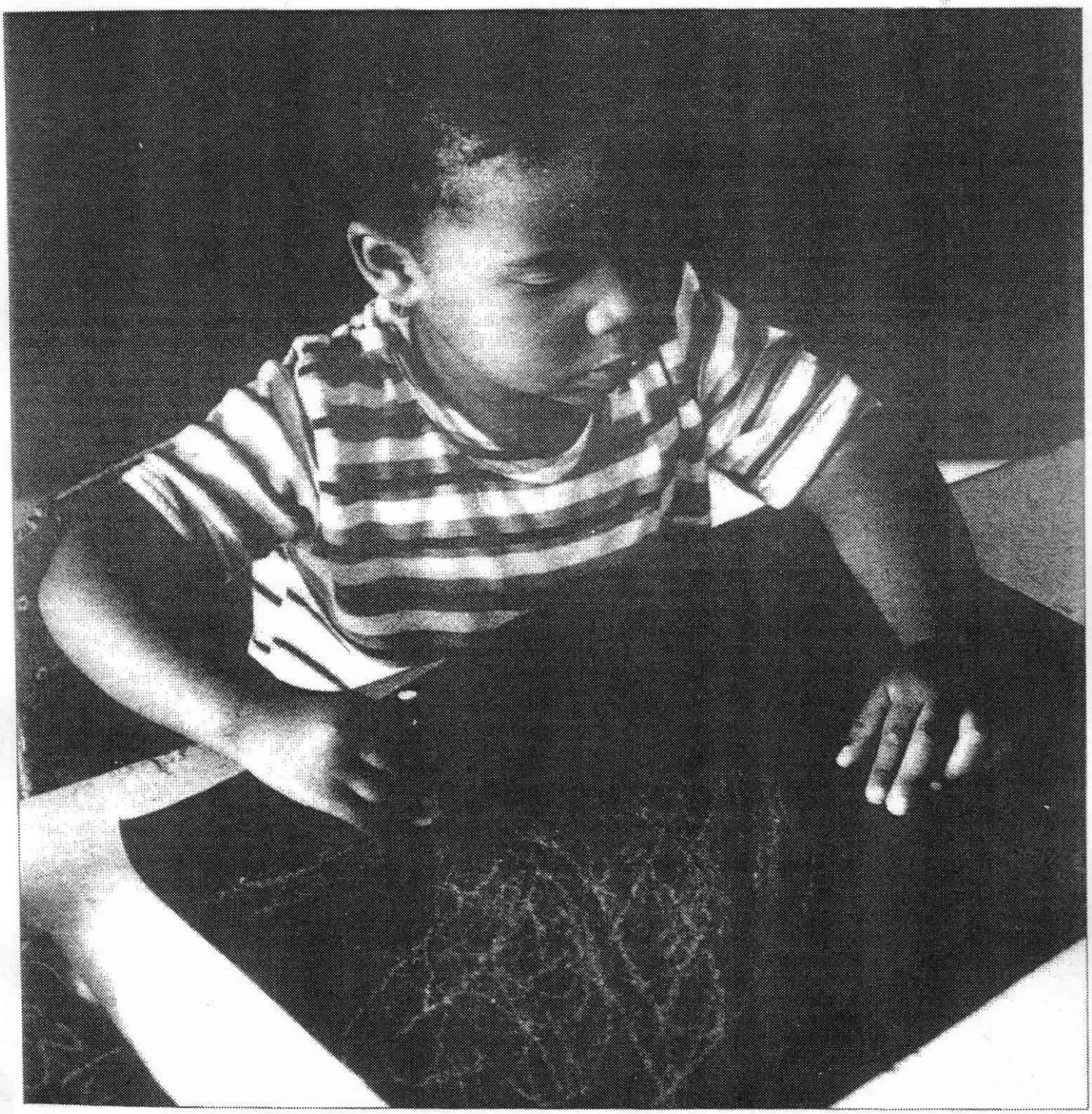
Die Kinderversorger ISSN 0258-3927 Vol.5 No.4 April 1987

The child care worker



NATIONAL ASSOCIATION OF CHILD CARE WORKERS
NASIONALE VERENIGING VAN KINDER-VERSORGERS

National Executive Committee
Nasionale Uitvoerende Raad

National Chairman/Nasionale Voorsitter
Ernie Nightingale NHCRCC Dip Pers Man AICB, Ethelbert Children's Home, 93 Ethelbert Road, Malvern 4093. Tel: 031-44-6565

National Treasurer/Nasionale Tesourier
John Saxey AIAC FICB(SA), P.O. Box/Posbus 3212, Cape Town/Kaapstad 8000. Tel: 021-71-7591

Members/Lede
Jacqui Michael (Transvaal), Revd/Eerw Roger Pitt (Eastern Province/Oostelike Provinsie), Ernie Nightingale (Natal), Ashley Theron (Western Cape/Wes-Kaap)

Directorate/Direktoraat

National Director/Nasionale Direkteur
Brian Gannon, BA (Hons) MA
P.O. Box/Posbus 199
CLAREMONT 7735
Tel: 021-790-3401

Regional Director/Streeksdirekteur (Transvaal)
Di Levine, BA (Hons) MA
P.O. Box/Posbus 8021
JOHANNESBURG 2000
Tel: 011-337-7010

Regional Secretaries/Streeksekretartsse

Transvaal
Cynthia Green, P.O. Box/Posbus 49106, Rosettenville 2130. Tel: 011-26-4146

Natal
Dr Jeannie Roberts, 104 Windmill Rd, Berea, Durban 4001. Tel: 031-21-5894

Eastern Province/Oostelike Provinsie
Lesley du Toit, The Children's Home, P.O. Box/Posbus 482, King Williamstown 5600. Tel: 0433-21932

Western Cape/Wes-Kaap
Merle Allsopp, St Michael's, Hoofweg 63 Main Road, Plumstead 7800. Tel: 021-77-4409

THE CHILD CARE WORKER
DIE KINDERVERSORGER
P.O. Box/Posbus 199, CLAREMONT 7735
Tel: 021-790-3401

The Child Care Worker is published on the 25th of each month excepting December. Copy deadline for all material is the 10th of each month. Subscriptions for NACCW members: R5.00 p.a. Non-members: R10.00 p.a. post free. Commercial advertisement rates: R2.50 per column/cm. Situations vacant/wanted advertisements not charged for. All enquiries, articles, letters, news items and advertisements to The Editor at the above address.

Die Kinderversorger word op die 25ste van elke maand, behalwe Desember, uitgegee. Kopie afsluittyd is die 10de van elke maand. Subskripsiegeld vir NVK lede: R5.00 p.j. Nielede: R10.00 p.j. posvry. Kommersiële advertensies: R2.50 per kolom/cm. Betrekking advertensies is gratis. Alle navrae, artikels, briewe, nuusbrokkies en advertensies aan Die Redakteur by bogenoemde adres.

Editorial Board/Redaksiekommissie
Merle Allsopp BA HDE, NHCRCC, Peter Harper MSc (Clinical Psychology), Dina Hatchuel BSocSci (SW) (Hons) PSW MSocSci, Peter Powis MA (Clinical Psychology), Renee van der Merwe BA (SW) (Stellenbosch)

Editor/Redakteur
Brian Gannon

The Institute of Child Care

Enclosed in this issue is an invitation to NACCW members who qualify by virtue of their training and length of service to submit their names for consideration for the Foundation Membership of the Institute of Child Care. There are a number of issues in the thinking behind the formation of the Institute —

- With the high turnover of child care workers, the NACCW devotes virtually all of its training resources to those in their first two years in the profession — and devotes little to those who have been in child care for two years and more. The Institute will specifically involve these more experienced staff academically and professionally.
- The profession is insufficiently directing and co-ordinating efforts towards research and practice standards, and the Institute will be able to mobilise its members to make a contribution to these ends.
- The child care profession has no method of identifying and accrediting qualified and experienced workers, and membership of the Institute will for the first time permit some form of registration of such workers to the mutual benefit of workers and employers.

Membership of the Institute will signify some tangible evidence of training, experience and practice skill.

It has long been a cause for concern that new workers enter child care to see a limited career pathway lying ahead of them. The common pattern is to do two years of formal training and then to remain for one more year before leaving the work. It is hoped that the Institute of Child Care will extend this pathway for child care workers further into the future by keeping their professional stimulation and development on the boil.

The child care service generally stands to gain from the existence of a body of trained and experienced workers. Unlike our sister professions like social work, teaching, nursing or psychology, child care has no academic or professional base provided by the state. Either child care is not regarded as important enough or the assumption is made that we can do it all for ourselves. Whichever, the Institute of Child Care will for the first time create a significant resource of experienced and qualified people who can make a valuable contribution to the academic, research, standards and practice development of child care in South Africa.

Die Instituut vir Kinderversorging

Bv hierdie uitgawe sluit ons 'n uitnodiging in aan alle NVK lede wat kragtens hul opleiding en dienstyd kwalifiseer vir aanwerging van Stigtingslidmaatskap van die Instituut vir Kinderversorging. Daar is 'n aantal uitvoersels in die denke agter die samestelling van die Instituut —

- Met die hoe omset van kinderversorgers, wy die NVK byna geen opleidingsbronne toe aan diegene in hul eerste twee jaar in die beroep — en wy min toe aan diegene wat twee of meer jaar by kindersorg betrokke is. Die Instituut sal spesifiek hierdie meer ervare personeel akademies en professioneel betrek.
- Die beroep se pogings op navorsing en praktykstandaarde is onvoldoende en die Instituut sal sy lede mobiliseer om 'n beter bydrae hiertoe te maak.
- Die kindersorgberoep het nie 'n metode om opgeleide en ervare werkers te identifiseer en in aansien te bring nie, en lidmaatskap van die Instituut sal vir die eerste keer 'n vorm van teboekstelling van sulke werkers toelaat wat beide werknemers en werkgewers tot voordeel sal strek. Lidmaatskap van die Instituut sal 'n vorm van tasbare bewys van opleiding, ondervinding en praktiese vaardigheid te kenne gee.

Dit is lank reeds sorgbarend dat nuwe werkers die kindersorgberoep betree om 'n kort beroepspaadjie voor hulle te sien. Dit is die gewoonte om twee jaar formele opleiding te voltooi en daarna vir nog 'n jaar te bly en dan die beroep te verlaat. Daar word gehoop dat die Instituut vir Kinderversorging hierdie paadjie vir kinderversorgers sal verleng deur hulle pot van professionele aansporing en ontwikkeling aan die kook te hou.

Die kindersorgberoep, oor die algemeen, sal voordeel trek uit 'n liggaam bestaande uit opgeleide en ervare werkers. In teenstelling met ons suster beroepe soos maatskaplike werk, onderwys, verpleging of sielkunde, word kindersorg van geen akademiese of professionele basis deur die staat voorsien nie. Kindersorg word of as onbelangrik beskou, of daar word gedink dat ons dit alles vir onsself kan doen. Wat ookal, die Instituut vir Kinderversorging sal vir die eerste keer 'n betekenisvolle bron skep van ervare en opgeleide persone wat 'n waardevolle bydrae kan lewer tot die akademie, navorsing, standaarde en praktyk ontwikkeling van kindersorg in Suid-Afrika.

Die Emosionele Ervaringswêreld van die Kinderhuiskind

Renée van der Merwe

In hierdie artikel ondersoek ons eers die psigo-sosiale behoeftes van die ontwikkelende kind en vergelyk dit dan met die ervarings van die kind in die kinderhuis.

Die feit dat menslike behoeftes onderling verband hou en interafhanklik is op 'n komplekse en konstante wyse, moet voortdurend in gedagte gehou word. 'n Kind mag weier om sy basiese behoefte aan slaap te bevredig uit vrees dat sy ouers hom sal verlaat, of 'n emosioneel verwaarloosde kind mag weier om te eet. Bowlby stel dit dat moederliefde vir die baba en kind se geestesgesondheid net so belangrik is soos vitamines en proteïnes vir liggaamlike gesondheid.

Eerstens het die kind 'n behoefte aan *liefde*. Hierdie behoefte word bevredig deur 'n stabiele, konstante, betroubare en liefdevolle verhouding met ouers. Hier word die kind se vermoë om later 'n bindende verhouding te vorm vasgelê. Wanneer 'n kind onvoorwaardelik, sonder onrealistiese eise aanvaar word, ontwikkel 'n gesonde selfbeeld.

Liefde word gekommunikeer deur fisiese versorging en kontak, beskerming teen en insiëring in die sosiale milieu, kommunikasie en dissipline. Eers wanneer die kind hierdie eerste noue bande gesluit het sal hy die behoefte aan "onmiddellike bevrediging" kan uitstel en selfbeheersing en morele waardes kan ontwikkel.

Tweedens het elke kind 'n behoefte aan *sekuriteit*. Hierdie behoefte word deur konsekwente verhoudings (beginselvastheid), die sekuriteit van 'n bekende omgewing en bekende objekte en die standvastigheid van 'n bekende roetine ontwikkel. As die gesinsverhoudings verbrokkel en die ouers vir watter rede ookal te behep is met hulle eie probleme, ontwikkel emosioneel versteurde, anti-sosiale of opvoedingsveroorsaakte ontwikkelingspatrone.

'n Derde behoefte is dié aan *nuwe ondervinding*. Die lewenstaak van die kind sentreer om speel en praat. Slegs die sekure kind sal dit na buite waag om te ontdek en te eksperimenteer. Hoe dikwels sien ons nie in die ondergestimuleerde verwaarloosde kind hierdie onontwikkelde potensiaal raak nie? Of die hiperaktiwiteit van die oorgestimuleerde, onstabiele kind nie?

Kinders het vierdens 'n behoefte aan *erkenning en aanmoediging*. Wanneer 'n kind se bydrae as waardevol aanvaar word en sy pogings aangemoedig word, ontwikkel hy in 'n selfstandige volwassene. Hoe dikwels sien ons nie die ondererkendheid en ontmoediging van die miskende kind nie?

Vyfdens het kinders 'n behoefte aan *verantwoordelikheid*. Wanneer die ouer glo in die vermoëns van die kind, hom leer en ferm perke stel, kan die kind gesonde keuses maak wat sal lei tot die ontwikkeling van selfstandigheid.

Die *normale* huisgesin bestaan gewoonlik uit 'n ouerpaar en 2 tot 4 kinders. In so 'n huisgesin is daar liefde en ondersteuning van die ouers onderling en ten opsigte van hulle kinders. Daar word voorsien in die gesin se basiese behoeftes, hulle word saamgebind deur hulle beginsels, kultuur, godsdiens en ken dus die aanslae van die buitewêreld, of dit emosioneel, sielkundig of materieël is, beter die hoof bied. Die kinders van so 'n gesin ervaar op 'n positiewe wyse die bystand, liefde en leiding van konsekwente ouers en het dus genoegsame sekuriteit om die buitewêreld te verken en om wanneer sake verkeerd loop na die veilige hawe van die gesinsverband terug te kan keer.

Hoe jonger die kind hoe groter die trauma wat met sy verwydering gepaard gaan.

Die *multiprobleem*gesin ervaar talle ontwikkelingskrisisse. Die ouers se krisis veroorsaak dat die samebindende faktore verdwyn en daar is nie die krag oor vir liefdevolle kinderopvoeding nie, die kinders word verwaarloos en word beskou as 'n oorlas. Weens verwerping, ondervoeding, verwaarlosing en ander maatskaplike probleme verloor die kind sy sekuriteit en sy veilige vesting. Dit is in hierdie omstandighede dat daar deur welsynsorganisasies ingetree word terwille van die kinders. Daar is veral twee redes waarop verwyderings gegrond word. Ten eerste wanneer ouers so arm is dat hulle nie die lewensmiddele het om die kinders te versorg nie, en tweedens, as gevolg van onbevoegde ouers. Laasgenoemde lei tot die meeste gevalle van verwysing van kinders na kinderhuise. Hulle ouers is die onopspoorbares, dronkaards/alkoholiste, verstandsgestremdes, kroniese werkloses of misdadigers wat nie die versorging van kinders kan waarneem nie.

DIE KIND IN DIE KINDERHUIS

Laat ons nou die emosionele ervaringswereld van die kind ondersoek wanneer hy in 'n kinderhuis opgeneem word en probeer vasstel hoe dit hom beïnvloed.

Verwyderingstrauma

Hoe jonger die kind hoe groter die trauma wat met sy verwydering gepaard gaan. Sy ouers, hoe ontoereikend ookal, is al wat hy ken en aan gebind is; die verbreking van die band is pynlik.

Die kind kom van 'n lewe van miskenning, verwaarlosing en soms mishandeling. Sy ouers het, weens die verbrokkeling van die gesin, nie hulle rolle vervul nie, hom teleurgestel, van sy sekuriteit ontneem en oorgegee aan die versorging en opvoeding van onbekendes. Baie kinders se ontwikkeling is so versteur dat hulle nie suksesvol kan kommunikeer nie en dat hulle fisiese groei ook benadeel is.

Die kind kom as vreemdeling, alleen, na die groepsomgewing van die kinderhuis. Hy moet nou 'n nuwe begin maak in 'n kinderhuis. Hy is onseker oor die behandeling wat hy gaan kry, die roetine, die mense en hulle verwagtings van hom is onbekend. Al waarvan hy bewus is, is dat sy aanpassing tot dusver nie suksesvol was nie en dat sy lewe voortaan gaan verander. Hy voel angstig, onseker en verward.

Emosionele Dualisme

Van die bogenoemde emosionele faktore word dikwels buite rekening gelaat. Swanepoel meen: "Dit is so dat sorgbehoewende kinders in 'n staat van dua-

Vandag se kinderhuis is gladnie 'n weeshuis nie.

lisme geplaas word en nou verwag ons resultate met hulle opvoeding en versorging. Ek vrees dan ook dat die bykomende dienslewering van die rekonstruksiewerkers hierdie gaping groter maak en daarmee 'n strenming in die emosionele lewe van die kind veroorsaak". As gevolg van die historiese ontwikkeling van kinderhuise het 'n belansverskuiwing plaasgevind. Die "weeshuis" van vroeër, waar kinders

soontoe ouers opgenoem is. Juis die dieselfde probleme in hulle verlede gehad het, want die ouers was vir gevind dat die probleem. Die kinders kon identifiseer met hulle nuwe opvoeders en was dikwels verder dankbaar vir die verbeterde lewensomstandighede in die weeshuis.
Vandag se kinderhuis is gelukkig 'n weeshuis nie. In sommige kinderhuise is inderdaad slegs een of twee weeskinders. Die meerderheid kinders in die kinderhuis is sorgbehoewend bevind.
Weens die gevorderde opvoedingsmetodes van vandag, en die lang tydperke wat sommige kinders in die kinderhuis moet deurbring, word spesiale aandag gegee aan die algehele opvoedings- en ontwikkelingsproses van die kind. Sodra die kind egter met verlof huistoe gaan word hy daarenteen opnuut blootgestel aan die "ongewenste huislike omstandighede" waaruit hy ten alle koste verwyder moes word. Of toestande verbeter het of nie, so is die beleid, moet die kind nie vervreem word van sy ouers nie. Die rekonstruksiewerkers stry hard en meestal vrugteloos teen werkloosheid, onkunde, alkoholisme, onmoraliteit en al die ander ongure invloede van die huislike omgewing om die gesin te rehabiliteer en verwag op hulle beurt dat die kind besoeke moet kom aflê ter realisering van die rehabilitasie van die ouers.
Dit het die gevolg dat die kinderhuiskind emosioneel verskeur word tussen die kinderhuis aan die een kant en sy onbevoeg bevinde ouerhuis aan die ander kant. Met die groot verskil tussen die beleid van die kinderhuis aan die een kant en die van die ouerhuis aan die ander kant, word 'n ketting van opbou en afbreek in die emosionele lewe van die kinders aan die gang gesit.

Huislike Norme

Indien die ouerhuis nie totaal onaanvaarbaar was nie sou die kommissaris nie tot die drastiese stap van verwydering van die kind ingestem het nie. Die kind het fisiese en emosionele gebrek gely. Uit die aard van die menslike natuur het hy hom hierby aangepas, en soms die ordelose en wettelose gedrag gedurende tydelik van selfbehoud. Sy eie weiering is ook dikwels deur onmenslike ouers geïgnoreer. Hy het leer leef met 'n vervreemde stel godsdienstige en morele beginsels.

Kinderhuis Norme

In die kinderhuis is die situasie feitlik die teenoorgestelde. In al die kind se fisiese behoeftes word voorsien. Die personeel probeer om die kind emosioneel te beskerm, goed te versorg en met liefde en verdraagsaamheid groot te maak. Al is die getalle in sommige woonneenhede groot, word die beginsel van bestaansreg vir elkeen beoefen en is daar 'n vaste roetine en reëls wat nagekom word. Personeel is spesiaal opgelei om die behoeftes van die sorgbehoewende kind op 'n konsekwente en liefdevolle manier te bevredig en om hom aanvaarbare lewensstandaarde aan te leer.
Die kinderhuiskind leer nou dat liefde en dissipline mekaar nie uitsluit nie. Sy ou metode om van skuwergate gebruik te maak is nie in die kinderhuis baie suksesvol nie. Hy word aan nuwe godsdienstige norme blootgestel en leer ander morele waardes aan. Hy word dus aan 'n volledige ontwikkelingsprogram

Die kind het fisiese en emosionele gebrek gely.

blootgestel. Daar word van maatskaplike werkers en ander professionele persone se dienste gebruik gemaak om hulp te verleen met die verwerking van konflikte, frustrasies en ander emosionele skade wat reeds in sy lewe opgedoen is.

Vertraagde Emosionele Ontwikkeling

Die kind word in die kinderhuis blootgestel aan 'n emosionele opbouingsprogram en in die ouerhuis aan 'n afbrekingsproses. Waar die kinderhuis hom aanmoedig om te leer sal die ouer hom aanspoor om te gaan werk en geld te verdien. Vir die kind is sy onsekerheid en ongelukkigheid lyk dit baie aanklik en is hy geneig om sy ouers te gis.

Die kinderhuiskind leer nou dat liefde en dissipline mekaar nie uitsluit nie.

Die morele waardes van die kinderhuis is onbekend vir die ouers en hulle bevestig dit nie. Vir die kinders is dit ook moeilik om soos so en ma van een losse verhouding na die ander te dryw. Wat langtermyn medikasie of terapie betref is dit ook so dat die kind dikwels as hy van die huis terugkeer na 'n vakansie weer die swaarste bedrewenheid, angsdrome en ander kwale openbaar omdat die terapie deur die ouer gestaak is.

Verdeelde Lojaliteit

Omdat die kind se opvoeding dikwels verdeeld is tussen die kinderhuis en die ouerhuis is dit vir sommige kinders onmoontlik om 'n spontane lojaliteit teenoor die kinderhuis te ontwikkel. Hy kom slegs lojaal voor wanneer dit 'n direkte voordeel vir hemself inhou. By die huis is hy weer lojaal teenoor die ouers wat hom eens verwerp het. Dit is egter interessant om daarop te let dat kinders wat geen verpantsing met hulle ouers het nie, wel lojaliteit aan die kinderhuis ontwikkel. Hulle lewens is vryer van konflik om dat hulle die leiding, opvoeding en morele waardes van die kinderhuis aanvaar as hulle eie.

Dubbele Standaarde en Morele Waardes

'n Kind wat blootgestel word aan ouerlike sorg, opvoeding en grafuheids bou 'n stel waardes en standaarde op. Dit is 'n lang proses van ontdek, beproef, verwerp en uiteindelik aanvaar van 'n eie waardesisteem. Die kinderhuiskind leer in die kinderhuis een stel waardes en standaarde aan en begin dit internaliseer. Wanneer hy by die huis kom moet hy óf bly by hierdie waardes (en spanning veroorsaak), óf maak soos sy gesin maak (en sy waardes tydelik opsy skuif). 'n Volwasse, selfversekerde mens kan dit dalk sonder te veel spanning doen, maar die kinderhuiskind wat onseker is en emosioneel 'n agterstand het, beleef die gesinger van een uiterste na die ander as 'n krisis.
Alle mense word gekonfronteer met waardes wat teenstrydig met hulle eie is en moet dan beslui wat vir hulle aanvaarbaar is. Die kinderhuiskind is egter werklik opgedra aan die kinderhuis wat sy volledige opvoeding moet waarneem.
As die kinderhuis ems het met hierdie taak, dissiplineer hulle die kind wanneer hy nie aan hierdie verwagtings voldoen nie. Hy bly egter nog in kontak met die negatiewe opvoedingsmetodes in die ouerhuis. Die kind het dus geen vaste waardes en beginsels nie en nie genoeg selfvertroue om sy eie besluite te neem nie.

Gebrek aan 'n Vertroueling

Vanaf sy vroegste jare het elke mens die behoefte aan die sekuriteit en liefde wat net 'n een tot een verhouding kan bied. Wanneer die kind uit die onstabiele ouerhuis in die groepsituasie van die kinderhuis beland is hierdie behoefte nog onvervuld. Dikwels keer hy hom tot maats vir die vervulling van hierdie behoefte, soms is hy gelukkig om 'n onderwyser of ander personeellid te hê wat hy werklik kan vertrou en met wie hy oor sy probleme kan gesels. Veral in die beneerjare het die kind 'n spesiale persoon, wat hy voel verstaan hom, baie nodig. Soms bikseer die behoefte in 'n onbekende of afwesige ouer en fantaseer die kind dat hierdie persoon die enigste oplossing vir al sy probleme is.
Dalk is dit hiermee toe te skryf dat kinders hulle ouers idealiseer en ingetuns na hulle wil gaan ten spyte van die teleurstellings en ontnugterings. Dit is dalk ook om hierdie rede dat die kinderhuiskind so maklik in ongewenste verhoudings beland, dit kom voor asof hulle behoeftes bevredig en probleme opgelos sal word.

Gebrek aan 'n Identifikasiefiguur

Normaalweg identifiseer 'n kind met sy ouer as rolmodel vir sy toekoms. Die kinderhuiskind het dit geen of 'n swak rolmodel om mee te identifiseer. Dit is

ook selde dat hy 'n personeellid genoeg idealiseer om met hom te identifiseer. Die probleem lê dalk by die feit dat daar 'n relatief hoë omset van personeel is.

Dit is ook selde dat hy 'n personeellid genoeg idealiseer om met hom te identifiseer.

Die kind steek dus vas in sy kinderlike onvermoëns, hy raak angstig, gespanne en konsentreer op sy gevoelens van minderwaardigheid en bou sodoende nie 'n lewensideaal op nie. Meeste kinderhuiskinders het reeds 'n swak selfbeeld en beplan dan nie doelgerig op die toekoms nie maar bly behep met "onmiddellike bevrediging" van korttermyn behoeftes.

Gebrek aan Individualisme

Elke kind ontwikkel teen sy eie tempo volgens 'n vasgestelde ontwikkelingspatroon. Die vermoë word vergemaklik deur aanmoediging en liefdevolle leiding. Almal bereik nie dieselfde mylpale op presies dieselfde tydstip nie. Daarom het elke kind die behoefte om as 'n individu behandel te word en dat eise volgens sy spesifieke vermoëns aan hom gestel word. Die einddoelwit sal wees om onafhanklik en selfstandig sy eie oordeel te kan vel en suksesvol in die samelewing te kan funksioneer. Veral in die adolessente jare is daar 'n sterk neiging om eie besluite te wil neem en onafhanklik te wees, gewoonlik gebaseer op die voorbeeld van ouers en groter maats. Omdat die lewe van die kinderhuiskind meer geregimenteerd is, is hy dikwels meer opstandig en aggressief om die bande te verbreek. Omdat hy soveel meer onseker is, is sy pogings dikwels meer drasties en desperaat.

Kinderhuispersoneel is dikwels, heel menslik, geneig om die "soeter", "makliker" kind wat nie opstandig is nie, te prys. In die proses word skuldgevoelens wakker gemaak by die kind wat so desperaat probeer om homself te individualiseer.

Gebrek aan 'n Duidelike Rol in die Samelewing

Vir die kind uit die normale gesin word sy status in die samelewing deur sy ouers en sy omgewing bepaal.

Om 'n suksesvolle aanpassing in die samelewing te maak vra die samelewing na jou oorsprong, jou ouers se status, jou godsdiens, jou goeie maniere, jou skoolrapport en jou kulturele belangstellings. Hierdie toerusting moet aan die kind in die kinderhuis gegee word sodat hy sy persoonlikheid kan uitbou. Hy staan egter geïsoleerd in die gemeenskap, word met bejammering bejeën, aalmoese gegee en staan dikwels onder verdenking. Die kinderhuis kan self daarvoor verantwoordelik wees met uniforme metodes van toetsmeting en beleid vir "spesiale voorregte" vir die kinderhuiskind. Die ongelukkige gevolg hiervan is 'n houding dat die samelewing "hom iets skuld" en in al sy behoeftes moet voorsien.

Bespreking

Wanneer bogenoemde faktore in ag geneem word is dit duidelik dat daar baie meer navorsing en diepe denke nodig is by die hantering van die kind in die kinderhuis.

Daar is 'n groot behoefte aan meer individuele, persoonlike leiding. Om met professionele aandag aan diep gewortelde vrese, ontmoediging en konflikte te werk, verg tyd wat dikwels nie beskikbaar is nie. Dit is dalk nodig om ouers en selfs vakansie- en gasheerouers meer noukeurig te evalueer, op te lei, en tot beter samewerking te motiveer. Rekonstruksiedienste moet geïntensifiseer word en ouers wat weier om die kind se belange te bevorder kan tydelik uitgeskakel word. Nouer samewerking tussen kinderhuise en gesinsorganisasies sal vir almal in die beroep van groot waarde wees. As die kind se situasie, afhangende van sy ouderdom en begripsvermoë, met meer eerlikheid en openlikheid met hom bespreek word, sal dit slegs in die belang van sy latere aanpassing wees. Soms word die kind se agtergrond, sy aanpassingsvermoë en ook sy latere ontwikkeling nie in ag geneem wanneer daar op 'n spesifieke kinderhuis besluit word nie. Die kind beland dan in 'n situasie waar hy die sosiale "voorregte" in sy nuwe omgewing nie kan hanteer nie.

Die einddoelwit sal wees om onafhanklik en selfstandig sy eie oordeel te kan vel en suksesvol in die samelewing te kan funksioneer.

Slotsom

Wanneer ons kyk na die skade wat dikwels reeds in die emosionele lewe van die kind gedoen is wanneer hy in die kinderhuis opgeneem word, klink dit na 'n onmoontlike taak om werklik sukses in sy opvoeding te behaal. Sy emosionele ervaringsveld is vol onsekerheid, dualisme en konflik. Tog moet die kind wat beklei vir 'n eie identiteit en soms halsstarrig voorkom aangemoedig word om sy probleme te oorwin en te veg vir sy regte, eerder as om te gaan lê en die probleme van die lewe gelate te aanvaar.

Die taak van die personeel van ons kinderhuise is 'n moeilike een wat volharding en 'n besondere roeping verg. Tog weet elkeen dat dit die liefde werd is wanneer 'n gelukkige [illegible] wanneer teruggekom in die kinderhuis [illegible] dag sê.

Bronne

Blake, Dr Y. *The effects of separation from the parents during different phases of childhood.* Ongepubliseerde lesing.

Pringle, Mia Kellmer. *The Needs of Children.* Hutchinson & Co. London, 1977.

Swanepoel, Dr J C. *Die emosionele ervaringswêreld van die kinderhuiskind.* Ongepubliseerde toespraak.

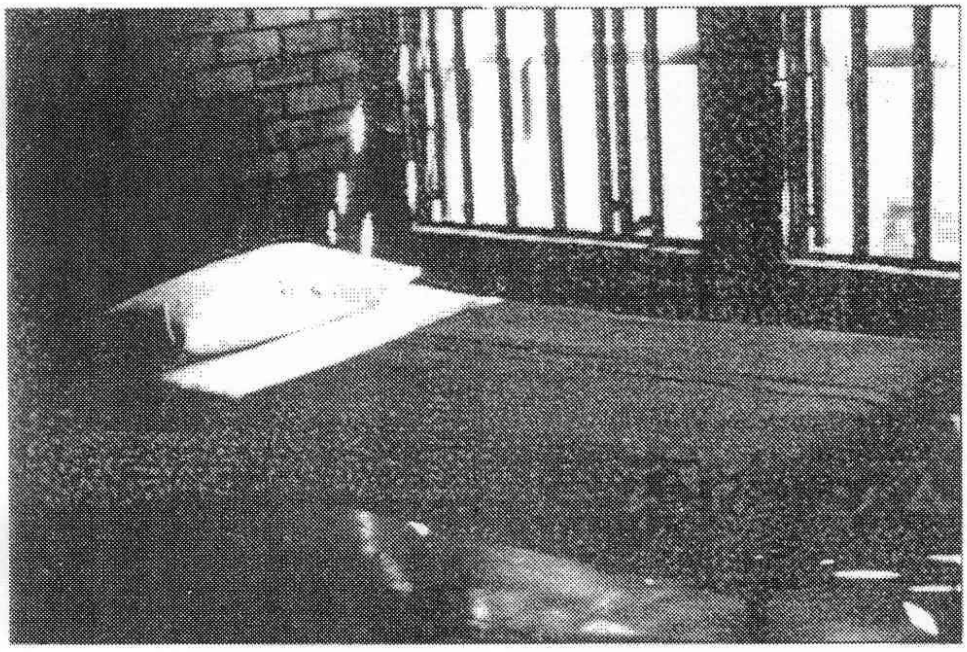
Summary

The psychosocial needs of the developing child are outlined, and the way these are met in healthily functioning families is contrasted with the experience of children who come into care. The needs for love, security, new experiences, acknowledgement and encouragement and responsibility are examined. While the children of a normal family are positively supported by parents in developing the security necessary for them to explore and manage their world, the multi-problem family is characterised by difficulties and crises which chronically deprive children of this security.

The child who is removed from home has to face the trauma of separation as well as the strangeness of his new situation. The article deals in detail with the conflict of interests and values represented in the institution and the child's own family, and explores the problems of emotional duality and divided loyalties, focusing on the children's home child's diminished capacity for handling these problems in the light of his lack of emotional maturity, and the lack of significant others, identity figures and individuality in the institution.

The need for more careful placement, more intensive individual and family work, more open communication and more research into the needs of emotionally damaged children is discussed.

Opening of the Tsosoloso Place of Safety at Rietgat



Mr J V Mbokhwa of the SA National Council for Child & Family Welfare with N.I.C.C.W. Transvaal Director, Di Levine

Di Levine

The opening of a new residential facility for children is invariably a joyful occasion. This is particularly true in the case of the black community where services for children are few and far between. However, the advance publicity that greeted the erection of the welfare complex at Rietgat was almost uniformly negative. It was thus with mixed feelings that I accepted the invitation to attend the official opening of the Tsosoloso Place of Safety which is the first phase of the complex.

Background

Whilst the essential aspects of the critical media reports were obviously valid, it is pleasing to note that some more positive aspects of the service also emerged.

The background to the creation of the complex is as follows. According to officials of the Department of Constitutional Development the need for residential facilities for blacks was identified some twenty years ago. Welfare organisations were not prepared to develop such facilities in the homelands, the government did not encourage the creation of services in the urban areas, and the backlog in unmet needs continued to grow. The treasury was approached to supply funds to provide a residential facility to serve black clients who either fell within the jurisdiction of state welfare services (for example children needing placement in a place of safety) or for clients who were "unpopular" or not catered for by the private sector (for example older children, severely physically handicapped, frail aged).

The funds became available and the building was started. The project was surrounded by controversy from the start. To begin with the National Councils dealing with the various client groups were not consulted at any point in the planning stages of the largest welfare complex in the country (probably the largest in Africa, and possibly the largest in the world). In August of 1986 representatives of the various councils were taken on a tour of the completed place of safety. Not only were they surprised and upset by their exclusion, but their reports on what had been created up to that point were discouraging – one report called the place "a monstrosity".

Criticisms by National Councils

Some of the major points raised by these National Councils include:

- The initial concept included the lumping together of different types of welfare clients — the aged, the mentally handicapped, the physically handicapped, a place of safety and detention in one enormous complex – between 1 200 to 1 400 welfare clients, plus staff housing to accommodate 2 000 people on one campus. Whilst some overseas welfare services have been known to experiment with linking of services such as the aged and children with benefits of shared administration and planned interaction of client groups, the gathering of such disparate groups has not been tried in practice or discussed in theory and whether any benefits might accrue either financially or in any other respect, is highly dubious.
- The complex is at least six kilometres from any black settlement and is literally in the middle of the bush. It is accessible by bus, but nevertheless remains very isolated. The choice of this site is clearly unsuitable in view of the need to provide "normative" welfare services — that is services that closely approximate "normal" life within the community. This is especially ironic in view of the fact that the Advisory Board set up in 1978 to improve the Van Rhyn Place of Safety in Benoni specifically recommended that "Future places of safety and detention be part and parcel of the community they purport to serve, i.e. such centres should be erected within the black residential areas so as to avoid the stigma of an isolated institution." In reply to a question on the unfortunate site chosen by the Department, the difficulty in obtaining land was raised. As much as one might try to avoid politics in welfare, there is no doubt that all land issues in this country are politically motivated, and although the social workers within that department may or may not have looked to Rietgat as a site of choice, they possibly had little option in this instance. In view of the complex political factors that surround the creation of black facilities, it is possible to understand how Rietgat came to be where it is.
- The other major criticism of Rietgat is that it is built with high barbed wire surrounding the complex and that the place of safety is surrounded by yet another set of barbed wire fences that effectively cordon it off from the rest of the complex. Furthermore, the windows have the most peculiar structure: each window is divided into little sections, so that in order to open an average size window, a child care worker would

Principal Mrs M J van der Merwe with Mr M N Beukes of the Department of Constitutional Development and Planning

have to open approximately six small barred sections. Outside these bars are two thin concrete slabs. The motivation for this is indeed an enigma. Again, looking at the report of the Van Ryn Advisory Committee, a recommendation to the effect that a place of safety and detention should not give the "fearful appearance" of a prison with a high security fence, was made. Furthermore, this advisory board recommended a relaxation of security measures at Van Ryn, i.e. no locking of the gates during the day, involvement of the community through regular visits to the institution etc.

Several officials of the Department were approached on the day of the opening and asked for explanations of the extraordinary security precautions. Answers included: "To keep those people in who should be in, and to keep those out who should be out." There will be few absconders from Tsosoloso Place of Safety. Another answer given by more than one person was: "The schools in Pretoria have high fences around them." Whilst the fears of the white parents in Pretoria can be understood, the relevance of these fears for abandoned and neglected black children is highly questionable.

"To keep those people in who should be in and to keep those out who should be out."

More Professional

Despite these very obvious shortcomings there is another more progressive side to the Ratgat story. The first comes through in the attitude and approach of the officials from the Department of Development and Planning. They clearly want the service to work on a much professional level than we have seen in the past. They see the service as starting to meet a desperate need in the community and sincerely want to create something good for the children. Although the windows have been heavily criticised, the buildings are generally attractive, built from a high quality face brick.

From the inside the rooms are sunny and cheerful. The children will be accommodated in twelve cottage-style groupings. There are no dormitories (except for the nursery) and the standard of the physical environment is overall far more superior to our older facilities. The gardens are being developed to soften the harsh bushveld, and a pets corner is in the preparation stage.

Apart from the place of safety there is also a locked unit for adolescent convicted criminals awaiting placement in a reform school. This unit is operated within the ambit of the Criminal Procedures Act and will cater for 45 boys and 15 girls. This is a step forward in our system of juvenile justice in that those children were previously held in jails. On the day of the opening we observed four boys happily playing Monopoly with their staff member. Perhaps a good dose of capitalism is considered therapeutic!

Qualified Staff

Any organisation is only as good as its staff, and it is here that the essentials of the service will in time emerge. It is very promising to note that the place of safety is headed by a qualified social worker. She is Mrs J. Van der Merwe who accompanied us on a tour of the facilities. She has a team of 4 social workers backing her, 28 child care workers, 10 nurses, and 6 teachers. The inclusion of 4 social workers is a major advance when compared to Van Ryn which has a social worker who comes in for one day a week. The number of child care workers for 200 children could be increased taking into account the services required of a place of safety which differ radically from those of a children's home. However, there are clear indications that the kind of service that children can expect to receive is of a higher standard than we have seen from some other residential facilities run by this department.

This visit to the newest place of safety in the country left me with mixed feelings — a sense of frustration, even anger, that mistakes were made that could easily have been avoided, combined with a measured sense of optimism that children who need placement may receive the help they desperately need.

Die Kinderversorger gesels met
LYNETTE ROSSOUW

Lynette Rossouw is pas gekies as ILEX wisselstudent vir 1997/98 en vertrek in Augustus na Amerika. Sy het haar Maatskaplike Werk graad aan die Universiteit van Stellenbosch behaal, en het nou haar eerste jaar honeurs voltooi. Sy het ook 'n Sertifikaat in Huweliksberaad en Voorligting.

Vertel ons eers 'n bietjie oor u ondervinding in kinderversorging.

LR: Nadat ek my graad in maatskaplike werk gekry het, het ek vir twee jaar by die ACVV Môreson Kinderhuis in George gewerk as maatskaplike werkster. Ek het ook gedeeltelik in een van die huise gehelp as huismoeder. Daarna het ek vir 'n tydperk by 'n rehabilitasie sentrum gewerk, maar sedertdien vir die afgelope vyf jaar, werk ek by Tygerberg Hospitaal waar ek aanvanklik gewerk het met buite-egtelike swanger pasiënte (minderjarigess). Ek was ook gemoeid met projekte by die skool waar ons voorligting gedoen het en ons het ook by die universiteite omgegaan en probeer om verstandhouding vir die eerstejaars meer inligting te gee oor onderwerpe soos aborsie, voor-huwelikse seks, ens. Die projek by die skool het ons in samewerking met FAMSA gedoen. By die hospitaal self het ek vir die afgelope drie jaar ook gewerk met kinders wat seksueel gemolesteer is. Die werk het ook gemeenskapswerk behels. Ek het baie lesings aangebied en ek was ook gemoeid met die opleiding van personeel in die hantering van sulke kinders. Ek het ook lesings aan mediese personeel en soms ook aan paramediese personeel gegee. Eksterne maatskaplike werkers kom ook dikwels na die lesings.

Wat was u indruk van kinderversorging oor die algemeen toe u by Môreson gewerk het?

LR: Dit was die huissteisel daar spesifiek, en alhoewel dit oor die algemeen 'n goeie model is wat individuele sorg vir kinders betref, was die probleem dat ons baie moeilik personeel getrek het wat geskik was omdat die salarisse nie hulle goed was nie.

Was die kinders geneig om lank daar te bly?

LR: Dit was een van ons groot probleme dat kinders vir onbepaalde tye in kinderhuise gehou word en dat daar nie 'n deurlopende beplanning oor die lengte van die verblyf gedoen word nie, want ouers is baie keer nie gunstig om gemotiveerd te wees nie omdat hulle nie die verantwoordelikheid hoef te dra nie maar nog nog vakansietye hulle kinders kan sien. In hierdie verband moet mens na 'n tydperk kyk na watter vordering die ouers gemaak het. Kyk na die hofverslag, kyk na hoe ver die ouers gevorder het, en as hulle geen vordering gemaak het nie, voel ek moet 'n mens ontlik die ouers dan konfronteer en die kinders wys hoekom hulle nie uit die kinderhuis kan gaan nie sodat hulle nie die personeel blameer nie. Hulle moet besef dat die ouers nie werklik moeite doen nie. Soms moet ons die ouers tot kontak met die kind aanspoor, of deur middel van besoeke of deur brewewisseling, maar dan moet 'n mens ook verseker dat dit 'n sinvolle kontak bevorder.

Baie sê dat ons nie die wêreld oornag kan verander nie en dat ons miskien kinders na onverbeterde omstandighede moet laat terugkeer; dat ons kinders moet bekwaam sodat dat hulle hierdie onverbeterde omstandighede kan hanteer?

LR: Ja, dat hulle nie altyd moet voel dat hulle omstandighede is 'n rede hoekom hulle nie iets in die lewe kan bereik nie. Hulle selfbeeld is vir my baie belangrik, want as jou selfbeeld sterk is kan jy meer selfvertroue deurkom. Kinderhuiskinders se selfbeeld is dikwels beskadig omdat ouers kinders baie keer blameer vir dinge wat in die huis gebeur het, omdat ouers hulle aggressie op kinders uitgehaal het, en kinders blameer hulself gewoonlik vir iets wat verkeerd gaan in die gesin. Of dit nou egskeiding is of wat ookal, hulle wonder altyd of dit nie hulle skuld is nie.

Dit is moeilik om 'n gesinsdiens te bied aan kinders in 'n plattelandse kinderhuis.

LR: Hulle het van verskillende areas gekom en dit was jammer omdat 'n mens dan nie daardie kontak met die ouer en die kind regtig kon bevorder nie. Hulle het dikwels een of twee maal 'n jaar besoeke afgelê en dit is moeilik want die ouer is vreemd vir die kind en die kind is vreemd vir die ouer. Ons het gevind die ouers wat in die omgewing was het baie goeie samewerking gebied. Ons het byvoorbeeld 'n kamp gehou met die ouers en die kinders saam en hulle waargeneem vir 'n volle naweek. Ons het groepe gehad waaraan die ouers en kinders saam deelgeneem het en ons het gevind dat dit die ouers meer verantwoordelik vir hulle kinders laat voel. Baie ouers het nie die vermoë om 'n ouer te wees nie omdat hulle dikwels in hulle eie huise nie goeie opleiding gekry het nie en 'n mens moet baie prakties raak wanneer jy met die ouers werk. Hulle moet eintlik van voor af geleer word wat

moeilikheid behels en dit kan jy net doen as hulle goeie kontak met die kind het. Dit is beslis 'n baie belangrike taak van die kinderhuis. Ek dink die ouers moet ook die kinderhuis sien as 'n hulpbron en nie as iemand wat teen hulle werk, of as iemand wat hulle kinders van hulle wil sink-om nie, want dit veroorsaak weer verdedigingsmeganismes en hulle kan die kinders negatief teen die inrigting beïnvloed. Maar as mens saam werk, dink ek help dit baie meer.

Wat van die rekonstruksiewerker se rol?

LR: As die gesin ver van die kinderhuis af woon moet die rekonstruksiewerker betrek word omdat sy die persoon is wat naby aan die ouers is. Dis dan weer die praktiese probleem. Maar waar die ouerhuis naby gelee is moet die kinderhuis definitief verantwoordelikheid neem.

Die huisstelsel word dikwels vir sy leegheid gekritiseer waar daar byvoorbeeld gebruik gemaak word van sentrale kombuise en washuise.

LR: By die kinderhuis waar ek gewerk het, het hulle self in die kombuis gehelp en hulle was inderdaad soos kinders in die huis. Hulle het byvoorbeeld naweekwerk saam met die huismoeder gedoen, saam met haar televisie gekyk, en al hierdie dinge gedoen. Maar ek dink miskien is die onkoste een van die faktore weer, want om vir vyf verskillende huise byvoorbeeld sparta genewe te voorsien is baie moeilik, so dit is seker kostebesparend as hulle dit so doen, maar dit is nie die ideaal nie.

Vir iemand wat in 'n hospitaal werk waar pasiënte al die nodige behandeling ontvang, hoe reageer u op sulke koste besparings in kinderhuise wat kinders uiteindelik in gebreke laat bly?

LR: Ek dink die kinderhuiskind word nie as belangrik genoeg beskou nie. Die kind van vandag is die grootmens van môre en die ma en die pa van môre en die sogenaamde bose kringloop moet mens probeer breek. Wat ook 'n probleem is met die kinderhuis, is dat wanneer jy uit 'n kinderhuis uitgaan, het jy noegenaamd geen ankers nie. Ek het baie met kinders hier in die Kaap te doen wat uit die kinderhuis is en wat nou in werke staan wat nog steeds kontak maak met my en my kom besoek. Hulle sê hulle het niemand nie. As hulle terug gaan kinderhuis toe is hulle nog maar eendere wat voorheen daar was. Jy kan nie dink dat die nuwe personeel dieselfde gevoel vir hulle sal hê nie. Ek dink dit is die ander ding waarna 'n mens moet kyk. Mens het van die kinders wat vakansie-ouers het, wat partykeer nog aangaan om kontak met hulle te hou, maar dis nogal vir my 'n groot konflik — die nasorg van hierdie kinders wat uitgaan.

Hoe het u werk met dweilmverslaafdes ingepas by kinderversorging?

LR: Ek dink dit het my baie gehelp in die sin dat ek meer kan verstaan wat 'n kind in 'n ouerhuis moet beleef waar 'n ouer drink. Ons het baie met die gesinne ook gewerk en probeer om die ander lede te betrek. Ons het toenemend al hoe jonger mense begin kry wat ingekom het vir behandeling en mens het so ook meer geleer van hulle frustrasies wat hulle beleef en hoekom hulle dink of hoekom hulle dwelmmiddels gebruik. Daar word geweldig baie druk op ons jong mense uitgeoefen in baie opsigte. Hulle moet baie verantwoordelikhede dra, dikwels op 'n baie jong ouderdom. Ek dink die nagal vir hulle 'n probleem. En weereens praat ons hier oor self-beeld — as jy nie goed voel oor jouself nie, dan drink jy of jy gebruik een of ander middel want dit laat jou beter voel. Waar ons weet die kind het byvoorbeeld geleer dat die ouer op 'n sekere manier probleme hanteer — die ouer drink as hy probleme het — moet ons baie sterk op probleemhantering spesifiek konsentreer, asook aan mense verhoudings aandag gee.

Bestaan daar nie 'n gebrek aan sulke programme in kinderhuise om kragte en bekwaamhede op te bou om die lewe in die werklikheid te hanteer nie?

LR: Ek het op 'n stadium die Dale Carnegie kursus gedoen en daar was twee hoerskool kinders ook wat dit gedoen het. Hulle het nou vir kinders ook so 'n kursus en ek het gedink hoe fantasties sal dit wees as kinders sulke kursusse kan doen. Dit is nie altyd vir alle kinders moontlik nie, maar die selfvertroue en die doelgerigtheid wat daardie kinders daaruit gekry het was indrukwekkend. Baie het nie regtig 'n sin van wat hulle in die toekoms gaan doen nie, of wat hulle toekomsplanne is nie. Wat kinderhuis personeel betref weet hulle nie hoe om kinders met sulke programme te help nie. En weereens omdat hulle nie die regte salaris betaal word nie. Ek weet nie wat dit nou is nie, maar destyds, mense wat kinderhuise wil betrek het, was pensionarisse. Mens kan niks sê teen 'n pensionaris nie. Daar is baie vandale hulle het kinders groeligmaak, ens. maar die mense is ook op 'n stadium waar hulle nie meer so baie geduld het nie, of nie meer so baie kans sien vir al die verantwoordelikhede nie. Ek dink dit is 'n groot probleem, daardie generasie-gaping wat ook kan plaasvind.

Kinderversorgers moet ook met groot groepe kinders werk.

LR: Die groepwerk wat ek by Tygerberg doen is met vyf tot ses kinders, maar nou en dan het ek ons met nie altyd sukses met die groepe nie omdat die kinders nog baie skaam is en hie nadag bymekaar wil kom en daarvoor wil praat nie. Ons moet baie motivering doen. Ons het 'n paar goeie groepe gehad en dan het ons ook groepe met ouers gehad, want die ouers van kinders wat seksueel gemolesteer is het self hulp nodig en hulle het ook nodig om daarvoor te praat. Maar dit is nog vir ons 'n struikelblok dat kinders nie maklik praat oor hulle gevoelens nie. In die kinderhuis het ek nie net een huis gehad met kinders nie. Al die kinders in die kinderhuis was eintlik my verantwoordelikheid as maatskaplike werkster. Dit was vir my 'n probleem omdat mens vir elke kind die beste moontlike aandag gee en op die ou end voel mens jy doen alles half. Dit is so in die meeste situasies in ons land dat 'n mens oorlaai word en op die ou end nie kwaliteit lewer nie. Ek dink dit gaan oor die kwantiteit meer as die kwaliteit. Dis nou maar hoe ek daaroor voel, maar dit is 'n probleem. Die kinders is ook kinders wat baie aandag soek en aandag nodig het omdat hulle swaargekry het en dit maak dit dubbel so swaar. Iets wat ek baie sterk oor voel is dat 'n mens meer moet dink daaraan dat die huisouers ook ruskanse kry, want hoe langer 'n mens met die kinders werk, hoe minder geduldig raak 'n mens en dis nog 'n ding wat ek voel, hierdie sogenaamde uitbrand van professionele persone dat ons nie genoeg daaraan aandag gee nie. Dit veroorsaak dat die kinders uiteindelik nie deurgaans die optimale aandag kry nie.

By Tygerberg het u as deskundige gewerk, maar nou gaan u na Amerika waar u voltydse kinderversorging gaan doen.

LR: Dit is vir my 'n baie goeie geleentheid want ek dink mens moet alle fasette van kinderserg kan doen. Dit gaan nie net oor sekere werk nie, en baie keer is dit meer op die praktiese vlak wat 'n mens 'n kind regtig kan help. As jy iets regtig saam met hulle deurgaan en direk met hulle werk dan dink ek bereik 'n mens dikwels meer. Ek het nogal gevind dat party van die huismoeders amper 'n sterker verhouding met die kind kon opbou omdat sy elke dag saam met die kind is, terwyl die maatskaplike werker, uit die aard van die klomp kinders wat daar is, nie die nodige verhouding kan opbou nie. Dit is baie belangrik om spesifiek op 'n kind se vlak te kan beweeg en nie vanuit 'n grootmens oogpunt met 'n kind te werk nie. Dit is 'n gevaar wat 'n mens loop. Ek dink voltydse kinderversorging is 'n belangrike ervaring wat 'n maatskaplike werker moet hê.

Kinderversorgers is dikwels kritiek oor beroepspersone wat vir hulle voorsê wat om te doen — dan gaan hulle om 5 nm. huistoe.

LR: By die kinderhuis waar ek was het ek egteskiv. Ek was 24 uur vier elke dag in die huis en ek moet sê dit het soms 'n probleem geskep omdat 'n mens eintlik nie baie vrye tyd het as mens by die kinderhuis bly nie, want die kinders wil altyd by jou wees en dan jou weer nie nanag hê. Maar in 'n groot mate was dit 'n voordeel, want ek het saam met hulle geëet en saam met hulle dinge beleef in die huis self en ek dink vanuit 'n maatskaplike oogpunt moet ons meer dink aan nie-tydgebonde werk nie — net van agt tot vyf nie, of van agt tot vier nie — maar byvoorbeeld ons by die hospitaal het 'n 24-uur spoeddiens en dis verbasend hoe baie keer 'n mens na-ure in 'n krisis mense baie meer kan help as gedurende kantoorure. Dit is ook iets wat aandag behoort te geniet, dat mens nie net kantoorure werk nie.

Vanselfsprekend is die grondrede van kinderversorging dat ons met die daaglikse lewe van die kind werk en nie met die sogenaamde terapie-uur nie.

LR: Dis reg. As ek dink aan geslagsvoorligting byvoorbeeld of inligting wat jy aan 'n kind gee, of engelets, is dit belangrik dat jy eers 'n vertrouensverhouding met daardie kind moet hê voordat jy met hom kan werk. In ons werk situasie word daar nie tyd toegelaat vir eers 'n verhouding opbou nie. Jy moet direk begin met dienslewering en dit is nie bevredigend nie. Ek dink nie mense besef altyd dat 'n kind nie so maklik praat oor sy gevoelens nie. Baie keer het 'n kind nie vertroue in 'n grootmens nie en hier kom nog 'n grootmens en verwag die kind moet alles sê wat hy voel en dink en ervaar. Dit werk ook nie. Dit is baie oppervlakkig en teoreties om te sê: "Ek bou fans 'n verhouding met 'n kind" bekare goed moet gebeur voordat veroordeling gemaak word. Ek voel dat 'n mens sulke klein goedjies, soos op die vloer saam met die kind sit en saam met hulle speel en saam met hulle eers dinge moet deurgaan. Ek woon byvoorbeeld hofsake saam met pasiënte by en ek doen nie terapeutiese werk as ek daar by hulle sit of by hulle staan in die getuiebank nie, maar ek is daar, ek is in die situasie by hulle. En na die tyd voel ek daardie kind het soveel meer vertroue om terug te kom na my toe want ek het saam met haar deur haar swaarkry gegaan. Of net belang te stel in wat 'n kind doen. Baie min mense vra eintlik hoe 'n kind skool beleef byvoorbeeld, daardie soort van prakterse goed wat nie altyd verband hou met die terapie nie, maar wat belangrik is vir 'n voorvertrouensverhouding op te bou. Dit kry mense min.

Is kindersorg nietemin te betrokke by blote fisiese sorg?

LR: Ja dit kan seker wees, in die kinderhuis wat ek was het hulle 'n bedienende personeel wat hulle geskeduleer het sodat hulle nie so baie bande kweek met grootmense nie. Maar juis die ander kant toe, as mens nou kyk na 'n gesinsorg wat 'n groot gesin het, dan het hulle ook baie verantwoordelikhede, maar ek dink het jy dit ook om saam met die kind dinge te doen. Selfs die werkies wat gedoen word, bv. saam pannekoek bak. Dis ook belangrik dat 'n dogter moet leer hoe om byvoorbeeld eendag 'n huisvrou te wees of 'n seun hoe om byvoorbeeld in die tuin te werk. Ons beswaar is baie keer dat mense gedwing is om 'n kinderhuiskind bietjie te beskerm, nom te gewoond te maak aimal doen dinge vir hom of vir haar. Dit is nogal 'n patroon wat hulle aanleer en wat hulle aanpassing na ontslag uit die kinderhuis kan bemoeilik. Mens kry by liefdadigheidsorganisasies wat goed bedoel, wat vir die kinders lekkers en speelgoed, ens. stuur, maar dan moet mens oppas dat die kind nie die idee kry van 'ek kry net' nie. Ek dink baie mense wil misken hulle gewete sus deur vir die kinderhuise goed te gee. Ek sê nie dis nie goed nie, maar ons het bv. gevind dat die kinders later so gewoond raak, as iemand kom kuier dan vra hulle, "Het jy koekies gebring?" of "Het jy vir my iets gebring?", sodat jy amper daardie 'gee my dit, gee my dat' houding kry en dit is vir my sleg. Hulle moet so normaal moontlik grootword, sonder enige ekstra dinge wat daarmee gepaard gaan.

Tog bestaan daar konflik. Ons sê terapie is onmoontlik sonder dat ons eers 'n verhouding opbou. Maar deur saam met kinders te woon gaan kinderversorgers so ver met die bou van 'n verhouding, maar gaan dan nie oor na terapie nie. Hulle laat dit aan die "beroepspersone" oor wie nie die verhouding ervaar het nie.

LR: Ek dink nie kinderversorgers is daarvoor opgelei nie. Dis baie sleg en ek dink ons moet maskien in Suid-Afrika wegkom van hierdie kompartemente: 'n maatskaplike werker doen dit; 'n arbeidsterapeut doen dat. Dat 'n mens maskien al hoe meer oor mekaar se grense moet opleiding kry sodat 'n mens mekaar kan aanvul. 'n Struikelblok sal wees dat die persone nie die regmatige vergoeding sal ontvang nie.

Hoe voel u oor u vertrek na Amerika in Augustus?

LR: Baie opgewonde. Ek sien baie uit daarna. Ek dink dat dit weer 'n nuwe uitdaging gaan bied wanneer 'n mens terugkom. Dat mens nuwe visie soker sal hê. Jy werk in jou bemerkte manier en dan gaan om te leer en te verbeter altyd. Ek is van plan om gerwig te skryf en kinderversorgers in Suid-Afrika te laat weet wat ek geleer het sodat die mense hier ook die kennis kan opdoen. Deur middel van 'n gepeelde verslag sal ek met julle almal in kontak bly.

Nuusbrokkies Newsbriefs

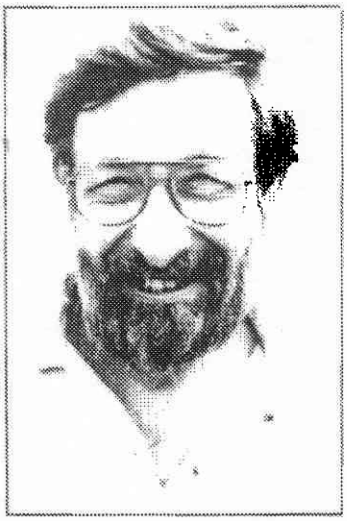
International

Conferences
The Second International Child and Youth Care Conference will take place in Washington DC from March 23-26 in 1988. The theme of the conference will be "Our Children, Our World, Our Future". The conference is sponsored by the National Organisation of Child Care Worker Associations (NOCCWA).
In the meantime the Quebec Association of Child Care Workers are hosting their 2nd annual conference at McGill University, Montreal, from 7-8 May 1987 on the theme "Creative Approaches". Larry Brendtro (co-author with Whitaker and Trieschman of *The Other 23 Hours*) will give the Keynote Address on "Enduring Values for Changing Times" – and there will be altogether nineteen other papers and workshops.

New National Association in Canada
Since the first National Conference on Child Care was held in Victoria in 1981 there have been plans to form a national association in Canada. In 1986 a final draft of a constitution for a National Council of Child and Youth Care Associations, which is to have its central office in Ottawa, was accepted.

New Journal
The Master's Program for Child and Youth Care Administrators at Nova University announces the inauguration of *The Child and Youth Care Administrator*, a publication designed for administrators, supervisors, managers, co-ordinators, and educators working in the field of residential treatment, group care, and community-based programs.
The first issue is scheduled for March of 1988. Those interested in making contributions should contact the editors at the following address:
The Child and Youth Care Administrator
Nova University, CAE
3301 College Avenue
Ft Lauderdale, FL 33314.

New Head for St George's



Barrie Lodge, Director for the past four years of Malcomess House (East London Children's Home) has been appointed as Headmaster of St George's Home in Johannesburg to succeed the present Head, Ken McHolm. Mr Lodge, previously on the lecturing staff of the Faculty of Education at the University of Durban-Westville, will move to Johannesburg with his wife Val and their children Clinton and Hyreath (standard 3 and 7) to take up his new appointment in mid-July.
Ken McHolm has been associated with St George's Home for the past 44 years and has been on the full-time staff of the home since 1958.

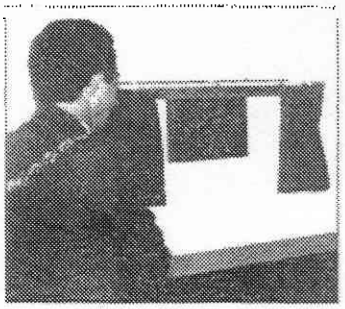
Natal

Workshop on Punishment
110 people attended a workshop on *Punishment* run by the National Director at Hilltops Children's Home in Pietermaritzburg on Friday 27th March. Among these were a contingent from the Vuma Reform School in KwaZulu who had left Eshowe at 05h00 to be there on time. Child care workers in Pietermaritzburg were particularly appreciative of the support of Durban members on this occasion. Groups discussed and contributed to various subjects included in the workshop.

Chris Willows and Jill Challenor of Hilltops (Maritzburg Child Welfare), our hosts

Angie Starling (Wylie House), Rani Naicker (student at Durban Westville) and Sr Philomena (St Theresa's) at the workshop

Official Opening
A large crowd attended the evening function on 27th March at which the Mayor of Pietermaritzburg, Councillor M. Cornell, officially opened the newly reconstructed building of the Mary Cook Children's Home. There was an audio-visual on the home, and the girls presented a song item. In his address, Brian Gannon congratulated the home on its development but stressed that when the building work ended the real work of the home now started. A major factor would be the community's involvement. "Every child here is coming to live in *your* community, and needs to learn what it demands and what it offers, how to contribute to it and how to use it", he said. "It won't help if the staff of Mary Cook instil a sense of 'out there' in the community – or if the public has a sense of 'in there' in the children's home. These are not the children's home's children; they are your community's children."



Councillor M Cornell opens the newly reconstructed building of Mary Cook Children's Home

Lynne Joubert (Department of Health Services & Welfare) with Mrs Priscilla McKay (Director (Child Welfare)) at the Opening

Western Cape

Namaqualand
Visitor to the NACCW's head office during April was Louise Angless, newly appointed social worker at the RC Children's Home in Kamieskroon. She expressed the critical need for training for child care workers in the Namaqualand area, who experience serious isolation from the rest of the profession. The Western Cape Regional Executive met on Thursday 16th April to plan a programme of training and outreach for this area.

Homes and Orphans Fund
At a function in the Homes & Orphans Fund Cape Town offices on Wednesday 15th April, contributions were made to the Bruce Duncan Home, the Salesian Institute in Green Point and the NACCW. Priscilla Hendricks of the Cape Town office reported that these donations were part of an Easter Campaign organised by fund-raiser Jonathan Derman, and that the money had been raised in the Western Cape.

Transvaal

Social Workers discuss New Act

Jackie Loffell was invited to lead a discussion on the new Child Care Act at the Residential Social Workers' Group held on 25th March at Johannesburg Children's Home.

The new Act has major implications for residential and foster care. The rights of the children's home and foster parents remain intact in terms of Section 53 regarding the transfer of parental powers. The powers and rights of foster parents have been greatly extended at the expense of the parents' rights. The position of the biological parent is more vulnerable in that the child can be adopted without parental consent. The emphasis on the parents' incompetence as against the child being found in need of care is likely to set up more hostility between parent and worker and thus lessen the ability of the worker to evoke co-operation from the parent.

Dr Levine felt that this aspect of legislation is in tune with overseas law and that the commissioners are likely to be very careful in their interpretation of the Act. She also felt that through the years there have been many children abandoned in care without good reason, and this Act may start to prevent this happening. Jackie Loffell expressed particular concern about working with abusive parents where she felt that the Act offered them no protection. Advantages in the Act include clear provisions for discipline of children and better provision made for permanency planning. The Act offers opportunity for fruitful use of work with contracts and using time-limited goals. The agency thus has the responsibility to clarify its goals and render appropriate services to parents. The next meeting will be held on 14th May at St George's Home at 09h00.

Students of the BQCC course at RAU. Right: A group from PROCESS who leave home at 5 am and who travel by taxi, train, bus – and then act a lift to RAU to be in time for classes at 10 am!

Clinic

The Adolescent Epidemic
ANOREXIA NERVOSA

D.L. Norris

Dr Norris is Senior Lecturer at Wits University Medical School and Senior Specialist and Head of the Eating Disorders and Adolescent Unit at Tara, H. Moross Centre

The *Diagnostic and Statistical Manual III* criteria for the diagnosis of anorexia nervosa appear in Table I. It should be noted that lack of appetite (anorexia) is not a feature, many sufferers actually complaining that they crave food but fear 'losing control' if they eat. When elicited, this symptom is virtually diagnostic.

Further diagnostic features

In nearly all cases the diagnosis of anorexia nervosa can be made on purely clinical grounds. It is rarely necessary yet so often done, to resort to time-consuming and expensive laboratory and radiographic investigations for the purpose of excluding physical diseases.

Physical signs and symptoms

Apart from the obvious and often gross emaciation other physical features are commonly present.

- Amenorrhoea develops early in the illness, sometimes antedating appreciable weight loss. The menstrual cycle will return to normal only after normal weight has been restored.
- Bradycardia and hypotension are present except in the bulimic subtype (see below).
- Disordered thermoregulation is evidenced by cold, mildly cyanotic extremities and complaints of always feeling cold.
- Lanugo-like hair growth may appear on the body. At the same time the patient may complain of loss of head hair. Axillary and pubic hair are unaffected.
- A history of excessive physical activity (sport, solitary exercising, ballet or simply being 'always in a hurry') is common. This is accompanied by a feeling of physical well-being unless the patient is grossly emaciated or dehydrated.

Psychological changes and abnormal behaviours

Commonly the anorexic subject exhibits denial of illness and strongly resists treatment, she is preoccupied with food and feeding others and has abnormal

TABLE I. *DSM III* DIAGNOSTIC CRITERIA FOR ANOREXIA NERVOSA

Intense fear of becoming obese, which does not diminish as weight loss progresses

Disturbance of body image, e.g. claiming to 'feel fat' even when emaciated

Weight loss of at least 25% of original body weight or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%

Refusal to maintain body weight over a minimal normal weight for age and height

No known physical illness that would account for the weight loss

Reprinted with permission: SA Journal of Continuing Medical Education

even bizarre, eating habits and food related behaviours; psychosexual awareness is absent; there is a compulsive drive to achieve perfection in all tasks but with little sense of satisfaction, concentration is defective, and there is increasing social isolation although work related interactions are maintained. In our experience this social withdrawal often precedes the onset of weight loss, a useful cue in distinguishing the early anorexic from the healthy adolescent who is frantically dieting as part of the 'sexual' competitiveness of her social 'scene'.

According to Bruch there are three core psychopathological characteristics of the anorexic: (a) a severe disturbance in body image and body concept, (b) a suppression or misinterpretation of interoceptive stimuli; and (c) a 'paralysing sense of ineffectiveness, which pervades all thinking and activities . . .'.

Because of this inner emptiness and helplessness, the anorexic girl typically cannot make decisions for herself or do what she wants to do, she can only respond or accommodate to the demands or expectations of others. Totally lacking a sense of inner control she resorts to strict dieting which becomes the central focus and sole concrete measure of 'being in control'. Bruch postulated a model of early disturbances in the mother-child relationship to explain these characteristics. Briefly stated, she describes a mother who fails to recognise or respond to the child's inner needs; instead she projects her own needs and expectations onto the child. The susceptible child, who cannot forcefully communicate her own needs, learns to accommodate to these maternal projections by progressively denying her own inner drives and realities.

The crisis is reached in adolescence when the biologically determined and culturally sanctioned drives for emotional autonomy and self-directedness emerge. Crisp succinctly describes how anorexia nervosa serves to resolve the inevitable conflict: 'Without doubt the state represents an avoidance posture . . . The rest of the body has joined the mind in a single biological protective stance' – a return to a prepubertal state. Garfinkel and Garner with their co-workers have made a detailed study of the cognitive disturbances in anorexic subjects. In their thinking these patients tend to over generalise, to magnify the significance of minor undesirable events, to reason in an all-or-none manner (dichotomous thinking), to 'base a conclusion on isolated details while ignoring contradictory and more salient evidence' (selective abstraction), to experience or interpret unrelated events as cause and effect (superstitious thinking), and to interpret impersonal incidents as referring to oneself (self reference).

As the psychotherapeutic management of anorexia nervosa must focus on correcting these cognitive disturbances it is worthwhile citing a few examples from our files:

- Selective abstraction and magnification: 'During a completely successful chemistry experiment a brilliant science student accidentally damaged a minor piece of equipment. As a result she described the experiment as "a total disaster".
- Dichotomous reasoning: 'How can I be angry with my parents for shouting at me. That would mean I hate them. I don't – I love them.'
- Self-reference: 'A successful young journalist on a popular magazine, referred for an impending relapse, described a highly illustrative incident: "I arrived at work that day to find a booklet on 'English style' on my desk with the compliments of the editor. I immediately decided to resign seeing that my writing was so bad. I felt such a fool when I discovered that we had all been given a copy of the booklet."'

There is in our experience a further complicating conceptual disturbance that terrifies the anorexic more than anything else. It might well be called 'no win' reasoning: 'If I don't give in to my mother I feel so guilty for upsetting her. But if I do it makes me cross and then I feel just as guilty.'

Today it is probably the commonest single psychiatric disorder affecting adolescent females of the middle and upper classes.

Pre-morbid personality

Retrospective studies based upon parental reports are notoriously unreliable. Nevertheless, numerous studies on the pre-morbid personality traits of anorexic patients do suggest an at-risk personality pattern. Perfectionism, introversion, compliancy and emotional dependency were the most frequently reported traits in my survey of 94 severe anorexics and their families. Other more detailed studies repeat similar findings, the common theme being that to the parents these were 'model' children.

The families of anorexics

This is a highly contentious area. At the one extreme Minuchin and his co-workers describe a highly specific family system in which there is mutual over-involvement ('enmeshment'), overprotectiveness, rigidity in maintaining a status quo, inability to resolve conflicts, and a subtle scapegoating of the child to keep parental conflict submerged. At the other extreme I study, Crisp and Hsu-ting have found that the range of family dynamics is wide and non-specific. They suggest that much of the observed family disturbance is a result rather than a cause of the illness, a view with which we fully concur. However, two characteristics are commonly described: high achievement orientation and a central dominant mother with a relatively absent father either 'too busy' or domestically opting out for love of peace. One must pose the question – are these not simply typical middle class family characteristics?

Whereas family pathology may be a relatively minor factor in the causation of anorexia nervosa, the strife resulting from the 'anorexic battle' is certainly important in the perpetuation of the illness.

The 'bulimic' subtype

Some anorexic patients resort to continuous or episodic binge-eating, self-induced vomiting and excessive use of laxatives (the quantities may be enormous) or, less often, diuretics. Beumont and his co-workers have carried out detailed and methodical investigations on this group of anorexic subjects.

Generally the bulimic or 'vomiting-purger' anorexic differs from the pure 'starver' anorexic in being more outgoing, more sexually active although usually with little satisfaction, and more prone to impulsive behaviours such as emotional outbursts, inconsistent work record, unstable relationships, shop lifting and substance abuse. They also frequently give a history of frank depressive episodes or long-standing personality maladjustment, in sharp contrast to the 'model child' developmental pattern of the starver anorexic. In our view the bulimic subtype represents a group of true anorexics who, because of personality or affective instability, are less able to sustain the desired dietary restriction.

Vomiting and purgation are usually carried out in great secrecy and flatly denied by the bulimic when accused thereof. Suspicious signs are erosion of dental enamel particularly at the gum margins, intermittent painless parotid swellings, muscle weakness and cramps, and cardiac arrhythmias. Low serum potassium levels are highly indicative. Irreversible renal tubular damage may follow after years of constant laxative abuse, and sudden death from cardiac arrest is well documented.

The body image distortion

It is usually obvious on close questioning that the patient has a grossly distorted view of her body, although some patients learn to conceal this fact. Slade and Russell were the first to measure this distortion using a device upon which the subject could make self-esti-

mations of various body widths, which were then compared with actual widths. They clearly demonstrated that anorexics grossly overestimate their body dimensions. Other studies have confirmed this finding but have shown that the overestimation is unstable, varying considerably in response to external influences such as suggestion or encouragement to be more accurate. In normal adolescents conflicting results have been reported. In a recent study I found that anorexic subjects, when retested after close self-examination of their bodies in a mirror, markedly reduced their estimations. A matched group of emotionally disturbed but non-anorexic adolescents also overestimated initially, but their overestimations persisted on retesting. Normal adolescents were remarkably accurate for all dimensions except head width.
Further investigation is indicated to determine whether this simple and inexpensive test-retest procedure will differentiate the healthy but overenthusiastic 'slimmer' from the early or potential anorexic.

Organic determinants of anorexic symptomatology

The biochemical and endocrine abnormalities found in anorexia nervosa have been extensively investigated. Essentially the hormonal changes are a manifestation of hypothalamic dysfunction and are non-specific, being present in all cases of starvation. The pattern is one of regression within the hypothalamic-pituitary-gonadal axis to a prepubertal state. It is completely reversible on restoration of weight. These changes do not in any way suggest a primary organic basis for anorexia nervosa. Rather one must take the view that the disease is a paradigm of true psychosomatic disorder in which the primary stressors are psychosocial and the target organ is the hypothalamus. A vicious cycle follows in which increasing starvation further aggravates hypothalamic dysfunction. Suppression of the hunger and satiety drives, of the sexual drive and the menstrual cycle, and of normal thermoregulation are clear manifestations of hypothalamic disorder.
Of greater importance from the viewpoint of treatment are the observations of Casper and Davis and others on the psychological disturbances occurring in states of starvation or semi-starvation. Preoccupation with food and feeding others, hoarding, excessively slow eating, embarrassment at eating in public, excessive use of condiments, poor concentration, indecisiveness and markedly reduced libido are some of the many features observed both in anorexics and starving individuals. This clearly suggests that the starvation process itself contributes significantly to the psychopathology of anorexia nervosa.

Anorexia nervosa – a phenomenon of our times

Not 20 years ago anorexia nervosa was only a sporadic disease. Today it is probably the commonest single psychiatric disorder affecting adolescent females of the middle and upper classes in the Western world. In this country the disease is rare but not unknown in the Asian and coloured groups but I know of no confirmed case in the black population. About 5 percent of all cases are in males. The peak age of onset is between 13 and 18 but we have seen 3 cases in 10 year olds and many with onset in the early twenties. A first attack over the age of 30 is extremely rare.
The actual prevalence of the disease is unknown. However, two surveys deserve mention. Crisp, Palmer and Kalucy found that 1 percent of girls over the age of 16 attending London public schools (equivalent to our private schools) were suffering from serious anorexia nervosa. A group of medical students recorded age, weight, height and body frame on 1 246 girls in Stds 8-10 at six schools serving the more affluent population of Johannesburg and, for comparison, one working class school. Compared with norms obtained from standard tables these investigators found that 2,3 percent were between 20 percent and 25 percent underweight; a further 0,6 percent were more than 25 percent underweight. Nearly half of these girls did not consider themselves to be underweight. As predicted the lowest percentage was at the working class school (1,9 percent). It must be noted that this survey did not specifically report on anorexia nervosa. Nevertheless, allowing for possible absentee sufferers and at least one known subject who refused to be weighed, it can be conservatively estimated that in the population of which this survey was a sample the incidence of anorexia nervosa is at least 2 percent.
To explain this alarming epidemic one can only assume that changing socio-cultural norms and values are exerting increasing pressures on susceptible individuals. As such pressures are subtle and hardly amenable to experimental validation, one can do no more than list some of the more likely influences in our society (Table II).

TABLE II. POSSIBLE SOCIO-CULTURAL FACTORS INFLUENCING THE PREVALENCE OF ANOREXIA NERVOSA

- The current fashion for thinness despite a general increase of average weights in affluent societies
- Commercial advertising pressures
  - Slimming medications, apparatuses and exercises
  - 'Body-cleansing' preparations containing laxatives
  - 'Health food' fads
- Over-zealous pressures to keep thin by teachers and coaches of ballet students, gymnasts and long-distance runners
- Iatrogenically induced health fanaticism in susceptible subjects as regards exercise, weight control and selective dieting
- Sensationalist over-publicizing of anorexia nervosa by the lay media
- Middle-class values that stress high achievement and competitiveness but restrict adolescent autonomy and individuality
- The vastly increasing range of socially approved career choices and life-style patterns for females
- Feminist pressures to reject traditional concepts of 'femininity'

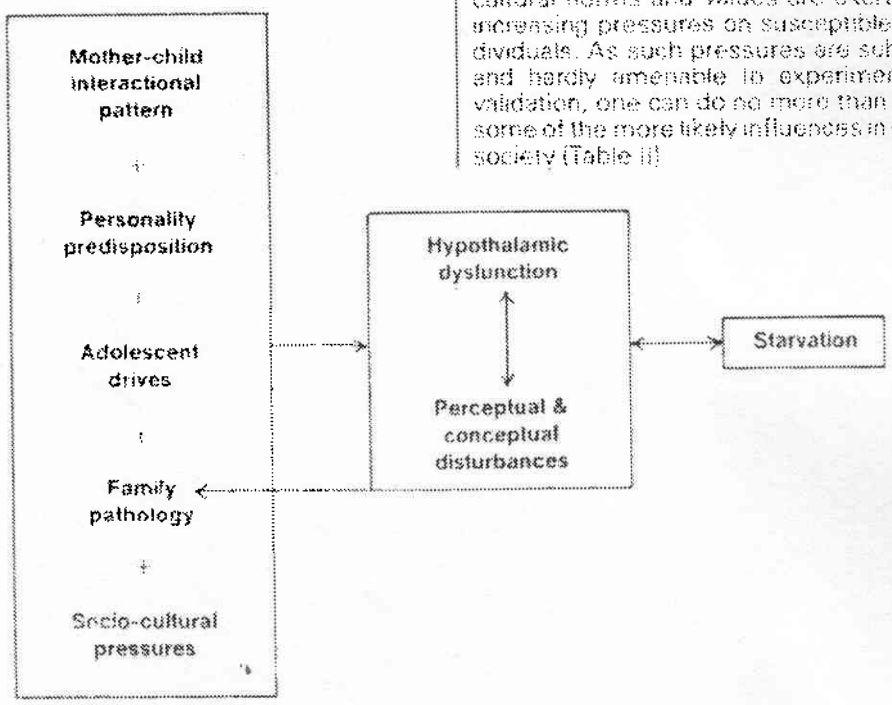


Fig. 1. Schema of interacting determinants of anorexia nervosa.

Treatment

I have attempted to indicate that anorexia nervosa is a disease with multiple converging and mutually reinforcing determinants. This is illustrated in summarised form in Fig 1. It follows that for successful treatment a multidisciplinary and multidirected approach is essential. However, with one or two notable exceptions, all serious clinicians in the field of eating disorders agree that the first goal of treatment must be weight restoration. For reasons that are obvious, yet often forgotten by ardent psychotherapists, it is futile to attempt psychotherapeutic 'reconstruction' in a patient who is still suffering from the psychological effects of semistarvation.

Hospitalisation

Except in the mildest of cases or the rare patient who will co-operate at home, the refeeding process has to be carried out in a hospital unit with all the necessary facilities, highly skilled nursing care, adequate recreational and occupational therapy services, a planned and carefully structured but individualised dietary programme, and a school facility because most patients will be in hospital for several months.

In our unit the weight restoration programme relies upon nursing-care strategies such as firm but kindly control and insistence, patience, encouragement, confrontation of abnormal behaviours, use of standard commercial high-kilojoule concentrates for those patients unable initially to cope with normal amounts of food, and a system of privileges granted both for weight gain and improving attitudes and behaviour. Force-feeding or tube feeding is not only unnecessary but also psychologically traumatic. One patient, who had previously been tube fed, described the experience succinctly: 'I felt as though I was being raped!' Similarly, rigid behavioural programmes involving initial deprivation of the basic comforts of life are rarely necessary and, according to Bruch, not without risk, too-rapid weight gain intensifies the anorexic and may induce bulimic-type resentment or even suicidal behaviour.

Initial 'rebound' oedema sometimes occurs. While alarming to the patient it requires no medical treatment and always clears after 1 or 2 weeks.

Medication

Chlorpromazine in high dosage is occasionally of great value in sedating restless or panicking patients. The benzodiazepines are of similar value but should be used for short periods only. Many other drugs with claimed specific effects have not proved their worth in carefully controlled trials.

Oral potassium supplementation is indicated if serum levels are very low. Constipation should be managed by dietary means, not laxatives.

Psychotherapy

Active psychotherapy should not be embarked upon until weight restoration is well on the way. The most effective psychotherapeutic approach is one geared towards cognitive and perceptual restructuring. The effective therapist acts as a source of 'reality presentation', not as a reliable, all-loving parent figure upon whom the patient will inevitably transfer all her dependency needs and compulsions to please.

The most effective psychotherapeutic approach is one geared towards cognitive and perceptual restructuring.

Family counselling

Parents must be given a clear understanding of the nature of anorexia nervosa and its complex origins. Their own guilt feelings will require sympathetic handling. On the other hand firm confrontation is vital should the parents unwittingly form a coalition with the patient against the therapeutic team in response to her tearful emotional blackmail. They then undermine the therapeutic programme by constantly challenging the alleged 'harshness' or 'pettiness' of its rules. In the end they may respond to their daughter's pathetic but manipulative pleas by prematurely removing her from the hospital. Rapid relapse almost invariably follows.

In some cases parents may have to be given a more realistic appraisal of their daughter's abilities hitherto exaggerated by her over-achievement drive. Finally the family will need considerable support and practical assistance in fulfilling the necessary tasks of 'letting-go' and of relinquishing their intensifying over-protectiveness.

In my view intensive 'family therapy' is both unnecessary and at times counter-productive even in the hands of a skilled therapist.

The vital roles of the family practitioner

While specialised multi-disciplinary care is essential, the family practitioner, with his intimate knowledge of the family, and their trust and confidence in him, should be an important contributor to the therapeutic programme.

- It is he who can best prepare the patient for admission to hospital on a voluntary even if reluctant basis. This may take weeks but a delayed voluntary admission is always preferable to a forced admission.
- The family doctor should maintain contact with the patient and her family, his continuing interest and support encouraging them to persevere with what may be a very lengthy and arduous treatment programme.
- He should also maintain communication with the hospital team. His knowledge of the family's idiosyncrasies may be of great assistance in the overall therapeutic management.
- Finally the family practitioner is in the best position to promote and sustain the patient's healthy readjustment both within her family environment and in 'the real outside world'. This he will do in collaboration with the follow-up therapist.

Despite all these therapeutic procedures, anorexia nervosa remains a serious disease with a high relapse rate. Follow-up studies indicate that 20 per cent or more became chronic sufferers or severely maladjusted individuals. In the long term, as many as 10 percent die either from suicide or medical complications.

It is certain that treatment is often life-saving; that present-day methods will materially influence the long-term outcome remains to be proved.

Acknowledgements

I have to thank the nursing staff and other members of Wards 1 and 2 Tara, H. Moross Centre who, by their insights, keen observation and sheer hard work, have taught me much of what I know about anorexia nervosa.

References

American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* 3rd ed. Washington, DC: AMA, 1980. 69.

Bruch, H. *Eating Disorders*. London, Routledge & Kegan Paul, 1974. 251.

Crisp, A.H. Diagnosis and outcome of anorexia nervosa: the St George's view. *Proc R Soc Med* 1977; 70: 464-474.

Garfinkel, P.E., Garner, D.M. *Anorexia Nervosa: a Multidimensional Perspective*. New York, Brunner/Mazel, 1982. 105.

Norris, D.L. Clinical diagnostic criteria for anorexia nervosa. *S Afr Med J* 1979; 56: 987-993.

Minuchin, S., Rosman, B.L., Baker, L. *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge, Mass., Harvard University Press, 1978. 23.

Kalucy, R.S., Crisp, A.H., Harding, G. A study of 56 families with anorexia nervosa. *Br J Med Psychol* 1977; 50: 381-395.

Beumont, P.J.V., George, G.C.W., Smart, D.E. 'Dieters' and 'vomiters and purgers' in anorexia nervosa. *Psychol Med* 1976; 6: 617-622.

Slade, P.D., Russell, G.F.M. Awareness of body dimensions in anorexia nervosa: cross-sectional and longitudinal studies. *Psychol Med* 1973; 3: 188-199.

Norris, D.L. The effects of mirror confrontation on self-estimation of body di

mensions in anorexia nervosa, bulimia and two control groups. *Psychol Med* 1984, 14: 835-842.
Casper, R.C., Davis, J.M. On the course of anorexia nervosa. *Am J Psychiatry* 1977, 134: 974-978.
Crisp, A.H., Palmer, R.C., Kalucy, R.S. How common is anorexia nervosa? A prevalence study. *Br J Psychiatry* 1976, 218: 549-554.
Ballot, N.S., Delaney, N.E., Erskine, P.J. *et al* Anorexia nervosa — a prevalence study. *S Afr Med J* 1981, 59: 992-993.
Bruch, H. Perils of behavior modification in treatment of anorexia nervosa. *JAMA* 1974, 230: 1419-1422.

Opsomming

Anorexia nervosa was altyd 'n seldsame siekte, maar het nou epidemiese afmetings aangeneem en die diagnose kan op suiwer kliniese grondslag gemaak word, sodat dit onnodig is om tydrowende en duur ondersoeke aan te wend.

Afgesien van drastiese vermaering, ontwikkel amenorree vroeg, saam met bradikardie en hipotensie, versteurde hitteregulering wat blyk uit koue ekstremiteite en veranderings in die hare.

Hierbenewens is daar 'n geskiedenis van oormatige liggaamlike aktiwiteit met abnormale slelkundige reaksies soos ontkenning van siekte en weerstand teen behandeling, saam met sosiale onttrekking wat dikwels gesinsgevegte voorafgaan. Versteuring van die liggaamsbeeld en onvermoë om besluite te neem kom voor, terwyl sekere premorbiede persoonlikheidstrekke aangetref word, soos opgesom in die beskrywing deur die ouers van die pasiënt as 'n 'modelkind'. Daar is meningsverskil oor die gesinseienskappe van hierdie pasiënte.

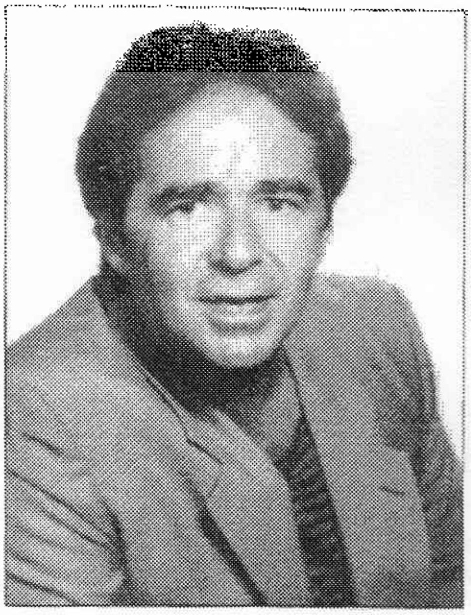
Een subtipe is die bulimielyer of 'braker', die subtipe waar die pasiënt dikwels minder teruggetrokke, seksueel meer aktief en meer onstabiel is.

Biochemiese en endokriene abnormaliteite is 'n manifestasie van hipotalamusdisfunksie, is nie-spesifiek en in alle gevalle van verhongering teenwoordig.

'n Multidissiplinêre benadering is noodsaaklik vir geslaagde behandeling en feitlik alle pasiënte moet eers 'n hervoedingsproses ondergaan in 'n hospitaaleenheid wat oor al die nodige dienste beskik. Gedwonge voeding of buisvoeding is nie net onnodig nie, maar selkundig traumaties. Chloorpromasien en die bensodiasepiene het 'n beperkte rol in die behandeling, maar orale kaliumaanvulling mag aangedui wees en hardlywigheid moet d.m.v. die dieet reggestel word en nie m.b.v. lakseermiddels nie. Daar moet nie met aktiewe psigoterapie begin word voor gewig goed herstel het nie en gesinsraadgewing is noodsaaklik om te voorkom dat die ouers teen die terapeut saamsweer. Die sleutelrol van die gesinspraktisyn word ten slotte beklemtoon.

Meet Thom Garfat

OVERSEAS GUEST AND KEYNOTE SPEAKER AT THE OCTOBER 1987 BIENNIAL CONFERENCE IN JOHANNESBURG.



A man who has done tough physical work in the "real world" and progressed all the way through the ranks of child care over the past fifteen years will provide valuable international input at the Johannesburg conference this October. Thom Garfat, now 40, started his "life after school" as a janitor, a salesperson, a truck driver and finally a lumber worker on a small camp on the northwest coast of Vancouver Island — quite a good grounding for child care work!

In 1972 he became a child care worker at Seven Oaks Residential Treatment Centre, and while completing a BA degree worked at a Reception and Diagnostic Centre in Victoria. In 1976 he completed his MA in Applied Clinical Psychology and is a Registered Psychologist with the British Columbia Psychologists' Association.

From 1976 to 1978 Thom was Executive Director of The Pacific Centre for Human Development which ran a community based programme for children aged 6-17 and which had a staff of 20 child care workers, psychologists, family therapists and life skills teachers.

Between 1978 and 1981 he was Assistant Professor in the School of Child Care at the University of Victoria teaching Family Therapy and Child Care Skill Development. During this time, as the Faculty Extension Co-ordinator, he was responsible for the administration of all Child Care Extension programmes for the province of British Columbia and the development and delivery of professional training programmes in the province. For the five years 1976-1981 he was also in private practice in child and family therapy and in child care, social work and other professional training.

Then, six years ago he was transplanted from the West Coast of Canada to Montreal "after falling in love with a French Canadian woman and following her home." At present Thom and his wife Sylvianne (who, we are delighted to hear, will be accompanying Thom on his South African visit) live just outside the city of Montreal.

There, since 1981, he has been a senior manager and administrator with Youth Horizons where he presently holds the job of Director of Treatment. The job summary for this post tells us a lot about the man who will be our guest in October. He is responsible for the management, supervision and development of all treatment services of the agency including two residential treatment centres, three emergency shelter programmes, an observation and assessment programme, eight group homes, one day-treatment program, two alternate schools, one back-up unit, supervised apartment programmes, professional foster homes and an independent-living programme. The Director of Treatment is also responsible for all clinical staff training and development programmes. Total staff: approximately 104 permanent child care workers, 80 part-time child care workers, 16 programme treatment supervisors, 2 programme directors. Budget: 6.5 million dollars. Client population: 205.

The Director of Treatment is also a member of the Senior Management Team, responsible for over-all administration and direction of Youth Horizons.

Thom Garfat will use the conference theme "Today's children, tomorrow's adults" as the title of his Keynote Address. He will give two other addresses to the conference: *Child Care Workers: Catalysts for a Future World* and *From Yesterday and Today to Tomorrow* in which he will look at various persons who have contributed to our knowledge, understanding and appreciation of troubled children by referring to their work and words. He will also give a review of current training in child care in North America at the One-Day Seminar on Child Care Worker Training on the day before the conference.

Thom sees the conference as "a unique opportunity to learn as well as to give", and assures us that during the four days he will be completely involved. His message to us during the run-up to Johannesburg: "I look forward to being with you in South Africa. You are providing me with an opportunity for which I am grateful."

Institute of Child Care/Instituut vir Kinderversorging

Die Instituut vir Kinderversorging, die navorsings-, standaarde- en praktyke-owerheid van die Nasionale Vereniging van Kinderversorgers, is gestig kragtens Artikel 3.5. van die Grondwet van die NVK. Stigtingslidmaatskap word saamgestel uit persone wie se diensperiode en akademiese studie hulle daarvoor bekwaam en wie dan deur die Nasionale Uitvoerende Komitee van die NVK genooi word.

Die Instituut se Oogmerke en Doelwitte is:

* Om navorsing op die gebied van kindersorg te bevorder, te koordineer; op te dra, te monitor en te onderneem;

* Om 'n standaardkode vir die versorging van kinders in residensiele inrigtings op te stel, dit deurentyd te evalueer, te versprei, te bevorder en daaroor te adviseer;

* Om 'n wakende oog te hou oor professionele praktyk op die gebied van residensiele kindersorg en om oor die algemeen 'n hoe standaard aan te moedig en te bevorder;

* Om verdere studie, bespreking, lees, akademiese geleenthede en betrokkenheid onder lidmate te bevorder;

* Om enige verdere take wat verband hou met hierdie oogmerke en doelwitte en wat deur die Nasionale Uitvoerende Komitee of die Tweejaarlikse Nasionale Konferensie van die NVK opgedra word, te onderneem.

U kom in aanmerking vir Stigtingslidmaatskap van die Instituut vir Kinderversorging indien u -

* 'n Lid van die NVK is

* Drie jaar diens in kinderversorging voltooi het

* Twee jaar erkende akademiese studie op enige gebied van kinderversorging voltooi het. Dit mag die volgende insluit: die Basiese Kwalifikasie in Kindersorg Sertifikaat, die Nasionale Hoer Sertifikaat in Residensiele Kindersorg, enige gelykstaande oorsese kursus, voorgraadse of nagraadse studies in Maatskaplike Werk, Sielkunde, Opvoedkunde of ander soortgelyke gebiede.

Indien u aan die bogenoemde bepalings voldoen en graag u naam vir oorweging wil instuur, voltooi dan asseblief die besonderhede hieronder:

Naam _____

Adres _____

_____

_____ Poskode _____

Huidige pos _____

Organisasie _____

Tydperk in hierdie pos _____ jaar _____ maande

Vorige kindersorg aanstellings - noem aantal jare

_____

_____

_____

_____

Kindersorg of verwante professionele opleiding/kwalifikasies

_____

_____

Indien u nie 'n lid van die NVK is nie mag u R15.00 subskripsie hierdie vorm vergesel. Stuur aan: Instituut vir Kinderversorging, Posbus 198, Claremont 7735.

Institute of Child Care/Instituut vir Kinderversorging

The Institute of Child Care is the research, standards and practice authority of the National Association of Child Care Workers, established in terms of Clause 3.5. of the Constitution of the NACCW. The Foundation Membership is formed of persons invited thereto by the National Executive Committee of the NACCW and whose length of service and academic study qualifies them for membership.

The Aims and Objects of the Institute are -

- To promote, co-ordinate, commission, monitor and undertake research in the field of child care;
- To draw up, constantly evaluate, distribute, promote and advise on a set of standards for the care of children in residential institutions;
- To maintain a watching brief over professional practice in the field of residential child care and generally to promote and encourage high standards of practice;
- To promote further study, discussion, reading, academic opportunity and involvement amongst its members;
- To undertake any further tasks which may be in accordance with these aims and objects and as may be assigned to it by the National Executive or the Biennial National Conference of the NACCW.

You are eligible for consideration for Foundation Membership of the Institute of Child Care if you -

- Are a member of the NACCW;
- Have completed three years of service in the field of child care;
- Have completed two years of approved academic study in any field related to child care. This may include the BQCC, the NHCRCC, an equivalent overseas course, undergraduate or graduate studies in Social Work, Psychology, Education or other related field.

If you satisfy the above conditions and would like to put your name forward for consideration, please complete the details below:

Name _____

Address _____

_____

_____ Postal Code _____

Present position _____

Organisation _____

Period in this position _____ years _____ months

Previous child care appointments with years

_____

_____

_____

_____

Child care or related professional training/qualifications

_____

_____

If you are not a member of the NACCW your subscription of R15.00 may accompany this form. Send to: Institute of Child Care, P O Box 199, Claremont 7735.