dependent and/or co-dependent themselves. "Most come, in fact, from at least a three-generational chemically dependent family system. Their age-expected developmental denial lulls them into taking risks in using chemicals, thinking `damage can't happen to me.' The denial is exacerbated by the fact that as co-dependent, pseudo-adult, pseudo-precocious, omnipotent-thinking adolescents, they and the world often see themselves as being older than they really are," he says. "If you aren't careful, you'll be lulled into the same attitude that enables their addiction." Practitioners must subtly recognize co-dependent adolescents' need to be friendly in an adult-to-adult fashion and deal with them in a way which does not reject them. At the same time, however, you must gently but firmly tell them that there is an age difference and that they are not adults.

2. Encourage them to develop relationships. Alcoholics Anonymous wisely teaches adults not to have a relationship within the first year of recovery, or else they risk an impulsive and ill-timed marriage or commitment. And adolescents, too, during their active co-dependency, may be prone to making serious but unhealthy commitments at a young age. Once this issue is worked out sufficiently, Dr. Buxton advises, adolescents, as part of their healthy identity formation as heterosexual beings, should be encouraged to have involvement in relationships. Your need to see adolescents as a developmental entity distinct from adults requires you to encourage them to have healthy relationships that are not compulsively rife with sexuality or co-dependent caretaking.

3. Intervene more to keep adolescents in therapy. Dr. Buxton notes that addiction counselors often adhere to the precepts of AA's "Serenity Prayer," that is being able to accept things that cannot be changed. This notion leads to addiction counselors' "laissez-faire" approach to treating adults, who may need to face more consequences of their addiction before they can be treated successfully. The adult clients themselves must decide they need treatment.

The nature of chemically dependent adolescents, however, requires a different approach, at least at the beginning of treatment. More often than with adults, chemically dependent adolescents enter treatment not of their own volition but because they either attempted suicide, showed other self-destructive tendencies, or because of trouble with the law. As a result, more activism must be used by the therapist in order to keep a

teenager in treatment, at least until the adolescent becomes enlisted in the therapeutic process.

Don't go overboard, however, and seduce the teenager into oppositional resistance, he warns. "Evoking opposition is one of the dangers of working with adolescents, who often are contrary in order to establish their identity and autonomy. So you must be careful not to let the issues of staying sober and sticking with recovery become involved in the adolescent autonomy struggle, while trying to intervene assertively and clarify identity confusions," he says.

4. Hold marathon sessions. Dr. Buxton uses this technique in an inpatient unit where staff members try to undo the alcoholic family types of communication and replace it with healthy family communication. He explains, "Often, we'll find that a number of the youngsters have known that another has been using drugs or is planning on going AWOL. Yet they did not speak up despite the fact that they themselves are doing well in recovery. As we track this down, we come to understand that the youngsters are recapitulating the unrecovered alcoholic communication system in that there are coalitions and alliances that avoid the truth of what is happening. So we'll 'close' the unit and keep the youngsters in a marathon intervention session, perhaps for hours at a time. The enabling denial of the process is addressed and resistance wears down, setting the stage for the reunification of healthy family lines of communication."

5. Use paradoxical intervention. This technique is invaluable if used delicately. Dr. Buxton finds it most helpful when a youngster is entrenched in a co-dependent position and cannot see it objectively. In such cases, he will ask the co-dependent youngster to be responsible for some difficult (if not impossible) task like seeing that another youngster is on time for group therapy. "It helps show the co-dependent adolescent his or her tendency to try to take care of people and control things as a way of avoiding their own issues," he explained. "You must be careful that the patient has enough insight to be able to understand the abstract nature of what is being said and does not take it literally." If a tone of humor, without sarcasm, is used paradox can be a very successful intervention technique with adolescents.

These aren't the only techniques that are helpful with adolescents dependent on drugs or alcohol. Addiction professionals must always look for innovative ways in dealing with clients at a sensitive age. They may stimulate your own ideas in dealing with the unique characteristics of adolescents, even if they have problems other than drugs or alcohol, he concludes.

Teen Concerns About Drinking

A study sponsored by the Alcoholism Council of Greater New York, suggests that teenagers are as concerned about the personal health problems associated with heavy drinking as about the social consequences. The study involved 108 adolescents, ages 12 through 18, who were asked -- in a questionnaire which never mentions alcohol -- to indicate their level of concern about specific health problems (such as acne, cancer, diabetes, and obesity) and behavior problems (peer acceptance, relationship with parents, and so on). Of 34 health issues, 19 represented problems that can be associated with heavy drinking, and 15 were not alcohol-related. All of the 19 behavioral items could be alcohol-related. Thomas Ashby Wills, assistant professor of psychology and epidemiology at Albert Einstein's Department of Epidemiology and Social Medicine, found the youths' concern about health problems "comparable to, and possibly greater than, their level of concern about behavioral problems. ... Concern about health consequences of alcohol may be an effective component of educational programs to reduce rates of alcohol abuse, in addition to the social consequences approach used in current alcohol education," he said.

Understanding the Polydrug User

A study of 433 high school students found that 12% were polydrug users or abusers and that the reason they used drugs was to seek pleasure or escape pain.

Polydrug use, in this case, means using more than one drug at the same time or in close sequence to produce different effects. The researcher, Loyd (sic) S. Wright, a psychologist at Southwest Texas State University, noted the dangers of the synergistic effects of polydrug use to users and abusers. In his study, seniors at two Texas high schools filled out confidential questionnaires on their drug using habits as well as how they perceived their parents and themselves.

Polydrug users and abusers are more likely to:

- Be physically abused or in conflict with their parents;
- Rate themselves as lazy, bored, rejected and unhealthy;
- Have serious suicidal thoughts, delinquent behavior, early use of marijuana and alcohol and the tendency to drink more than six alcoholic drinks at a sitting; and
- Agree with the statements "If something feels good, I usually do it and don't worry about the consequences" and "I try to play as much as possible and work as little as possible."

Wright concluded that the results confirmed the notion that polydrug users seek either relief or pleasure and, therefore, do not see their drug use as problem. He writes, "a variety of treatment and prevention strategies are necessary. Any drug abuse treatment program that hopes to have an impact on the pleasure seekers must get them to reexamine their basic philosophy, remove their peer support, and provide alternatives that will meet their needs for excitement and adventure."

The School: An Avenue for Change for Drug-Using Teenagers

Alcohol and drug use by teenagers has been a troublesome problem for high schools since the 1960's. Whether they used pot, LSD, or cocaine -- not to mention the ever-present alcohol -- adolescents using chemicals have been an issue for two decades and most communities are frustrated in their inability to stem the tide of drug use on a broad scale.

Since teenagers are required to participate in some kind of formal education process through the age of 16 by law in most states, schools have a large stake in the drug issue. In most cases, teens bring their drug problems to the schoolhouse door, forcing the school as well as communities and parents to have equal responsibility in dealing with problem.

In recent years, there has also been an increase in the number of teenagers appearing in courts throughout the country for drug and alcohol-related violations. Most courts send the teenagers to correctional facilities or put them on probation, ignoring what created the problem: drugs and alcohol. In addition, physicians, social workers and teachers are seeing increasing numbers of adolescents with drug problems. These professionals rarely have adequate training or experience in substance abuse to enable them to feel comfortable and competent in helping teens who abuse drugs.

In Newton, Massachusetts, the Newton Youth Drug/Alcohol Program has created an unusual alliance between schools and the courts, the two institutions most important in the life of the drug-abusing teenager. Now in its eighth year, the program has linked court probation departments and public school staff to meet the needs of approximately 40 adolescents in trouble because of drugs each year.

It should be noted that, in Massachusetts anyway, school administrators are often unenthusiastic about the concept of alcohol and drug treatments operated through the public school system. Schools are for education, they believe, not for medical or mental health treatment. Schools are reluctant to take responsibility for students' emotional and physical problems.

The Newton community, however, believes that when school is the only constant in an adolescent's life and when children bring their drug and alcohol problems into the school environment, then the educational system is obligated to implement change.

At Least a Year

Students enter the Newton Youth Drug/Alcohol Program either as a condition of probation or as a school requirement. Court-referred teens remain in the program for the duration of their probation, usually one to three years or until they are ousted for failure to comply with the program's requirements. School-referred students commit themselves for a least one year.

Satisfactory completion of the program means earned high school credit for all participants. Unsatisfactory performance means denial of credit for those referred from school and surrender and final disposition for those on probation.

Participants must attend either Alcoholics Anonymous and/or Narcotics Anonymous as well as group therapy and individual counseling. Vocational assistance, and a court liaison are available to each student. Students are required toattend all meetings on time. Absence and tardiness are not tolerated and result in termination from the program. Furthermore, students must attend meetings sober and free of any mind-altering chemical.

Lack of Limits

The program's philosophy is based on the premise that the lack of limits in an adolescent's life promotes the drug abusing lifestyle. Adolescents are frightened of the decisions they are forced to make in their teenage years -- on values, shared life goals -- so they respond to firm guidance and strict limits. Program workers are available to students 24 hours per day, seven days per week, and 52 weeks a year in case of crisis.

The program has grown steadily during the past five years. In the 1980-81 school year, the courts referred eight youngsters, seven of whom completed the program and remained in school. None were referred by school officials. During 1984-85, 53 were enrolled in the program, 46 referred by the courts and 7 by the schools. Completing the program in 1985-86 were 30 of the 46 on probation (40 are still in school) and 5 of the 7 school-referred youths. (All are still in school). Of the 46 on probation, 24 were new enrollees while the remainder had continued from the previous year.

The program is designed for various life situations (through AA, NA, and discussion), with high school credits as an added incentive for success and a road back for those who dropped out of school. It is a mechanism for the schools and courts to monitor the student offenders' behavior.

Successful Completion

A student will have successfully completed the program if he or she is able to state thoughts and feelings which lead to abusive drinking and/or drug use; identify moments when he or she is beginning to feel out of control concerning alcohol or drugs; list alternatives to use at such moments; and practice skills or alternatives (ways of han-

dling arguments, conflict, tension and boredom) which take control of his or her future, by describing specific actions in his or her personal plan for future development.

Individuals with drug and alcohol problems continually suffer from unrealistic aspirations. Students learn through discussion the type of risks they usually take. The effect of consistently taking high risks is discussed in groups, in the context of resolving family disputes, work, recreational activities, driving and abusive drinking and drug use. Students are encouraged to seek help from other professionals, and to view it as a way of using resources rather than as a weakness or character defect. Emphasis is placed on seeking personal change that is realistic. There are benchmarks for testing the program periodically. For many students, plans for maintaining sobriety and continued treatment become an essential part of their future goals. The program has had extensive contact with impatient detoxification and treatment/rehabilitation facilities throughout the Northeast, making referrals as well as being used as an aftercare placement for students coming back from these facilities.

Treatment and prevention are closely allied, and the Newton program combines the two effectively. Once a student is "straight," he or she becomes a staunch advocate of abstinence and an evangelist in approaching their drug using friends. Many young people ages 17 to 22 are teachers by example to their peers. One such group of young people started an NA and AA group of their own in Newton and are speaking to other young adults about alcohol and drug dependency.

The program is broader than the cooperation between schools and courts implies. Students are not only referred by school officials and probation departments but by police and city human services departments. It provides support services to adolescents returning to school from residential chemical dependency programs and to parents and staff who are being trained in the identification of potential problems in adolescence.

Attitudes of disbelief and denial are often found among community members. For the most part, students are ingesting their drugs outside the school building, but are playing out their trip either in the classrooms, the corridors, the washrooms, or the cafeteria. Most often when questioned about their drug problem, these kids don't see it as a problem at all.

One 17-year-old interviewed provides a stark example. He said he began using drugs and alcohol at the age of 10 and identified his use of illegal substances as "moderate" by the time he reached age 12. At that time, he smoked an ounce of marijuana and drank a six-pack of beer daily. He used LSD weekly. He was identified in school and in the community because of his occasional criminal behavior and was remanded to the State Department of Youth Services for a two-year period. It was upon incarceration that he stated, "My drug use then began to get bad."

This case simply exemplifies the attitude of individuals as well as the community surrounding a teenager's use of drugs and alcohol. The outward behavior, criminal activity, is punished, and the root of the problem continues to grow. In addition, teens are often unaware that their drug use or their friends' drug use is dangerous, life-threatening, and produces negative consequences.

The Newton program is set up on the premise that education is the primary tool to break through this denial. Legal controls have proved largely ineffective in controlling alcohol and drug use by youths. Preaching and scare tactics generally have also met with failure.

If the problem of alcoholism and drug use is to be managed in the future, it will be because young people have adopted a responsible attitude. They gain this through adult examples of responsible behavior as well as through learning all the facts about drug use

and recovery. Programs like the Newton Youth Drug/Alcohol program, which link education, adjudication, and rehabilitation, accomplish this task.

Eating Disorders

Five Signs to Look for in Bulimic Teenagers

Bulimia, the eating disorder characterized by binging and purging, can stem from, and cause, a multitude of problems. It is more prevalent and more widely recognized today than ever before. Its signs and symptoms, psychological roots, and problems of identifying individuals at high risk, are factors that continue to elude family members, teachers and counselors alike.

If you suspect someone of having bulimia, here are five characteristic tendencies to look for:

1. How often, how much and what does she (most eating disordered individuals are female) eat? For example, if she eats a big breakfast at 8 a.m. and a snack at 9 a.m., you have reason to suspect that she threw up that big breakfast? The content of her meals is also a big clue. Does she eat an extremely large amount of one food in particular? Sweets or carbohydrates? Does she refuse to eat at all on occasion? Does she abuse laxatives and diuretics?
2. Is she obsessed with thinness and irrationally afraid of fatness? Be aware of her psychological orientation. Behind every bulimic is a varied and complex set of reasons for having this disorder. The standard, overgeneralized ones, such as society's equating beauty with thinness or lack of emotional expression on the part of a parent, do not hold up as sufficient explanations. Often, only professional psychotherapy can uproot the bulimic's true problems.
3. Does she have a scar on her hand? Above the knuckles on her first three fingers is a good place to look for redness and scratches. If she is throwing up frequently, her fingers and knuckles will probably be cut from touching against her teeth when she sticks her finger(s) down her throat. Some bulimics use other objects to induce vomiting, however.
4. Does she have stained or spotted clothing? The bottoms of skirts and shoulders are good places to look after she comes out of the bathroom. These are places where vomit has splashed up from the commode and onto her clothes.
5. After returning from the bathroom, is she teary-eyed, flushed in the face, or have wet hair? These are sure signs of purge behavior. When vomit or water from the commode splashes onto her face and hair she will rinse it off. The redness, teary eyes, and flushness in the face result from physiological changes her body undergoes while vomiting.

Never underestimate the power of this disorder. Bulimia can kill. First, the bulimic will see blood in her vomit and then stool, and experience more and more frequent dizzy spells. Other warning signals include low blood sugar, and unbalanced electrolytes. Instantaneous death can occur from a heart attack or internal bleeding.

Fortunately, there has never been a better time to help those with bulimia. Information is being disseminated through various forms of the media. Differing treatment options, including support groups (Overeaters Anonymous), counseling, psychotherapy, group therapy, and if necessary, hospitalization have all been used with success. It is possible, but not easy, to break this deadly addiction. The first step is recognition.

Anorexia Nervosa: 20th Century Scourge

"To call it loss of appetite--anorexia--but feebly characterizes the symptom. It is rather an annihilation of appetite, so complete that it seems in some cases impossible ever to eat again." Thus wrote Weir Mitchell in 1897 of anorexia nervosa, the nervous disorder first described by Sir William Gull in 1874. Gull attributed the disorder to a

morbid mental state," in a description which was foreshadowed by Lasegue's (1873) account of "anorexie hysterique," a hysterical derangement of the digestive tract.

Although the disorder was uncommon until recent years, it was so striking that its clinical features were described accurately quite early. Gull, for example, noted the anorexic's "curious and persistent wish to be on the move, though the emaciation was so severe."

Anorexia nervosa usually begins in adolescence. It is much more common in girls. The onset and course of the disorder are remarkably predictable. Sometimes following an upset, such as a failed romance, and sometimes without a clear precipitant, the patient begins to diet. After a time the dieting becomes driven by a fear of losing control of the appetite. Many go no further, hovering, sometimes for years, on the brink of a more serious disorder. In some young women, however, severe dieting metamorphoses into an implacable pursuit of thinness, an obsession with food and calories, and a sheer abhorrence of body fat.

Denial Common

Commonly, the anorexic denies her illness, does not perceive herself as emaciated, and exaggerates her body proportions. In order to expend calories, she jogs and exercises relentlessly. Physical changes accompany weight loss. Menstrual periods soon stop and ovulation ceases. The skin dries out, cheeks and forearms become covered with downy hair, the heart rate and blood pressure drop, and the manufacture of blood in the bone marrow is depressed.

Many patients get rid of the meals they are persuaded to eat by secretly vomiting, purging, or using diuretics. Consequently, the chemistry of the body becomes deranged. In extreme cases, the teeth decay, the kidneys begin to fail, body musculature seizes up, and the heart begins to beat irregularly or stops altogether.

In some women, episodes of anorexia nervose are punctuated by binges of eating (bulimia) which in turn are terminated by self-induced vomiting. In other cases, bulimia is the central system, and anorexia is less prominent.

The treatment of this condition has made great strides during the past twenty years. Hospitalization is required for patients who have lost a great deal of weight, who binge and vomit, or who have not responded to less intensive treatment. A full course of therapy might involve:

- The restoration of fluid and chemical imbalance by intravenous therapy;
- The assurance of adequate caloric intake, by supervising mealtimes (or even by tube feeding in extreme cases);
- The prevention of self-induced purging, diuresis, or vomiting;
- The regulation of excessive exercise, by bed-rest, if necessary;
- Behavior therapy to reinforce eating;
- Individual psychotherapy; and
- The prescription of antidepressant or appetite-stimulant medication.

The significance of the family in this disorder cannot be overstressed. Family therapy is an essential ingredient of a comprehensive treatment program.

Treatment, therefore, requires the coordination of psychiatrist, pediatrician, nutritionist, psychologist, social worker, and nursing staff. Ultimately, although it is often not difficult to reverse the loss of weight, it is very difficult to allay the patient's fear of losing control of her appetite, and to induce her to take responsibility for a normal food intake. Treatment can be a lengthy proposition.

The striking physical features of anorexia nervosa have led some physicians to postulate a neurological cause. Detailed studies of the derangement of hormones in anorexia, however, have unearthed nothing that could not be explained as a concomitant of severe starvation, or, possibly, of a psychological depression. It seems that the cause of anorexia nervosa must be sought in a complex mixture of genetic, developmental, psychological, familial, and sociocultural factors.

There is some evidence, for example, of a clustering of mood disorders in the families of anorexics. Perhaps these patients have a genetic predisposition involving instability of mood. Often, though not universally, the anorexic was originally a compliant, conscientious child, dependent upon, and dominated by, her mother, yet remote from a distant, busy father. Entering adolescence, such a predisposed child may be ill-prepared for the demands of education, and the stresses of sexual maturation and social competition. It is at this time also that rifts may appear in the fabric of the parents' marriage, rifts which the child may strive to hold together.

Why in the 20th Century?

The wasting away of a young girl, perhaps disappointed in love, was a frequent sentimental theme of Victorian literature. How ironic that anorexia nervosa should have become such a scourge at the liberated end of the 20th century. Why so?

Not long ago, an advertisement for perfume appeared frequently on national television. It showed a beautiful, svelte young woman in a business suit, carrying a briefcase, off to work. "I can bring home the bacon," she sings. Next, home from work, she fries the bacon for dinner and puts a child to bed. Finally, in a shimmering evening dress, she winds at the camera as she dances the night away in the arms of her handsome husband. Could it be that this conflicted, unattainably idealized image, an image purveyed daily in the popular media, suggests a cause for the near epidemic of this perplexing disorder?

Alcohol Use Linked with Stress, Purging Among 10th Graders

Stanford University researchers have linked alcohol use to stress and purging behavior among high school sophomores. Previous studies have linked bulimia and alcohol use only among adults. Because this age group is likely to have absorbed society's dysfunctional attitudes toward body weight and eating, the researchers, led by psychologist Joel D. Killen, consider high school students as a high risk group.

The researchers surveyed 1,728 northern Californian 10th grade students in 1985 to assess the prevalence of purging behavior, alcohol and drug use, and reported physical and psychological distress. Thirteen percent of the sample reported purging behavior, with females outnumbering males 2 to 1. Female purgers not only reported higher incidence of drunkenness than nonpurging females, but also reported greater frequency of daytime alcohol use. Female purgers' responses to stress were significantly more intense than female nonpurgers. The purging females reported higher levels of depression than the nonpurging females. Male purgers and nonpurgers reports were not significantly different, except that male purgers reported less stress and depression than did female purgers.

When drug use was scrutinized by specific substance used (cigarettes, alcohol, marijuana, cocaine), purgers reported more drug use than nonpurgers. Significantly, 46% of male purgers used alcohol for stress management, as compared to 36% of female purgers.

Preventing Eating Disorders

Although the incidence of eating disorders has increased over the past 20 years, more effort has been put into the establishment of treatment clinics than into the widespread prevention of these diseases. In a recent article, Catherine Shisslak of the University of Arizona and her colleagues outline a prevention program that they believe could be successfully implemented in junior and senior high schools across the country.

The two most prevalent eating disorders are anorexia nervosa and bulimia. Over 90% of the young victims are female, and most belong to the middle or upper class. Previous studies have indicated that these women suffer from a "poor relationship with the self." They tend to feel powerless in relation to the world around them and lack a sense of identity. Unable to develop a coherent system of personal values, they may latch onto low body weight as a sign of their own worth.

The researchers claim that young women might be prevented from developing eating disorders if they were provided early on with "the training needed to master the broader tasks of maturation." According to them, prevention at the junior high level should focus on making the female student more aware of her body and personal needs. Educational material should, however, "extend beyond the facts of physiology to include the psychological and social components of maturation (e.g., increased emotional arousal, relationships with boys, problems with parents)." They also recommend the use of peer-directed discussions on such topics as "the ideal body," in which students would be led to consider such questions as "What would be the advantage of having certain aspects of the ideal body?", "How important are these advantages to you?", and "What are ways of getting these advantages other than through the way your body looks?"

Education in senior high schools would be along the same lines, but presented on a more detailed and sophisticated level. Teachers could stress, for example, "specific health consequences of anorexia nervosa and bulimia, the role of women in society, the media's portrayal of women, problems that arise between parents and teenagers, and assertiveness skills." The authors also suggest that assertive, healthy and successful women be brought into the school as guest lecturers with the hope that they will serve as role models and inspire students to pursue whatever naturally interests them.

The authors believe, furthermore, that prevention programs such as the one outlined here should be implemented and assessed systematically. They recommend the use of both experimental and control groups, as well as two to three-year follow-ups of the knowledge, attitudes, and behavior of the participants.

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