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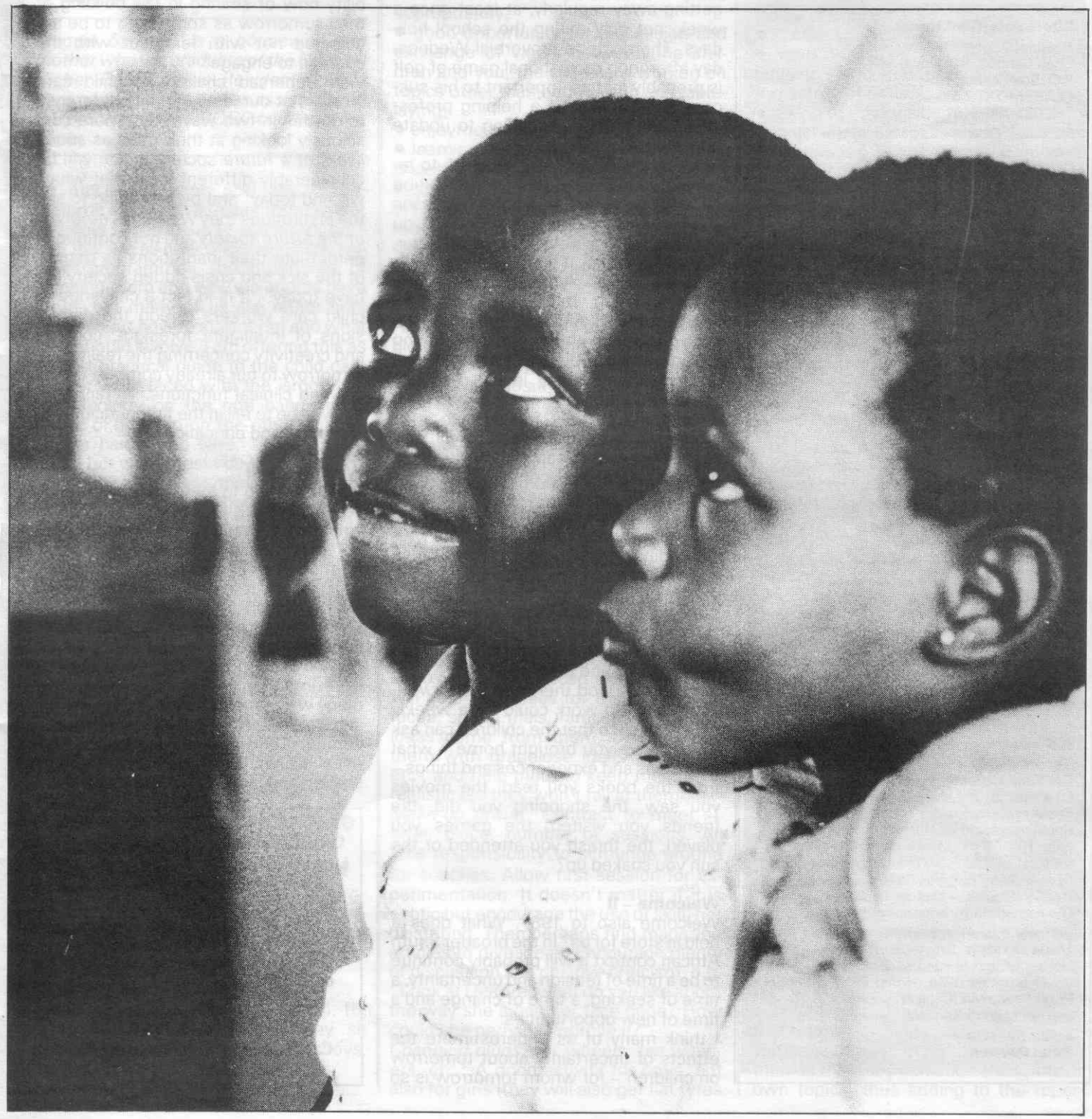
Die kinderversorger



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NASIONALE VERENIGING VAN KINDER-VERSORGERS

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National Chairman/Nasionale Voorsitter
Ernie Nightingale NHCRCC Dip Pers Man AICB, Ethelbert Children's Home, 93 Ethelbert Road, Malvern 4093. Tel: 031-44-6555

National Treasurer/Nasionale Tesourier
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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/Streeksekretarisse

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

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Welcome

Welcome – I

Welcome back to work – those of you who were lucky enough (dare I say it?) to get away from children for a spell during the holidays. How important it is, really, for us to do that: to get away from the pressure-cooker existence of group care situations, where our horizons so easily shrink so that the never-ending problems, irritations and deadlines assume a disproportionate weight in our total lives. We should all make a point of getting away regularly, at least once a week, not only during the school holidays. The doctor's proverbial Wednesday afternoon recreational game of golf is probably just as important to his success and survival as a helping professional as his regular reading to update his medical knowledge.

A good test of our own approach to recreation is to ask ourselves the question "In what ways am I growing as a person *apart from my child care career?*" If you come up with a zero for your answer, that's bad news. It's bad news for you because it probably means that you are not distributing your energies healthily over a range of activities and interests, and your work with children is becoming too important. You are laying yourself open to unnecessary levels of disappointment and hurt from the inevitable upsets and failures in your job – or worse, you will start *defending* yourself against these disappointments and hurts by being over-controlled or over-controlling. It's bad news for the children, too, not only because they will experience these consequences of your impending burn-out, but also because you will become an unstimulating and frankly boring person. People who have stopped growing themselves have little or nothing to give to children. Worse, such people often find it difficult to *permit* those around them to grow.

It would be good therefore if your welcome back to work could be a *weekly* experience, so that the children can ask "What have you brought home – what new ideas and experiences and things – from the books you read, the movies you saw, the shopping you did, the friends you visited, the games you played, the thrash you attended or the sun you soaked up?"

Welcome – II

Welcome also to 1987. What does it hold in store for us? In the broader South African context it will probably continue to be a time of tension and uncertainty, a time of seeking, a time of change and a time of new opportunities.

I think many of us underestimate the effects of uncertainty about tomorrow on children – for whom tomorrow is so important – and thus underestimate the urgency of resolving the questions South Africa faces at this time. Certainly, those of us who work with children (and who therefore know that there is hope even in the most hopeless-looking situations) must realise that we have a seriously challenging task ahead of us in this country, both in terms of its magnitude and in the probably radically altered shape and style of our work. But just as we enjoy the privilege already of working alongside children and helping them shed their fears and defences as they grow from one set of circumstances into another, so we have the responsibility now of sharing in the building of their tomorrow as something to be anticipated not with fear, but with the courage to engage.

Vish Supersad challenged child care workers at our last national conference to do this in two ways: by "more consciously looking at their roles as *socialisers of a future society* which will be considerably different from that which we find today; and by beginning to see the institutions they work in as *embryos of the future society* and not continue to perpetuate their institutions as mirrors of the sick and crisis-ridden society we have today". It is in fact a challenge to child care workers to add the dimensions of intelligent foresight, courage and creativity concerning the realities of tomorrow to our already complex custodial and clinical functions. To fail to do this will be to fail in the first principles of child care and education.

Welcome – III

Welcome also to 1987 as a conference year. The 6th Biennial National Conference takes place in Johannesburg from 6-8 October and it will be the first conference to make provision for a number of special-interest sessions at which South African child care workers can share with interested colleagues those particular aspects of our work which they have been exploring, developing or experimenting with. It is hoped that many will respond to the Call for Papers and Presentations published in our November 1986 edition, so that Conference '87 will be truly an occasion for sharing and learning from each other.

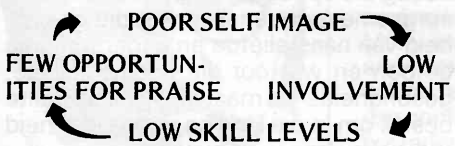
Programmes for Living

Maggie Slingsby

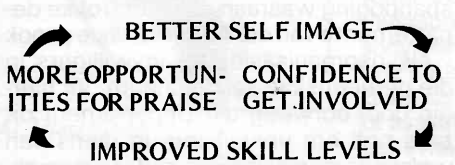
Maggie Slingsby is a housewife and mother who is a graduate of the National Higher Certificate in Residential Child Care course, and who has assisted with the teaching of the BQCC course in the Cape.

So much has been said about 'programme planning' in recent months that it seems superfluous to add more; but I feel that we all now understand the value of programmes, the importance of planning them and why we should have them, but many of us are rather confused about how to start them and what they should involve. I am offering this as a short practical guide to the child care worker who, faced with the jargon and the ideology on the one hand and a bunch of children on the other, throws up her hands and says, "Yea, sounds great, but what must I *do*?"

The most important thing to do is to create good, positive opportunities for the child so that he can feel good about his contributions, and you are able to give him *valid* affirmation that will improve his self-esteem. In other words we want to turn the vicious circle of



to the positive cycle of



We want to create situations where children can't fail but can feel good about their involvement.

Examples? Here are a few:

Target group: 3 or 4 girls, age 13, 14, 15. They're difficult to occupy, they sit around talking endlessly about boys, clothes, hair styles, etc.

Activity: Window shopping.

How to set it up: "Let's take an hour for the next two Wednesday afternoons to go window shopping." (i.e. contract with them to come *both* Wednesdays). Sort out the best time and place to meet (let them have a say in it). Say that you would like them to be dressed appropriately — not school uniform, not latest disco threads. If you're not too confident about behaviour you might make it clear that the first session at least is only window shopping, not going into the shops.

Gains to be made:

- the girls taking the responsibility to fulfil the contract — be on time — dress appropriately;
- good opportunity for discussion and exchange of views between the children and you, the child care worker, on topics other than bed-making and table-laying;
- enjoyment for all of you;
- learning for all of you, about clothes, prices, fashion and fashion sense, etc.
- good starting point for the girls to join in planning further programmes, eg. arranging a visit to a 'high fashion' shop or show, or getting together to sew that very simple skirt in Edgars' window or dyeing some old clothes to make them more fashionable.

A programme like this might seem simple to the point of being trivial but it does incorporate very few opportunities for failuie with positive contact with the child care worker, added to the fact that when we have *done* something with our afternoon we feel much more positive about ourselves.

Let's try some more ...

A roller skating group: Talk to the children you feel would benefit, or the ones who have expressed an interest. Plan and contract — perhaps 4 sessions. You will undertake to arrange that the staff park elsewhere so that that lovely smooth tarred area is available. They must be there every session and on time, and only this group, no extras. Aim at novices or advanced skating — they will help with ideas for tricks, obstacle races, speed trials, ramps, etc. Let the ideas come from them. Don't saddle them with grandiose ideas of shows, etc., and help them to keep their ideas realistic (so they won't fail at them).

Make-up group: Contract to meet — time, place, number of sessions. All take responsibility to scrounge around for supplies. Allow first session for experimentation. It doesn't matter if it is exotic but encourage the use of skill, not plastering. Then perhaps find magazine articles to give ideas. Encourage plenty of discussion and *positive* criticism, e.g. "Look at Deirdre, what do you like about the way she's had her face done? How could she perhaps improve it?"

Changing plugs, car wheels, tap washers, etc.: A good activity for boys, but also for girls (they will also get flat tyres sometimes). Contract for the number of sessions, bearing in mind that to half know these skills is worse than knowing nothing. They must undertake to make themselves proficient, even if it means extending the number of sessions.

What is so special about these kinds of activities, or living programmes? Absolutely *nothing*, because these are the kinds of ordinary activities that an ordinary child would be involved with in an ordinary home. They provide many excellent opportunities, both in the children's home and in the family home, for —

- good and meaningful group and individual interaction;
- success in learning and doing;
- valid occasions for affirmation and building self-confidence;
- mastery of skills;
- taking of responsibility.

The activities are the vehicle for these opportunities but it is the child care worker, his attitude and sensitivity to the activity and the children involved in it, who bring all these gains to fruition. You should only enter into the activity if you feel that it is going to be pleasant. If you regard it as a chore it will fail. Remember that it is the children's activity too — let them have a say in the planning and in the way it progresses (without letting them highjack it). Choose activities that you have some interest in, and perhaps a little experience and knowledge of. Remember that the interaction and exchanges of ideas are, from a therapeutic viewpoint (and human viewpoint), as important as the activity, if not more so.

"But", I hear you shout, "I have 14 children. How can I run specialised groups that only cater for some of them?" There is no definite answer to that question, but where there's a will ...

There are these aspects of living programmes:

- They need not last all afternoon. Some could be as short as 45 minutes, in which case you could probably arrange for someone to cover for you, especially if you had children from other sections in the group. Sessions should be planned to be fairly short, save some of the excitement for the next session.
- Not all activities need to be supervised all the time, e.g. the roller skating. You could arrange for the dressing-up clothes to be available in one room for the smaller children once a week, where they can play undisturbed and largely unsupervised.
- Living programmes may be the perfect occasion for encouraging your staff who are not on-line to have positive contact with the children — your principal, secretary, social worker, homework tutor, caterer, groundsman, etc. The advantages of a variety of people running them is that they can each choose their own topics, thus adding to the reper-

toire. Don't let them throw their arms up in horror; there are some homes where it happens already.

• Volunteers. This is the perfect type of activity for the well-vetted volunteer. The swimming coach could do 4 sessions of diving, the housewife has a wide range of skills and interests she could share for a couple of hours a week (and she usually has plenty of experience of dealing with children). Active retired people could involve children in their interests, as could a garage mechanic, builder, craftsmen, etc. Everyone has something to offer, and you mustn't be snooty about we volunteers! But, wouldn't it be rather fun to do some of these yourself? Do none of these ideas tempt you?

Story group: Two sessions to read a thoroughly amusing and short book like *Chilly Billy* the little man who turns the light on in your fridge. This could then develop into more sessions for another book, visits to the library, etc.

Kite flying: *Start* with the flying over two sessions and *then* negotiate about the kite-making sessions.

Marble championships: Let them make the rules, write them down, appoint an adjudicator, find a prize, etc.

Orienteering or treasure hunts: Set simple, and progressively more complex, clue trails around the section, the grounds or the suburb, depending on the age group.

Hut building: Import materials (branches, scrap wood, corrugated iron, etc.) and provide hammers and nails. Contract for responsibility for the tools, safety measures, etc.

Night walks: Always fascinating with 8, 9, 10-year-olds on a warm spring or autumn evening. Everything looks so different and it helps them to overcome fear of the dark.

In consultation with the individual child's treatment programme, one could perhaps select programmes that would be particularly appropriate for his specific needs, e.g. high intelligence with low performance at school — the museum programme doesn't require formal writing and learning, but could stimulate involvement in school history. A child who needs to learn about organising himself might be involved in the marble championship. What is important is the creativity of finding things for children *to move on to* from each type of activity — at least until they develop their own momentum and can progress by themselves. A *developing* sense of exploration, experience and mastery is a preferred aim to children "not growing out of" repetitive satisfaction.

The possibilities are endless and it won't be long before the children will be coming to you with ideas of their own. You can help them formulate them and carry them out. Another boost to their (and your) self-esteem.

'n Opheffingsprogram

Gee u Kind 'n Kans

Ansi Strydom

Gee u kind 'n kans – dit is die pleidooi en ernstige beroep wat tans landwyd op ouers gedoen word in 'n opheffingsprogram wat deur die Departement van Gesondheidsdienste en Welsyn, Administrasie: Raad van Verteenwoordigers, geloods word.

Die meeste maatskaplike probleem-verskynsels in die gemeenskap raak die kind direk en daarom fokus die opheffingsprogram hoofsaaklik op die kind. 'n Onrusbarende aantal kinders word sorgbehoewend bevind en bring bykans die grootste gedeeltes van hul jeugjare in substituutsorg deur of groei op in gesinne en gemeenskappe waar hul kanse om gesonde waardes en norms aan te kweek en om 'n redelike kwaliteit van lewe te lei ernstig aan bande gelê word.

Vandag se Kind is Môre se Volwassene

Dit is derhalwe noodsaaklik dat voorkomingswerk op die kind en sy huidige onbevredigende omstandighede gefokus word om sodoende te poog om die bose kringloop van sosiaal-ekonomiese agterlikheid te verbreek.

Die Program: Gee u kind 'n kans is gemik op voorligting aan individue, gesinne en gemeenskappe oor doeltreffende wyses om die kind se ontwikkeling te bevorder.

Doelstellings van die Program

Om die fisiese, opvoedkundige, emosionele en maatskaplike ontwikkeling van die kind binne sy gesin en gemeenskap te bevorder sodat hy sy volle potensiaal kan ontwikkel en as gebalanseerde volwassene sy rol in die samelewing kan vervul.

Om bogenoemde ontwikkeling te bevorder deur op die volgende fasette te konsentreer:

Ten opsigte van die individu om geleenthede te bied wat die persoon se opgewassenheid om eise te hanteer en bevredigend te funksioneer deur die volgende aspekte te bevorder:

• liggaamlike en geestelike gesondheid
• korrekte voeding gedurende swangerskap
• gesinsbeplanning
• verantwoordelikheid
• selfstandigheid
• die ontwikkeling van aanvaarbare norms en waardes
• positiewe selfbeeld
• die vermoë om positiewe verhoudings te handhaaf
• emosionele volwassenheid

Ten opsigte van die gesin word die volgende nagestreef:

• die ontwikkeling van 'n bestendige gesinslewe
• die hantering van die huweliksverhouding
• die hantering van die werke/beroepseise van die ouers
• die hantering van finansiële eise en die gesinsbegroting
• die ontwikkeling van kennis en insig in die sosialiserings- en opvoedkundige ontwikkeling van die kinders in die gesin
• die bevordering van gesonde eet- en lewensgewoontes
• die hantering van konflik

Ten opsigte van die gemeenskap word beoog die opbou van 'n genoegsame en sorgsame gemeenskap wat die gesindheid van naasteliefde en ondersteuning betoon en wat oor die nodige fisiese, gesondheids- en maatskaplike fasiliteite beskik om in die kind se verskeidenheid van behoeftes te voorsien.

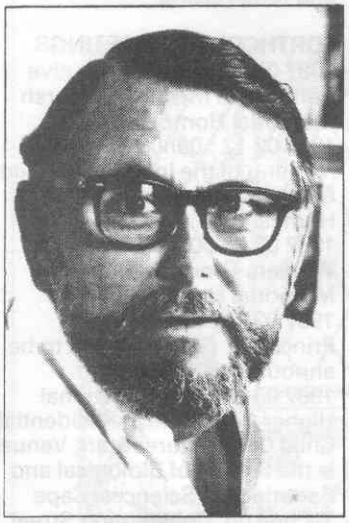
Die uitvoering van die program is 'n spanpoging waaraan al die betrokke departemente van die Administrasie asook welsynsorganisasies en vrywilligers in die gemeenskap sal deelneem. Vir hierdie doel oorweeg die Departement dit tans ook om vrywilligers in diens van welsynsorganisasies en ander organisasies in die gemeenskap te subsidieer. Die idee is om mense uit die gemeenskap toe te rus om kennis uit te dra en sodoende gemeenskapsbetrokkenheid, selfwaarde en selfbeeld by mense te verhoog.

Nuusbrokkies Newsbriefs

Whole Days, Whole Lives

This is the title of the Inaugural Conference of the Albert E. Trieschman Centre based on the Walker School in Boston USA to take place in March this year. From the Conference programme:

"The theme *Whole Days, Whole Lives* is the title of a book Dr Albert E. Trieschman never had time to finish. Al Trieschman believed in competence and wellness as the focus of residential treatment. He put into practice these concepts learned at Harvard from Dr Robert White, a renowned scholar of psychology and personality.



Al Trieschman

Dr Trieschman often said that the major goal of professional child care work is to help children learn to function as whole, competent individuals. This meant teaching life skills such as brushing teeth and tying shoes. It meant teaching to read and to subtract. It meant teaching self-control — not to throw the bat after striking out and not to swear at a parent when assigned an unpleasant household chore. It also meant teaching youngsters to take risks in developing relationships and in trying out new behaviour. In short, Al wanted every child to have a chance at a 'whole life'.

To help children meet this goal, we as adults must be competent caregivers. We must strive to make the treatment environment the best that it can be. This necessitates a continued review of our beliefs, our biases, our goals, and our practices, a never-ending search for the 'better way'. When we attempt this, we will become the kind of professionals that Al Trieschman dared us all to be — 'the acknowledged companion of children and youth in an adventure full of challenges, obstacles, and opportunities'. This, then, is the theme of the Conference — adults learning how to teach children, challenging ourselves to become more competent professionals.

Many leading North American and overseas child care figures will be taking part in this three-day conference which is preceded by an Educators and Trainers' Day co-ordinated by Karen vanderVen and Ray Peterson. There will be over sixty sessions given by almost one hundred presenters. Subjects include management of assaultive behaviour, sexual behaviour, and running away; positive peer culture, permanency planning, death and mourning, individual psychotherapy, recreation and creative arts, team models, decision-making, crisis and conflict handling, and institutional abuse. Major themes are youth empowerment and preparation of youth for independent living.

Handleiding vir Besture

Die Departement Gesondheidsdienste en Welsyn, Administrasie: Volksraad, het onlangs 'n nuwe Handleiding vir Besture van Kinderhuise uitgegee. In sy Voorwoord, spreek Dr Slabber, Hoof Uitvoerende Direkteur van die Departement, die volgende mening uit: "Die bestuur is verantwoordelik vir die daarstelling van 'n volledige opvoedende versorgings- en remediërende milieu. Hierdie Handleiding is derhalwe opgestel met die doel om die bestuurslid bewus te maak van die groot, maar uitdagende taak waartoe hy hom bereid verklaar het."

Alhoewel die Handleiding ietwat onvolledig is, moedig dit bestuurslede aan om meer ingelig te wees wat kindersorg aan betref veral deur middel van hierdie joernaal. Van groot belang is die aanbeveling dat besture, uit hulle lede en met of sonder koöptering van ander persone, subkomitees saamstel om bepaalde aspekte te bestudeer en aanbevelings by die bestuur te maak. Vier noodsaaklike subkomitees word voorgestel, nl. Behandelingskomitee, Personeelkomitee, Geboue- en terreinkomitee en Finansiële komitee. Die voorkoms van hierdie stuk word verwelkom.

White Subsidies

The Department of Health Services and Welfare of the House of Assembly have informed the children's homes in their administration that their new subsidy of R344.55 (retrospectively payable from 1st October 1986) is an interim measure pending the introduction of a new subsidy scheme. The Department hopes to introduce a differentiated system which will take into account, amongst other things, of the quality of professional services rendered by children's homes. This is an encouraging development following on the NACCW's representations to the Department from the 1985 National Conference. An appeal was made to those children's homes who were still not spending the equivalent of the subsidy to make use of the new rates to improve their services.

Thinking about Education

The Cape Town Child Welfare Society in association with the NACCW is undertaking a study of educational needs amongst children in alternative care with a view to developing practical educational programmes. Chris Giles, Clinical Psychologist with Child Welfare, the co-ordinator of the study, points out that available evidence suggests that while many children in care are handicapped by being a year or two behind their peers at school, others are at a more profound disadvantage. For example, Annette Cockburn, principal of The Homestead, reports that some children of 15 are in Standard 2, and more radical educational alternatives must be sought if such children are to leave school with the security of having some marketable skills. All Cape Town children's homes and foster care agencies are being asked to co-operate in the initial research for this programme. At the same time a sub-committee of the NACCW's Transvaal Executive consisting of Dulcie Mbere and Maggie Nkwe, both principals of Soweto children's homes, together with Jacqui Michael and Di Levine, are studying similar problems in the Johannesburg area. Consideration is being given to a video programme. Some interest has been shown by the British Council, and SACHED is being approached for advice.

Transvaal

The Biennial General Meeting was held in December at the Johannesburg Children's Home. This was a successful event attended by 150 people. Joy Hansen, our guest speaker shared with us some of her experiences in Canada, and compared the developments in rural community work with the Canadian Indian population to some of the problems facing our rural blacks. Thank you Joy for a most interesting talk.

The willingness of people who came forward to stand for election to the Executive Committee demonstrated the interest and enthusiasm of our children's homes in the work of the NACCW. New Committee members include Sister Irene,

Principal of Nazareth House, Jonathan Pearce, Principal of Epworth, Joan Rubenstein, Principal of Johannesburg Children's Home, John Ennis, child care worker from St George's, Vuwisa Zala, social worker from PROCESS. Jacqui Michael, the Director of the Homes and Orphans Fund was elected as Chairperson and Rudolph van Niekerk was elected Vice-Chairman. Cynthia Green, Principal of St Mary's has undertaken the task of Secretary. We look forward to a dynamic and exciting year filled with NACCW activities.

Training News
An orientation course for new staff members will be held in February on Wednesday 4th, 11th, 18th and 25th. The four sessions last two hours each and aim to give the workers background information on the children and start to develop basic child care and skills.
Venue: Rand Afrikaans University, Block C LES 404.
Time: 10h00-12h00.
Session 1 — Wednesday 4th
Introduction to the field.
Presenter is Di Levine, Regional Director of the NACCW.
Session 2 — Wednesday 11th
Who are the children, how do I start to work with them?
Presenters are Di Levine and Hilary Smith, child care worker, Child Welfare Society.
Session 3 — Wednesday 18th
The structure of our service, the reconstruction agency, the children's home and the team-approach to child care.
Presenter is Evelyn Goodwin, social worker, St George's.
Session 4 — Wednesday 25th
Common sense fundamentals of child care. Presenter is Jacqui Michael, Director of Homes and Orphans Fund.
Lectures in the BQCC will start at the beginning of March. Further details will be enclosed in next month's *Child Care Worker*.

People News
It was with regret that we bade farewell to a long-standing member of the Transvaal Executive, namely Major Ray Trollip from Firlands Children's Home. He has been transferred to the Cape and will be working in a rehabilitation centre for alcoholics. In the eight years that he was there, Major Trollip introduced many progressive changes to Firlands and he will be sorely missed by all who knew him and appreciated his calm and unruffled approach to

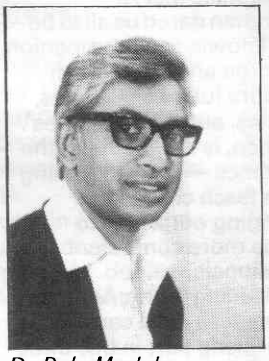
Joan Rubenstein

all tasks he undertook.
The chief post at Firlands has been assigned to Major Lotter, a Salvation Army minister with 21 years' of field service. This is his first appointment in the social service area and he is looking forward to the new challenge this work presents. He has a special interest in sport activities and hopes to develop a full sports programme at Firlands, to include soccer, tennis, squash and boxing. His wife, Irene, will take over as matron. The Lotters have three children, two girls, already grown up, and one son living with them.
The Johannesburg Child Welfare Society has also seen major changes in their personnel. The Director, Mr H. Ferreira, has retired and Dr Adelle Thomas has been appointed as the new Director. A new residential services manager of the Society started in January. She is Jackie Losfell, a social worker with 15 years' experience. Jackie has worked for Child Welfare for many years, her last post being that of manager of the foster care and adoption section. There are four Child Welfare group homes falling under her control, namely Noradene, Hoernle, Pim Cottage and Lucy Kennedy. She has two social workers on her staff and five child care workers. These homes serve 44 children. Guild Cottage has also acquired a new Principal, Jean Wright, a social worker with many years experience in the field of residential care.
The NACCW welcomes these newcomers and wishes them every success in their positions.

Natal

Regional Meetings
The first Regional Meeting of the Association will take place on Friday 27th February at Ethelbert Children's Home in Malvern. The meetings for the first half of 1987 will focus on practical ways of empowering children, helping them to set for themselves goals, standards and values, and to handle peer pressure — specifically relating to increasing incidences of alcohol abuse amongst adolescents. These meetings take place on the 4th Friday of every month.
It is hoped that information regarding forthcoming meetings of the Principals' and Social Workers' groups will be made available after the first meeting of the Regional Executive Committee on the 27th February.

Training
Plans are being finalised for the Basic Qualification in Child Care modular course (BQCC) to be offered as from February for non-matriculants in the Durban area. Norma McCormack, Dr Bala Mudaly, Kathy Mitchell and Sister Maria will be co-ordinating the course which will take place at St Philomena's Home.
Enrolment for the National



Dr Bala Mudaly

Higher Certificate in Residential Child Care, for matriculated students, will take place at the new campus of the Natal Technikon in Berea Road at 11h00 on 3rd February 1987. Course fees are R80.00 per subject, that is R320.00 per year of study. Further information is available from Ernie Nightingale on 031-44-6555.

Hello and Goodbye
Muffie White, who has for the past seven years been Principal of Wylie House on the Berea, has taken a lecturing post in the School of Social Work at the University of Natal. She was

Muffie White

formerly a social worker with Durban Child Welfare Society, and her enthusiatic presence at NACCW functions will be missed by many colleagues.
Tom Hamber, former Principal of Teen Centre in Rondebosch in the Cape, takes over as Principal of the Durban Creche and Children's Homes at the beginning of 1987, and we welcome him to the Natal Region.

Western Cape

This Region has started 1987 with aggressive enthusiasm, sending to all members a calendar containing events together with a statement for their membership and journal subscriptions. The Executive Committee plans to operate on a portfolio basis with members accepting responsibility for such areas as education, membership, public relations and fund-raising.

FORTHCOMING MEETINGS
1987 02 05 : 08h45 Executive Committee Meeting at Marsh Memorial Homes.
1987 02 12 : 09h00 Inaugural Meeting of the Institute of Child Care at Marsh Memorial Homes.
1987 02 26 : 09h00 Social Workers Group at Marsh Memorial Homes.
1987 03 13 : 10h00-15h00 Principals' Group (Venue to be announced).
1987 03 11 : 08h45 National Higher Certificate in Residential Child Care lectures start. Venue is the School of Biological and Paramedical Sciences, Cape Technikon, Constitution Street, Cape Town.
1987 03 19 : 09h30 Full Regional Meeting. St Michael's Children's Home, 63 Main Road, Plumstead.
1987 03 26 : 09h00 Social Workers Group. Marsh Memorial Homes.
1987 04 08 : 09h00 Basic Qualification in Child Care Modular Course lectures start. St Michael's Children's Home.

A Do-it-yourself Research Project

The Child Care Career

On October 22nd the National Director was asked to run a workshop in Durban on "Survival in Child Care". Instead of allowing this to turn into some sort of gripe session at which all the old stereotyped career problems could be tracked down and wallowed in, it was decided that we would rather undertake some instant do-it-yourself research on our career. The aim was to objectify and quantify issues in our service conditions — and then to spend the last half hour considering our findings.

Method
All who were present at the start of the workshop were asked to complete a questionnaire. While the completed questionnaires were being analysed participants broke into nominal groups to identify the three best and the three worst aspects of child care work. After tea the results were analysed and discussed.

Questionnaires
94 questionnaires were completed. Of these, ten were completed by Social Workers, fifteen by Principals, Programme Directors and other senior/supervisory staff, and 68 by on-line child care workers. Of these 68, four were incorrectly completed, leaving 64 for analysis.

I know child care work is getting you down, dear, but you *have* to go to work today.

The 64 Child Care Workers
The average length of service was 39,3 months. The shortest was 1 month and the longest 168 months. The distribution was as follows:

Months in service	*Number*
1 – 34	39
35 – 67	14
68 – 101	4
102 – 134	4
135 – 168	3

When asked how much longer they thought they would stay in child care, respondents answered as follows:

Period	*Number*
No longer	3
One year	11
Two years	12
Three years	8
More than three years	30

It is of interest that almost half of the child care workers expected to remain in the career for "more than three years". From the non-significant correlation (r = 0,17) between length of completed service and expected further period of service, it is clear that the "intending stayers" include both newcomers and old stagers.

Training
Most disappointing figures in the study related to training. While 19 respondents reported that they received in-ser-

vice training, only 11 had attended any formal training courses and three others had done courses such as STEP and Lifeline. 50 (78 percent) stated that they had done no training in child care.
With regard to *present* training, 57 (89 percent) stated that they were doing no coursework as against 7 who were enrolled for child care or university courses.

Client Groups
Respondents were asked how many children there were in the groups with which they worked. Responses were distributed as follows:

Group size	*Number*
0 – 6	1
7 – 12	32
13 – 19	24
20 – 25	6
26 – 32	1

The average number of children per child care worker was 13,39.
Respondents were asked to estimate how many of the children in their group were "average and easy to work with", "more difficult and harder to work with", and "disturbed and very hard to work with".
The average numbers of children falling into these groups were as follows:

Type of child	*No. per worker*
Average, easy to work with	**8.05**
More difficult and harder to work with	**3.28**
Disturbed and very hard to work with	**2.06**
TOTAL	**13.39**

Many of the career problems experienced in child care are no doubt attributable to the fact that child care workers, on the whole untrained, are working with large numbers of 13 children, 40 percent of whom they perceive as difficult or very difficult to work with.

The Job Satisfaction Indexes
Included in the questionnaire were nine aspects of child care work which respondents were asked to rate on a scale of 1 (very poor) to 5 (very good). 3 represented an average rating. Below are the average ratings of the respondents on these nine indices:

	POOR AVERAGE GOOD
Hours of work	3.14
Salary	2.81
Accommodation	3.55
Time and space for privacy	2.61
Training and growth opportunities	3.13
Support from superiors	3.47
Promotional prospects	2.16
Stimulation and challenge	3.42
Use of skills and talents	3.63

If we rank the ratings of these nine indexes, we see a clearer picture of what child care workers see as the best and worst aspects of their jobs:

1. **Use of skills, talents and abilities**
2. **Accommodation**
3. **Support from superiors**
4. **Stimulation and challenge**
5. **Hours of work**
6. **Training and growth opportunities**
7. **Salary**
8. **Time and space for privacy**
9. **Promotional prospects**

A tenth index, namely Job Satisfaction, was imbedded in the above nine: It was hypothesised that these nine indices would prove to be statistical components of Job Satisfaction. In the event, though all nine indices correlated positively with Job Satisfaction, four correlated highly significantly ($p < 0,01$): Accommodation, Time and space for private life, Support from superiors, and Stimulation, challenge and variety. Further, the mean rating of Job Satisfaction was 3,84 which was higher than any of the other indices, and this suggests that the concept of Job Satisfaction is made up of more components than the nine selected for this study.
Of interest is the fact that there was a significant positive correlation between Job Satisfaction and the expectation to stay in the career for a long period. ($r = ,25$, $p < 0,05$), and a significant negative correlation between Job Satisfaction and the number of children in the group perceived to be disturbed and very difficult to work with ($r = -0,32$, $p = 0,01$).

The Groups
Each group was asked to identify the three best and the three worst aspects of child care work. Items rated best or worst respectively were given a score of 3, second best or worst, 2 and third best/worst, 1.
The following items, together with their scores, were regarded by the groups as the most important positives of child care:

1. **Seeing progress and growth in the children (28)**
2. **Receiving affection from the children (15)**
3. **Work satisfaction and personal satisfaction (8)**
4. **Self-awareness and self-development (6)**
5. **Challenge and variety (5)**
6. **Developing skills in practice (5)**
7. **Uniting children with families (4)**
8. **Support from seniors and management (3)**

The following were the most important negatives:

1. **Lack of support from management superiors and peers (13)**
2. **Salaries, working conditions and lack of privacy (13)**
3. **Personal failure and sense of inadequace (13)**
4. **The large numbers of children in groups worked with (8)**
5. **Lack of funds for essential work (8)**
6. **Pressure of work, tiredness and burn-out (6)**
7. **Bureaucracy hindering work (4)**
8. **Poor role and task definition (3)**
9. **Partings of children and staff colleagues (3)**
10. **Poor job security and promotion prospects (2)**
11. **Problems relating to own families and children (2)**

The above items may help to fill out our picture of what constitutes job satisfaction in child care work. The first two positives should clearly have been included in the questionnaire. The first one, "seeing progress and growth in the children" — or "success" — is easy to understand as a factor in job satisfaction. The second, however, "receiving affection from the children", sounds a note of warning to employers and supervisors. It suggests that where job dissatisfaction exists, workers are reduced to deriving compensatory satisfactions from their intrinsic relationships with the children. The dangers here are that relationships with the "easy to work with" children may become preferred or indeed *needed* by staff, or that staff, who may in any sense become dependent on the children for their work satisfactions, will be hurt when the children, almost by definition, fail to meet their needs.

Discussion
There is a lot of material in this brief do-it-yourself research report which can be of value to employers, principals, social workers and supervisors. It is far from a "respectable", carefully controlled empirical study, but it nevertheless allowed child care workers a voice regarding their jobs, and it isolated a group of factors which, if intelligently applied in our employment practices and work procedures, can build positive child care teams and help to avoid dissatisfaction, burn-out and high staff turnover.

Selfmoord en Selfmoordpogings by Kinders en Adolessente

Annette M. van Zyl

Dr Annette van Zyl is die Hoof van die Afdeling Kinderpsigiatrie by Tygerberg Hospitaal in Kaapstad

Die toenemende voorkoms van selfmoord en selfmoordpogings by jong mense in verskeie lande maak dit noodsaaklik dat daar indringend gekyk word na die redes waarom hierdie toename, veral sedert die 60-erjare, plaasvind en hoe dit beter geidentifiseer, behandel en voorkom kan word.

Epidemiologie

Selfmoord Kinders onder 10 jaar pleeg selde selfmoord. Verskeie studies toon 'n beduidende styging in die voorkoms van selfmoord onder jong mense (15-19 jaar) – meer as wat weens bevolkingstoename verwag kan word.

Studor en Kruger het die aantal selfmoorde in die RSA vanaf 1939 tot 1971 ontleed en die voorkoms by jeugdiges gevind soos in Tabel I weergegee.

In die VSA was die voorkoms in 1978 in die ouderdomsgroep 10-14 jaar 0,81/100 000 en 7,64/100 000 in die 15-19 jaar-ouderdomsgroep.

Selfmoordpogings Selfmoordpogings is meer algemeen as selfmoord. Van Zyl se bevindings by adolessente van 12-18 jaar word in Tabel II weergegee.

Selfmoordpogings is meer algemeen onder meisies. Sy vind dat selfmoordpogings die algemeenste simptoom is waarmee adolessente by Tygergerg Hospitaal presenteer.

Minnaar *et al* het 723 selfmoordpogings in 1978 in Durban geëvalueer. Die piekouderdom wanneer hulle gepresenteer het, was 20-29 jaar met 'n tweede piek by 10-19 jaar.

Faktore wat voorkomssyfer beïnvloed Die beskikbaarheid van dodelike middels speel 'n rol. Kreitman toon 'n verlaging in die selfmoordsyfer nadat giftige gasse nie meer beskikbaar was nie. Die kwaliteit en die beskikbaarheid van behandeling verlaag die mortaliteitsyfer in ontwikkelde lande. Onderrapportering word ook aangetoon. Shaffer toon dat die meeste kinders van 10-14 jaar wie se dood onder 'onbepaald of dood toevallig of doelbewus' geklassifiseer is, wel waarskynlik selfmoord gepleeg het. Hollinger en Offer het bevind dat daar 'n beduidende positiewe korrelasie tussen die aantal adolessentselfmoorde en veranderings in adolessentbevolkingstal en veranderings in die proporsie adolessente in die bevolking van die VSA van 1933-1975 was.

Die seldsaamheid van selfmoord by kinders word verklaar deur die beter sosiale en emosionele ondersteuning en hegtheid binne gesinsverband, die laer voorkoms van depressiewe siekte voor adolessensie en die vlak van kognitiewe maturasie. Kognitiewe vermoëns wat met adolessensie ontwikkel is antisiperende denke en beplanning, 'n groter bewuswording van hom/haarself soos gesien deur andere en die vermoë om versonke te raak in abstrakte denke.

TABEL II: SELFMOORDPOGINGS BY ADOLESSENTE

	Selfmoord	*Pogings*
Blankes	1	74
Kleurlinge	0	123

TABEL 1: PERSENTASIE VAN TOTALE AANTAL SELFMOORDGEVALLE

	BLANKES		*KLEURLINGE*		*ASIËRS*	
Ouderdom	M	V	M	V	M	V
10 – 14 jaar	0,5	0,7	1,1	2,1	0,6	2,6
15 – 19 jaar	0,9	5,9	5,9	15,7	6,8	30,6
20 – 24 jaar	10,6	8,4	16,0	18,9	19,1	22,1

Etiologie

Selfmoord word gewoonlik verklaar deur drie modelle, nl.

- Die psigodinamiese model wat selfmoord verklaar as die gevolg van intrapsigiese faktore soos die begeerte om met 'n oorlede geliefde herenig te word, die internalisering van woede wat teen die ego gerig raak in die vorm van skuldevoelens en depressie, en manipulering om ander te beinvloed om liefde te kry of te straf.
- Die sosiologiese model wat selfmoord sien as verstaanbare gedrag in die persoon se lewensituasie of posisie in die samelewing. Durkheim omskryf die konsep anomie ('n gebrek aan sosiale integrasie), of groepsdinamiek wat lei tot verminderde identifikasie met die gemeenskap, asook polities-ekonomiese druk soos siklusse van werkloosheid, as moontlike patogene faktore.
- Die psigiatriese siekte-model wat selfmoord sien as 'n simptoom, van 'n onderliggende siektetoestand soos depressie of alkoholisme. Verskeie studies bevestig dan ook die verband tussen depressie en selfmoord, bv. die psigiese post mortem-studies van opeenvolgende selfmoorde. Hierdie modelle sluit mekaar nie uit nie. Sosiale faktore mag bv. lei tot verhoogde stres en verminderde sosiale ondersteuning, wat weer aanleiding gee tot 'n gevoel van hopeloosheid en in 'n persoon met 'n geneties bepaalde affeksteuring tot depressie kan lei – 'n bose kringloop van negatiewe gedagteterugvoer, isolasie en gedagtedistorsie wat die persoon in wanhoop laat verval.

Al meer bewyse akkumuleer dat monoamiene in die sentrale senuweestelsel 'n rol speel in depressie en selfmoord. 'n Balans tussen katesjolamiene, serotonien en asetielcholien word geimpliseer. In affektiewe siektes is die hipotese dat daar 'n verlaagde breinserotonienvlak moet wees en indien die noradrenalienvlak daal, word depressie gepresipiteer. Die noradrenalienvlak mag relatief laag wees a.g.v. 'n primêre styging van asetielcholien. Reseptorafwykings word ook geimpliseer: 'n hipersensitiwiteit van die presinaptiese a2-adrenergiese reseptore, asook die adrenergiese b-reseptor wat gekoppel is aan adenielsiklase-aktivering. Verskeie ondersoekers toon 'n verband tussen lae serotonienvlakke in die brein en pasiënte met selfmoord aan.

Kliniese Beeld

Selfmoord is meer algemeen by seuns, gewoonlik 12 jaar of ouer. Emosionele

en antisosiale gedragsveranderings word by die meeste kinderselfmoordgevalle voor hul dood beskryf. In 40 persent van die kinders is selfmoordgedrag vooraf waargeneem. Waar selfmoord deur 'n dissiplinêre krisis voorafgegaan word, verhoog dit die sosiale isolasie. 'n Hoë voorkoms van depressie en selfmoordgedrag is by die ouers en broers en/of susters van dié kinders waargeneem. Shaffer vind veral 4 groepe:

- Kinders wat geirriteerd en oorsensitief vir kritiek is;
- Gevalle wat impulsief en plofbaar is;
- Kinders wat stil, met 'n lae kommunikasievlak en moeilik bereikbaar is;
- 'n Groep perfeksionistiese kinders met hoë standaarde, wat baie self-krities is en bang is om foute te maak.

Kinders met selfmoordpogings kan hoofsaaklik in twee groepe verdeel word:

- 'n Groep met 'n hoë intensie om dood te wees, wat dikwels 'n psigiatriese siekte toon, waar verskeie negatiewe psigososiale faktore teenwoordig is en wat gevoelens van hopeloosheid ervaar;
- 'n Groep waar die poging minder gevaarlik is, maar waar dit dikwels deur 'n akute interpersoonlike krisis presipiteer word. Dit is meestal meisies van 'n jonger ouderdom, sonder 'n formele psigiatriese siekte. Hulle poog gewoonlik om iets te bereik in hul onmiddellike omstandighede.

Cohen-Sandler *et al* het 76 kinders met òf 'n selfmoordpoging of 'n depressie, òf met 'n depressie en/of 'n psigiatriese siekte vergelyk. Die kinders met 'n selfmoordpoging het meer dikwels depressie getoon en 'n stygende en opvallende verhoogde stres ervaar namate hulle ouer geword het, insluitend 'n aantal spesifieke en ontwrigtende gesinservarings wat tot verliese en skeiding van hul belangrike mense gelei het.

Die selfmoordmetodes wat gebruik word, is by meisies meer dikwels middelinname, veral middels soos salisilate, parasetamol of psigotropiese middels. Die eerste twee groepe is vryelik oor die toonbank te koop en lg. is dikwels aan die ouers voorgeskryf. Kommunikasieprobleme is algemeen en die onmiddellike presipitant is gewoonlik 'n verhoudingsprobleem (76 persent met ouers, 58 persent met die skool, 52 persent met 'n nooi of kêrel), dikwels met meer as een persoon gelyktydig.

Toolen beklemtoon dat die kind dikwels meer kwaad lyk as depressief. Net na die poging mag hulle tydelike verligting van hul simptome ervaar. In vroeë adolessensie mag 'n depressie gemaskeer word deur voordoengedrag of misdadigheid. Ouer kinders mag middels, alkohol of seks gebruik om hul pynlike depressiewe gevoelens te onderdruk of mag verveeld of rusteloos wees en 'n onvermoë toon om alleen te wees.

By navraag kan 'n onderliggende depressiewe toestand geidentifiseer word: 'n gemoedstoestand wat vir ten minste 2 weke daagliks teenwoordig kan wees en etlike ure per dag duur. Die geskiedenis word by die kind self gekry. Dit is opvallend hoe min ooreenkoms daar tussen die kind en die ouer se weergawe van die kind se gevoelens is. Die ouers ontken dikwels patologie weens die swak empatie en kommunikasie, uit skuldgevoelens of weens hul verhoudingsprobleem met die kind. 'n Persentasie van die ouers is dikwels self bedruk.

Minstens vier van die volgende simptome moet ook met die depressiewe gemoedstoestand teenwoordig wees om 'n major depressiewe episode te diagnoseer:

- Gewigsverandering, swak eetlus of opvallende gewigsverlies (sonder dieet) of 'n gewigstoename;
- Slaaploosheid of vermeerderde slaap;
- 'n Verlies aan belangstelling of aan genot in die alledaagse aktiwiteite;
- Energieverlies en 'n gevoel van moegheid;
- Gevoelens van waardeloosheid, selfbeskuldiging of ontoepaslike skuldgevoelens;
- Konsentrasieverlies by die skool en tuis;
- Herhalende doods- en selfmoordgedagtes;
- Psigomotoriese agitasie of vertraging.

Dikwels is die skoolprestasie swakker en sosiale onttrekking mag plaasvind.

Die voorkoms van psigiatriese toestande, bv. alkoholisme, depressie en huweliksonmin, by die ouers is hoog. Die gesin mag 'n geslote gesinsisteem vorm wat intimiteit buite die gesin belet, maar die kind binne die gesin isoleer. Die ouers is rigied en koud in onderhandelings met die kind, en toon 'n lae toleransie vir 'n krisissituasie.

Behandeling

Primêre voorkoming Beter diagnose en behandeling van depressie asook beter ondersteuning en behandeling van swak funksionerende gesinne is noodsaaklik. Meer nagraadse seminare aan algemene praktisyns, gemeenskapsusters, maatskaplike werkers en onderwysers moet aangebied word. Die instelling van besprekingsgroepe in skole om tegnieke soos o.a. probleemidentifisering, alternatiewe modelle vir probleemoplossing, konflikhantering, stres-immunisasie, ens. aan te leer kan die jeugdige help om krisissituasies te hanteer.

Sekondêre voorkoming Mediese noodbehandeling soos aangedui deur die tipe middel en sy newe-effekte moet beskikbaar wees. Meer effektiewe en gedetailleerde evaluasie van die adolessent, die gesinsituasie, die psigiatriese status van die ouers en die wese van die gesinsinteraksie is noodsaaklik. Tydens die inisiële evaluasie moet die geneesheer probleemgeoriënteerd wees en goeie terugvoer van sy begrip van die probleem aan die adolessent en sy gesin gee. Die gevoel van verligting by die adolessent moet nie verkeerdelik as verbetering vertolk word nie. Tydens die krisis is daar 'n tydperk van disorganisasie van die pasiënt se persoonlikheid waar sy bestaande probleemoplostegnieke onvoldoende is en waar krisishantering dus meer effektief is. Indien die pasiënt egter in die hoë risiko-groep val, is hospitalisasie aangedui.

Probleme

Oorwerkte nooddiensspan Mehr *et al* wys daarop dat die oorwerkte nooddiensspan dikwels die besluit moet neem of die adolessent huis toe moet gaan of opgeneem moet word. Studies toon dat waar die pasiënt ontslaan word met vae aanduidings om psigiatriese hulp te kry, dit meestal nie gebeur nie en die jong mens so terugkeer na die omgewing wat aanvanklik sy selfmoordgedrag gekataliseer het.

Opvolgstudies toon dat pasiënte wat nie verdere hulp ontvang het na die inisiële noodbehandeling nie, 'n swakker prognose het as die groep waar een of ander vorm van kontak behou is. Dit is dus belangrik om 'n vroeë terapeutiese binding te vorm en as afsprake misluk, is 'n tuisbesoek aangewese.

Motivering van pasiënt en gesin Daar is ambivalensie en soms weerstand teen hulp by hierdie kinders en hul gesinne. Kulturele waarde word geheg aan selfhelp, simptome word weggerasionaliseer, daar is dikwels 'n gebrek aan simpatie by die ouers en 'n neiging om psigiese stres aan eksterne of vorige ervarings toe te skryf. Dié faktore verlaag die waarskynlikheid dat hulle hulp aanvaar, daar hulle voel dat dit aan faktore buite hul beheer toegeskryf kan word.

Verhoudingsbou Toolan toon dat hierdie kinders gebruik maak van ontkenning en projeksie as hoofverdedigings om hul gevoelens van depressie te vermy. Baie geduld mag nodig wees, want hul gedrag mag tartend wees. Hulle wil graag 'n nabye verhouding vorm maar vrees dit, want hulle vrees om dit weer te verloor, soos hulle alle vorige verhoudings verloor het. Die vorming van 'n verhouding is egter essensieel. 'n Algehele vertroue in die terapeut help hulle om die krag te kry om die pynlike verliese en gevoelens van onwaardigheid onder oë te neem.

'n Major depressiewe episode moet erken word aan die kriteria daarvoor voordat antidepressiewe behandeling gegee word. Wag 'n paar dae en doen eers 'n evaluasie van die totale beeld voordat antidepressiewe behandeling toegepas word. Daar is geen aanduiding vir oorhaastige behandeling met middels nie.

Indien middels voorgeskryf word, moet voorsorg te alle tye getref word dat die adolessent nie toegang daartoe het nie. Die middels word aan 'n verantwoordelike volwassene gegee, wat dit in bewaring moet hou en toedien. Nadat goeie ontleding van emosies plaasgevind het, gesinsinteraksies waargeneem is en 'n empatiese vertrouensverhouding gevorm is, moet die geneesheer sensitief en belangstellend, maar ferm bly. Die probleem word dus geidentifiseer en alternatiewe oplossing geëvalueer en 'n taakgeoriënteerde optrede beplan.

Kognitiewe terapie is van waarde. Irrasionele idees word geidentifiseer, bv. waar selfmoord gesien word as die enigste oplossing vir 'n andersins hopelose probleem. Pasiënte word gehelp om hul redes om te lewe of om dood te gaan te evalueer. Spesifiek alternatiewe oortuigings word ontwikkel en rasionele selfgesprek word geoefen. 'n Tipiese wanopvatting is dat hulle die wêreld op 'n alles-of-niks-wyse ervaar. Hulle oorveralgemeen en doen selektiewe abstraksies. Hulle toon 'n negatiewe self- en wêreldbeeld. Hulle ontken dat hulle ooit gelukkig was of kan wees. Alle interaksie met mense of die wêreld word as vernederend of as gering gesien. Positiewe en neutrale ervarings word ontken of geignoreer. Wanopvattings soos "Ek moet geliefd wees en aanvaar word deur alle belangrike persone; anders is dit aaklig", kan vervang word met "Dit sou lekker wees, maar selfs daarsonder kan ek nog myself en ander aanvaar en die lewe geniet".

Alternatiewe probleemoplossende strategieë word geidentifiseer en kan dan deur tegnieke soos o.a. rolspel geoefen word. Tipiese krisissituasies wat mag ontstaan en waarmee hulle gekonfronteer kan word, word geidentifiseer, oplossings uitgewerk en selfhandhawende gedrag geoefen as 'n vorm van stresimmunisasie. Die wanaangepaste oneffektiewe response word herken en kognitiewe selfkontroletegnieke, bv. om angs te beheer, word geoefen. Adolessente met selfmoordgedrag mag 'n nie-selfgeldende gedragswyse toon en selfhandhawingsopleiding mag nodig wees.

Gesinsterapie is dikwels nodig. Richman vind na 14 jaar van gesinsterapie aan pasiënte met 'n selfmoordpoging en hul gesinne dat daar dikwels interne simbiotiese bande met 'n vrees vir skeiding is, wat hulle dan behandeling laat saboteer. Hul oordrag is ambivalent en hulle gee dubbele boodskappe. Die kind kan nie na die gesin draai om hulp nie, maar word ook verbied om dit van ander te kry. Dikwels word die boodskap deur die gesin aan die pasiënt gegee dat hy homself moet doodmaak. So 'n kind sal dikwels eerder woede verduur as onttrekking of verlating, want dit herroep die ondraaglike ervaring van verlies en skeiding.

Verbale sowel as nie-verbale kommunikasie in hierdie gesin is erg versteurd. Verwerping is algemeen. Rolrigiditeit is prominent. Sodra die kind sy rol (bv. swartskaap) probeer verander, word hy dikwels drasties teruggedwing. Die pasiënt moet gehelp word om meer gedifferensieerd en realisties te wees in sy rolgedrag. 'n Gebrek aan empatie deur die gesin teenoor die kind is opvallend.

'n Risikopasiënt Die risiko vir ware selfmoord is hoog by blanke manlike adolessente met 'n hoë intelligensie wat reeds 'n selfmoordpoging aangewend het, opvallend bedruk is, 'n geskiedenis van antisosiale gedrag het, dwelms of alkohol misbruik, 'n familiegeskiedenis van selfmoordgedrag het, die selfmoordgedrag wegsteek, 'n metode gebruik met 'n hoë potensiaal van dodelikheid of wie se poging dui op beplanning, asook kinders wat wegloop van hul huise af.

Stanley en Barter toon in 'n kontrolestudie dat adolessente met selfmoordpogings in 50 persent van gevalle hul destruktiewe gedrag bly voortsit na ontslag.

Die algemene praktisyn bly die eerste kontakpunt waarheen kinders en adolessente met 'n selfmoordpoging gaan en wat dus die geleentheid het om die pasiënt en sy gesin te behandel of te laat behandel.

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English Summary

The increasing incidence of suicide and suicide attempts in the youth of various countries has made it necessary to take a hard look at the reasons for this phenomenon so that it may be better identified, treated and prevented.

Children under 10 years rarely commit suicide but there is a rise in its occurrence in youths aged 15-19 years. Suicide attempts are commoner in girls. Attempted suicide is the commonest symptom with which adolescents present at Tygerberg Hospital.

Three models have been used to explain suicide – the psychodynamic model, the sociological model, and the psychiatric illness model. They are not mutually exclusive. Attempts have also been made to show that there are biochemical changes in the central nervous system that play a part in depression and suicide.

Suicide is commoner in boys aged 12 or more. Attempts at suicide are often preceded by emotional and antisocial behavioural changes. There is also a familial trend in these children.

Children who make suicide attempts can be divided into two groups, a group intent on dying and often showing signs of psychiatric illness and a group making a less dangerous attempt often precipitated by an acute interpersonal crisis. The latter are usually younger girls with no signs of former psychiatric illness.

Underlying suicide attempts are problems of communication and relationship, together with a depression uncovered by questioning the child and often unrecognised by the parents.

A number of symptoms are linked to depression; they include changes in weight, poor appetite, insomnia or increased sleepiness, loss of interest in or enjoyment of everyday activities, loss of energy, feelings of unworthiness or

guilt, lack of concentration at school or at home, repeated thoughts of death and suicide, and psychomotor agitation or retardation. Often there are also signs of disturbance in the parents.
There is a need for better education of medical practitioners and other members of the health and welfare team in all aspects of primary and secondary prevention. Problems encountered include staff overload which hampers assessment of the patient by the emergency team, motivation of the patient and the family, and construction of relationships between the therapist and the child. There are also problems associated with medication, cognitive therapy and family therapy.
Patients at the highest risk of suicide are white male adolescents with high intelligence and a history of a suicide attempt and of antisocial behaviour, drug or alcohol abuse, and a family history of suicidal behaviour, particularly if they use a method with a high potential for fatality or whose attempt indicates prior planning.
Finally, since the general practitioner is usually the first point of contact for children and adolescents who make suicide attempts, he has the best opportunity to treat or to refer for treatment the patient and his family.

Situations Vacant

REGISTERED SOCIAL WORKER
Home for 65 boys aged 10-18 currently housing 29 requires a Social Worker who should preferably be bilingual and have experience working with children. This important post offers commensurate salary, medical aid and other fringe benefits. Telephone the Principal, St John's Hostel, on 021-23-1316.

Situations Wanted

Staff Nurse, 16 years with Cape Town City Council Clinics, Standard 10, Certificate in Family Planning, one-year diploma in Psychology, widow (51) seeks position in child care. Contact Mrs Marian Bloys at P.O. Box 769, Westridge, Mitchells Plain 7832.

Houseparent post sought in Cape Town area. Available end January 1987. Contact Mrs A.J. Correia, 10 Saddle Road, Devil's Peak, Cape Town 8001.

Young single man available from July Ist 1987 seeks child care position with view to career. Good references, three-and-a-half months' previous experience. Contact Noel Pratten at P.O. Box 1, Simonstown 7995 or telephone 021-86-2818.

Child care position sought in Cape Town area from 1 Frebruary. Contact Ms C. J. Hanssom, 21 Mortimer Gardens, Twilley Street, Kenilworth 7700 or Telephone 021-61-2112.

A Contextual View of Psychosexual Development

Marina Petropulos
The Facts of Life
Tafelberg, Cape Town

Marina Petropulos' first book *Baby and Child Care* has been an invaluable source of information to thousands of South African parents, including myself. This, her second book, is likely to become as widely read and re-read.
In the foreword, it is claimed that this book, on the physical and psychosexual development of adolescent boys and girls, is essential reading both for those working with young people ,and for young people themselves. In my opinion such a book should firstly convey in understandable language as much practical information as possible. The reader who then chooses to disregard this information will at least know about the consequences of his actions. Secondly, such a book should provide the reader with the opportunity of clarifying attitudes towards him/herself, towards sexuality and towards human relationships. Readers may then begin to define their own value system and act accordingly. In my opinion Petropulos succeeds in both these functions.
Apart from the clarity of her language and presentation, she succeeds because she continually links biological facts and their practical implications to more intangible issues like self-esteem and interpersonal respect. In doing so she never becomes dogmatic or moralistic; she shows how knowledge of biological and medical facts speaks for itself, enabling one to enhance autonomy and avoid moralising.
After the introduction, Chapter 1 deals with the physical and biological changes of adolescence in boys and girls. The myths surrounding issues such as masturbation and menstruation are dispelled, and factual information is provided. Practical hints are also offered (for example to girls dealing with menstruation for the first time).
Chapter 2 deals with body-image issues. Information and selective but sound advice is offered on hair care and dealing with hair, diet and slimming, exercise, and acne and skin care. There is also a brief discussiion on eating disorders.
Chapter 3, "Getting your mind right", deals with self-respect and factors influencing ego and psychosexual development. Some child care professionals will need to know that no attempt has been made to deal with issues arising from extreme socio-economic deprivation.
Next is a discussion on physical and emotional aspects of sexual attraction, sexual arousal and the processes of orgasm and ejaculation. This leads into the next chapter which discusses the age-old distinction between lust, infatuation ("love-sickness") and love. Readers are indirectly challenged to examine their motivation for becoming sexually involved. Common ill-considered reasons for sexual involvement are discussed after which some fundamental aspects of a responsible, respectful attitude to (sexual) relationships are presented. This chapter achieves a delicate balance between down-to-earth realism and a sensitivity to emotional and relationship issues which should appeal to the inner sensitivities of young people. A review of the symptoms, possible causes and treatment of male and female sexual problems concludes this chapter.
The next chapter deals with the biology of conception and contains a comprehensive review of the facts, myths and methods of contraception. While she has provided sufficient information to enable young people to avoid unwanted pregnancies, the author knows that some unwanted pregnancies will still occur. She proceeds to discuss the choices available to young "unplanned parents". Abortion, adoption, the rights of the unmarried mother and legal obligations of the father are discussed in sufficient detail. Here the facts speak for themselves and should enhance a responsible attitude towards sexual intercourse.
Inevitably there is a comprehensive, up-to-date chapter on sexually transmitted diseases, followed by the final chapter – "Everything else you wanted to know". This chapter deals briefly but informatively with alcohol, cosmetic surgery, homosexuality, incest, rape and many other issues. There is a glossary of definitions of relevant terms, and a list of organisations to which the reader may turn for help in a wide range of problem situations.
In order to test the response of adolescents to this book, I lent it to a 16-year-old girl at Tenterden. She read it eagerly and it is still elusively doing the rounds – going from adolescent to child care worker and back. We must remember that psychosexual development cannot come from books but evolves in a network of influences of which stable relationships are the most important. Nevertheless, this book provides an excellent basis for disussion between child care professionals and adolescents, regardless of religious persuasion. It is indeed essential reading for parents, young people and helping professionals working with young people.

Peter Powis