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Die kinderversorger

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CLAREMONT 7735
Tel: 021-790-3401

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P.O. Box/Posbus 8021
JOHANNESBURG 2000
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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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Kollega — Waar is Jy?

Weet u dat hierdie tydskrif, *Die Kinderversorger*, enig van sy soort is? Ja, selfs Amerika het nie 'n dergelike professionele tydskrif, spesifiek gerig op die breër veld van kinderversorging nie. Daar is byna geen boeke in Afrikaans beskikbaar in die veld nie en ingevoerde boeke is skaars en baie duur.

Nou vra ek hoe word kennis i.v.m. kinderversorging oorgedra? Is hierdie tydskrif nie die belangrikste hulpmiddel in die opleiding van kinderversorgers nie? Die bekendstelling forum vir ons idees en projekte wat suksesvol is nie?

Ek is self 'n maatskaplike werkster, "Stellenbosch Afrikaans", en betrokke in die veld van kinderversorging. My Afrikaanse kollegas, hierdie maand sal net my noodoproep en die gewelnaam van hierdie Suid-Afrikaanse, tweetalige tydskrif in Afrikaans verskyn. Op ons onlangse redaksionele vergadering was daar nie 'n enkele Afrikaanse bydrae vir oorweging nie. Selfs ons rondgeskarrel na bestaande artikels in ander tydskrifte was nutteloos, omdat hierdie bron ook uitgeput raak. Maar besef u dat sestig persent van kinderversorging in Suid-Afrika in Afrikaans gedoen word?

Ek kom gereeld in kontak met Afrikaanse kinderhuise, met professionele kollegas in gesinsorganisasies, met studente en glo dat u 'n geldige en verdienstelike bydrae het om te maak. Ek hoor gereeld van waardevolle en interessante nuwe werk wat gedoen word in die veld. Behoort u ondervinding nie ook genoteer te word nie?

Dit is nou tyd dat elkeen van ons ons bydrae maak in die uitbouing van kinderversorging kennis en in die opleiding en ondersteuning van kollegas wie se roeping die toekoms van vele minderbevoorregde kinders is.

Renée van der Merwe

New Blood

Those who drew up the Constitution of the NACCW would probably not lay claim to such foresight which, in retrospect, can be seen to have given the Association a valuable structural continuity. In "odd" years, that is 1977, 79, 81, 83, 85, etc., the Biennial Conference sets policy directions and elects the National Chairman, and then in "even" years the Regions elect their Chairmen and Executive Committees. The effect of this is that Regional Executives remain in power for a full year after National Conferences which gives them time to implement decisions and policy guidelines from Conference. It also means that new Regional Executives have been in power for a full year before National Conferences, which means that they arrive as informed and experienced delegates at Conference. Regional elections in fact also affect the national leadership since the chairmen of the Regional Executives are automatically members of the National Executive Committee. As it happens, three of the four Regions now have new chairmen, which significantly alters the composition of the National Executive Committee which is therefore (a) representative of the Regions and (b) is not allowed to grow stale. In the Transvaal, Ds Rudolph van Niekerk gave over the reins to Jacqui Michael, in the Western Cape Ashley Theron took over from Vivien Lewis, and in the Eastern Cape, Barrie Lodge has replaced Roger Pitt. Fresh from the Regional hustings, these three new members bring valuable new blood to our national body.

This review of events, far from being a lecture in Constitutional History, serves to emphasise the role of the NACCW as *your* Association. What it does and what is says must reflect the membership at grassroots level. It cannot, of course, please all of the people all of the time, but if the NACCW is not doing something you would expect from it, the national leadership is as near as your Regional chairman and the professional staff are as near as your post box or your telephone.

Briewe

Graag wil ek baie dankie sê vir die insiggewende artikels in Kinderversorger. Ek verwys spesifiek na *Kindermishandeling* en *Handling Sexual Abuse in Residential Care* in die Februarie 1987 uitgawe. Wat ek veral waardevol vind, is die feit dat die artikels feitegerig, kernagtig en nie onnodig lank is nie.

Ek het onlangs 'n werkseminaar aangebied vir Kleuterskool Onderwyseresse, en kon beide artikels *baie* sinvol aanwend. Ek meen ook dat die voorkomingsgerigtheid baie belangrik is.

Die verdeling tussen Afrikaanse en Engelse artikels is ook baie gesond.

Weereens, my hartlike dank. Met vriendelike groete.

Die uwe

(Mev) M. Knoetze
Praktykopleier/Supervisor

Christelik-Maatskaplike Raad
Kaapse Skiereiland
Parow

Management of Crisis Situations

M. Vera Bührmann

M. Vera Bührmann is Part-time Consultant at the Child and Family Psychiatry Unit at Red Cross War Memorial Children's Hospital and Psychotherapy Supervisor in private practice

My reasons for this choice of subject are partly personal and partly the extensive changes in modern society.

The personal reasons are that during 1984, within a relatively short period, I received several requests for advice on the management of survivors in families who had experienced some crisis in connection with traumatic and violent events and/or from families in which violence had become a real menace. In my work as supervisor/counsellor several crisis situations also had to be dealt with.

In thinking about these cases I became acutely aware that during the past 20-30 years society and the world scene had changed dramatically. We are living with, and have to adjust to, increasing violence and major and dramatic events affecting the lives of children, such as family murders and car accidents that wipe out several family members but also leave survivors. There is increasing mobility of families, and increases in parental suicides, the divorce rate, terrorism, public violence and general violence in families often leading to wife and child battering. Traumatic and painful events to which young men serving on the border are exposed must also be considered when we talk about crisis situations.

It seems to me that caretaking personnel and organisations are poorly equipped to deal with these situations. For humane and preventive reasons this should be rectified.

Our surgical colleagues have made rapid strides within their own disciplines. At the major hospitals casualty and accident units have been established where usually efficient and highly skilled assistance is given, and cases requiring more intensive and prolonged treatment are accommodated in hospital. Severed limbs are re-attached, with the aim of full restoration of function. Plastic surgery is done on even minor injuries so as to leave no ugly scar.

I ask myself why such prompt attention is not given to psychic injuries, why the efforts to prevent psychic scars are so feeble, and why so little is done for children who suffer a loss or injury of some kind?

We are living with, and have to adjust to increasing violence and major and dramatic events affecting the lives of children.

The answer is not simple because the psyche is more complex than the body and because it is such an emotional and subjective area that objectivity is difficult to maintain. Kliman states, 'the psychological fact is that death of a loved person is a hazard to the mental health of the survivor or survivors'. There are numerous studies to confirm this. Why is this fact not acted on?

How often do the abovementioned trauma units call on mental health personnel to assess the psychological situation when they deal with the casualties? By this I do not mean attention to the injured person only but to assess the total situation and its effect on the rest of the family.

I think we have failed to pass on our knowledge to other disciplines and to thus increase their awareness. I fear that one of the reasons is that this kind of work is low on our list of priorities and that professional people in general are loath to really share the pain and suffering of bereaved and injured people.

There is a general 'stiff upper lip' attitude.

There is a general 'stiff upper lip' attitude. We as child psychiatrists get involved only when children are referred to us when some kind of maladaptive behaviour has become firmly established following a traumatic experience. Often the link between behaviour and event is not made and the children are brought only because the parent or relative cannot cope any more. By that time it is already a psychotherapeutic problem and a full-blown neurosis may have developed. In many cases a pre-existing neurosis is present which is then exacerbated by events that have not been dealt with promptly. This has been demonstrated by several research workers.

Prompt attention and planning for future management need not be very time-consuming. From a large volume of research certain situations or combinations of events most likely to give rise to subsequent pathology have been isolated. Simple informative lists have emerged. These can be used at any trauma or casualty unit. Therefore, although we have little time at our disposal it should be possible to come to some decision about management. This does not require a high degree of skill but certainly some special training.

The full psychodynamic assessment of the individual and the family is more time-consuming and requires considerable skill. It is not known in how many cases this will be required if prompt attention is given to the crisis in the first instance. In this area the main thrust should be towards increasing awareness in several other disciplines, the assumption being that greater awareness of the pathological sequelae will lead to sympathetic and meaningful interven-

The family doctor should resist the temptation to prescribe tranquilisers and rather lend a listening ear and encourage those involved to ventilate their feelings.

tion at an early stage. The family doctor should resist the temptation to prescribe tranquilisers and rather lend a listening ear and encourage those involved to ventilate their feelings. Other key people are the clergy, who are always involved to a greater or lesser

extent, teachers, parents and substitute parents and a variety of caretaking personnel.

Crisis intervention is not to be confused with first aid, except in so far as it consists in prompt assessment of the situation and deciding on the likely degree of disequilibrium to be expected in those involved. Its aim is to restore the previous balance of the individual or the family. If it appears that the child or the family had never functioned well, the case becomes one for psychotherapy and this is not the aim of this commentary.

Teamwork without consideration of prejudices, rivalry or status is essential in crisis intervention. The person best suited to do the job should become the facilitator or educator. Such a person should have the ability to enter into the life and situation of the individual, family or group to alleviate the impact of the crisis inducing stress in order to help mobilise the resources of those directly affected as well as those who are in the significant social orbit. It seems to me that social and cultural closeness could be more important in this context than professional status.

Immediately after the event and during the acute phase people are usually emotionally more accessible to help and advice than they would ordinarily be, because their ego defence mechanisms have been disturbed and are functioning less effectively. They can therefore be assisted with a minimum of intervention. I have experienced this in a variety of crisis situations, for example, after failed suicides and in mother/child relationships during infancy when the mother's coping mechanisms break down and the infant stirs up feelings the mother is not ordinarily aware of or can usually keep under control.

Because the ego is temporarily more open to outside influences, educators or helpers should guard against behaving in a way or saying things that may be wrongly interpreted, for this is a period of great psychic vulnerability and sensitivity. In most crisis situations during the stage of disequilibrium there is a recognisable pattern that facilitates management and prognosis, including the well-known stages of impact, recoil, adjustment, or in some cases maladjustment.

What happens to children if the necessary early understanding and support are not provided? In general terms it can be said that they resort to pathological defence mechanisms that are often regressive in nature, such as splitting, dissociating, repression and denial. If they are not given an opportunity to become acquainted with the true facts and to express their own concepts, thoughts and feelings openly they respond with rich and usually unrealistic fantasies. This can absorb so much libido that little is available for the normal activities of childhood and they may appear listless and depressed. Their response will depend on a multitude of factors that cannot even be touched on here. An obvious one is that they start failing in their schoolwork.

In one family that recently came my way all the children, one after the other, were noticed to fail in their schoolwork. This was a happy well-adjusted family with several children before the youngest died tragically. At home, the surviving children, all under 14 years of age, tried to appear alert and coping, so as not to cause their parents more distress, thus protecting the parents. The teachers had to draw the attention of the parents to the poor achievement of the youngest who was then taken to a child psychiatrist with so-called 'learning problems'. With a few interviews and some parent counselling there was rapid improvement. The same sequence of events followed with two others. In the end the oldest child said to his mother, 'I'm not failing at school but I also need help and also have to talk'. The mother said, 'but we are tahe answered, 'No we're not, you don't know how guilty I feel inside, you don't know about my bad dreams, you don't know how often he comes to me in my dreams', etc., etc. It was therefore clear that there was some kind of communication but it was at a superficial level that did not touch the split-off repressed material.

Another recent case was that of a family murder where one seriously wounded child survived. On discharge from hospital he went to live with a sympathetic family who were involved in the tragedy. They thought he was coping well until a mutual friend came to me and expressed concern about the child's clowning on his bicycle in the streets and the danger of his being run over. During a discussion the caretaking father expressed surprise when asked about psychological help after the event. He thought that this had been attended to while the boy was in hospital for his physical injuries. Poor communication was again obvious. It eventually emerged that they were all so depressed that they were not communicating properly, and were deaf and blind and not available to each other.

These and other cases have demonstrated to me the need for help from outside the family. Those who are too closely involved do not have the objectivity to assess needs and are usually coping with their own state of disequilibrium and mourning.

Apart from improving our existing skills and expanding the network of helpers or educators by improving their effectiveness, I wonder if we cannot learn something from the funeral rites and management of bereavement from our black compatriots. This entails lengthy support, with 2 weeks of intense family and community involvement that decreases in intensity until it ceases at the end of 3 months.

After a period of regression ever-increasing demands are made on healthy ego-functioning and coping is actually encouraged. It must be kept in mind that successful coping with a crisis, an emergency, or any threatening situation is ego strengthening. These situations must be accepted as unavoidable parts of life, presenting with dangers as well as opportunities.

Intervention must be effective but minimal so as to give the people concerned the opportunity to find their own strengths.

My plea is therefore that our intervention should be geared towards preventing unnecessary suffering and future pathology. It must be effective but minimal so as to give the people concerned the opportunity to find their own strengths. Briefly, it aims at:

- Bringing comfort for humane reasons
- Reducing anxiety to manageable proportions
- Assisting the ego with mastery and reality orientation to reduce the mushrooming of fantasies
- Promoting open and reality-orientated communication.

I see the role of the child psychiatrist in crisis intervention as the educator and guide of other disciplines. He cannot be directly involved in all the traumatic events that occur in the lives of children, but as a child and family psychiatrist he is in a unique position to have a wide overview. It is presumed that he is well acquainted with child, adult and family psychodynamics. In addition, he must be well aware of what this kind of work stirs up in caretaking personnel. Many people have psychic scars from unresolved traumatic events in their own lives and they may find this kind of work too painful. Their ego defences are threatened; they either withdraw, fortify their ego defences and remain cold and distant, or they identify to the extent that they lose the required degree of objectivity.

The psychiatrist must therefore be aware of the multiplicity of psychic and other factors that can help or hinder this work. Each case is unique, often with a long pre-history that cannot be ignored.

References

Kliman, G. *Psychological Emergencies in Childhood* London: Grune & Stratton, 1968.

Cain, A.C., Fast, I. Children's disturbed reactions to parent suicide *Am J Ortho-*

psychiatry 1966, 36: 873-880.

Further Reading

Bowlby, J. Violence in the family as a disorder of the attachment of care giving systems *Am J Psychoanal* 1984, 44: 9-27.
Rosenblatt, B. A boy's reaction to his sister's death *J Am Acad Child Psychiatry* 1969, 8: 321.
Cain, A.C. Legacy of suicide: observations on the pathogenic impact of suicide upon marital partners *Psychiatry* 1966, 29: 406-411.

Opsomming – Hantering van krisissituasies

Ons samelewing en die wêreld het gedurende die afgelope 2 of 3 dekades dramaties verander. Ons moet saamleef met en aanpas by toenemende geweld wat gesinne ernstig ontwrig. Ouerselfmoord, egskeiding, toenemende gesinsverhuising, openbare sowel as private geweld, waaronder voorvalle binne die gesin, veroorsaak almal krisissituasies. Nietemin skenk die mediese professie, wat oor die kundigheid beskik, binne en buite hospitaalverband baie min aandag aan die voorkoming van geestelike letsels wat deur hierdie krisissituasies ontstaan, deels omdat professionele mense nie graag in die pyn en lyding van bedroefdes en beseerdes deel nie. Die kinderpsigiater word gewoonlik eers betrek wanneer die kind verwys word nadat die een of ander abnormale gedragpatroon stewig gevestig geraak het a.g.v. 'n troumatiese ondervinding. Die kind word verwys omdat die ouer of familielid hom nie langer kan hanteer nie, maar teen dié tyd het 'n volwaardige neurose moontlik reeds ontwikkel.
Stipte aandag aan 'n krisis en beplanning vir die toekomstige hantering daarvan hoef nie baie tydrowend te wees nie; dit kan selfs in die ongevalle-afdeling moontlik wees om 'n besluit oor hantering te neem. Volledige psigodinamiese evaluering van die individu en die gesin verg meer tyd en aansienlike vaardigheid – 'n situasie wat vermy kan word indien die krisis ten aanvang behoorlike aandag kry. Krisisingryping is gemik op 'n herstel van die ewewig van die individu of die gesin en vereis spanwerk sonder vooroordeel, wedywering of statusoorweging. Indien vroeë begrip en ondersteuning nie gebied word nie, kan 'n kind hom tot patologiese verdedigingsmeganismes wend, bv. druip van skoolwerk. In sulke gevalle sal die gesin te nou betrokke wees en buitehulp sal verkry moet word. Sodanige hulp van buite moet doeltreffend, maar minimaal wees om aan alle betrokkenes die geleentheid te bied om hul eie krag te ontdek. Die kinderpsigiater moet as opvoeder en gids optree teenoor die ander lede van die span.

School Phobia

I. Goolam Hoosen

Dr I Goolam Hoosen is a psychiatrist at Addington and King Edward VIII Hospitals in Durban. He is also part-time lecturer at the University of Natal

Prolonged or recurrent absence from school is a serious cause for educational concern. Poor attendance from school falls under three main headings:
1. In association with serious or chronic physical illness.
2. In association with social malaise. Here two subgroups have been identified, namely: (i) children kept at home by their parents or staying at home for domestic reasons, and (ii) truancy.
3. As a symptom of a major psychological syndrome:
- Syndromes with school refusal as the *most prominent symptom*. These are divided into three sub-categories: (i) a separation anxiety, also called school phobia; (ii) specific fear of school and schooling; and (iii) part of a complex widespread neurosis.
- Syndromes with school refusal as a subsidiary symptom – this occurs in two major conditions in childhood, depression and schizophrenia.

Since it was first noted in the literature there has been controversy about all aspects of school refusal. It is not certain whether the disorder is a single syndrome that presents with a variety of symptoms or a variety of syndromes with a common presenting symptom.
Illness is much the commonest reason for school absence. Failure to attend school despite the physical capacity to do so takes many forms. Two important forms have been truancy and school refusal (school phobia).

Distinction between truancy and school refusal

It is clinically important to distinguish truants from school phobics. It has been shown that the families of the school phobics have a higher rate of family neurosis; the school phobics have had less experience of maternal absences; they are exposed to more consistent but a rather over-anxious type of discipline, and come from smaller families. In the case of truants, the rate of neurosis in the family is said to be lower; they are exposed to more parental absences, especially of the father; the discipline is less consistent and the family is larger. At school the phobic children's work is considered to be of a good standard and when actually at school they conform more; they have had less frequent changes at school, and when not at school they display considerable concern about the work they are missing. As regards personality, phobic children were found to be passive, dependent and overprotected. The truants' work at school tends to be poorer, their behaviour more undisciplined and they also have had more frequent changes of school; finally, they tend to lack concern about poor attendance.

Clinical features of school phobia

School phobia is a type of school refusal in which the child has a fear or dread of going to school that is both conscious and unconscious. The fear may be of the entire school environment or may be focused on a specific aspect such as a teacher, tests, or even the toilets.
The problem often starts with vague complaints of school or reluctance to attend, progressing to total refusal to go to school or to remain in school in the face of persuasion, entreaty, recrimination and punishment by parents and pressure from teachers, family doctors and social workers. The behaviour may be accompanied by signs of anxiety or even panic when the time comes to go to school and most children cannot even leave home to set out for school. Many who do, return home before reaching school and some children reach school but rush home in a state of anxiety. Many children insist that they want to go to school and prepare to do so but cannot manage when the time comes. An acute onset is commoner in younger children whereas older children and adolescents usually show a more insidious development of school refusal. Precipitating factors can often be found at all ages: a minor accident, illness or operation, leaving home for a school holiday, a move to a new house, a change of class or school, the departure or loss of a school friend, the death or illness of a relative to whom the child was closely attached.
All these events appear to represent a threat to the individual child, arousing anxiety he cannot control. In older children and adolescents there is often no abrupt or definite change in personality but a gradual withdrawal from peer group activities formerly enjoyed such as scouts, youth clubs and sporting activities. The youngster ceases to go out, clings to and tries to control his mother and may express a general fear or dislike of the world outside him. He may also

become stubborn, argumentative and critical in contrast to his earlier compliant behaviour and often his anger is directed against his mother. Frequently there is no clear precipitating factor other than a change to high school that may have occurred as long ago as the previous term. Very often the school refusal is one indication of the young adolescent's general inability to cope with the increased demands for an independent existence outside the family, and the entry into normal peer group relationships. The diagnosis is often missed when the clinical picture takes on a 'somatic disguise', necessitating a very careful assessment by the family practitioner to clarify the underlying problems. The most common complaints are gastro-intestinal, abdominal pain, nausea, vomiting or diarrhoea. Headache, elevated temperature, sore throat, dizziness or fear of fainting are less common. If the parents press the child to go to school he may become panicky and physically resist. If the child remains at home, anxiety quickly dissipates and somatic symptoms disappear. The child who has somatic complaints is usually obedient, does well in school and says that he would like to attend school but is unable to do so because of his illness.
These symptoms are usually worse on Sunday evenings or early on Monday mornings. At times the somatic symptoms are not actually experienced but fearfully anticipated, so that the child may avoid school in case he may faint or vomit in situations such as at the school assembly. School phobia can occur in an acute form, a transient episode or in a chronic form in which the child attends school despite feelings of discomfort but has frequent absences.

Prevalence
The prevalence of school refusal has proved difficult to establish because estimates based on clinic populations are grossly inadequate. It is known that family practitioners deal effectively with early or incipient cases of school refusal that never reach a specialised clinic. A national study of general practitioners revealed that four-fifths would themselves manage a straightforward case of persistent school non-attendance while only one-fifth would refer such children to a clinic. School refusal affects boys and girls equally and there is no social class bias although incidence seems to be higher in the middle and upper socio-economic groups, where much value and concern is placed on education.
Various studies show a pattern of prevalence that appears highest at three periods of school-going age: at entry and soon after between the ages of 5 and 7 years when it is probably associated with separation anxiety; at 11 years when it is associated with change of school and a variety of neurotic disorders; and again at 14 years and older.
It appears that the last group differs substantially from the other two in the type of severity of psychiatric disorder, the frequency of depression and in the outcome of treatment and prognosis. In younger children the school refusal appears to be a more discrete 'neurotic' episode whereas in adolescents the origin appears to be long, insidious and unrecognised. School refusal in adolescents tends to indicate more severe psychopathology with deeply internalised conflicts that usually reflect a 'characterological' disorder.

Differential diagnosis
Not all reluctance to attend school is school phobia. Some schools have incompetent or disturbed teachers. Usually a change of school or class relieves this condition. The child who is a truant has no conscious manifest anxiety regarding separation from home or attendance at school. However, the truant openly dislikes school and clearly enjoys not being there. He also avoids home, while the school phobic feels safest at home. The truant usually has done poorly in school while the school phobic has done rather well. Many truants come from families where education is not valued. A large percentage of truants also have associated learning disabilities.
The presence of learning disabilities can produce reactions that simulate school phobia. When children have done poorly in school for a long time they tend to withdraw from the source of their frustration, lack of success, and shame – the school. Thorough work-up of the school refusal is needed to discriminate between a true school phobic and an aversion to school based on a learning disability.
In some cases a transient episode of school refusal may be due either to an acute stress at home, such as the birth of a sibling or to the child's inability to cope with intrapsychic stress. Usually parents will recognise this as a transient state that requires firm yet supportive handling. Parents may keep children at home because family needs require that the child do housework or care for siblings. Education is unimportant to some parents. This attitude may be communicated and may lead to school refusal. Some severely disturbed parents keep their children home for their own pathological reason.
Depressed children may be reluctant or apathetic about attending school. This more severe disorder is usually accompanied by other signs and symptoms that are characteristic of childhood depression.
School refusal may also be one manifestation of an insidious psychotic process or a personality disorder, especially during adolescence.

Aetiology and psychological mechanisms
Because of the heterogeneity of the concept of school refusal there has been little agreement on the psychological mechanisms responsible for this disorder. Persistent non-attendance at school is most often a manisfestation of neurotic symptom formation. The term school phobia is used by those who explain the behaviour in terms of individual psychopathology based on the classic psychoanalytic theory of phobic symptom formation, arising from the externalisation of frightening impulses and their displacement onto a previously neutral object or situation which is then avoided, for example the teacher or the school.
Another explanation is based on learning theory that also emphasises individual psychopathology in which the learning of maladaptive responses through conditioning processes lead to avoidance behaviour maintained by fear and resultant school phobia.
Psychodynamically school phobia can be viewed as a problem of separation and individuation. It is usually based on conflicts originating with the home but is sometimes precipitated by something that has occurred at school. The essential problem for the mother and child is separation. A covert symbiotic relationship exists between mother and child. It is said that the mother has severe unresolved unconscious conflicts with her own mother that lead to a relationship that is intense, dependent, resentful and ambivalent. This unresolved conflictual relationship is played out with her own school phobic child. Quite often there are marital conflicts and disharmony in these families. Either parent may be indulgent and overprotective. Too often the parents subvert the school or the teacher, yet are overeager to blame the school. It may be that the child and parents may view separation as being akin to death so that the child must stay near the mother to ward off death. Many theorists believe that the child uses the mechanisms of 'splitting' – the mother is the 'all good' object while the teacher or the school is the 'all bad' object. This enables the child to deny the extreme ambivalence felt towards the mother.

Treatment
Most child psychiatrists regard school phobia as a psychiatric emergency. The child should not be kept out of school because the longer he stays at home the more difficult it becomes for him to return. If physical symptoms are present, a thorough medical assessment should be made. If no abnormality is found this should be stated in a forthright manner to the family and the child should be returned to school. It is important for the

child to know that he is expected to stay in school and that his parents are committed to this course of action. In some cases somatic complaints have led to hospitalisation and multiple surgical procedures. Here consultation with the paediatric and surgical staff is invaluable in dealing with the differential diagnosis.

Parents should be told that school phobia is a family problem. They must be helped to understand their role in the aetiology and the treatment of the disorder. The therapist, whether medical practitioner, social worker or psychiatrist, should make himself/herself available to parents particularly in the morning when the difficulty mainly occurs. He or she should also be available to school authorities so that the treatment plan can be implemented.

Individual treatment for the child supplemented by family sessions is usually quite beneficial. In some cases desensitisation techniques may be used. For example, it may be necessary for the child to go to school but not to the classroom, or to go to school for only a short time, or to meet the guidance counsellor each day before class begins. Imipramine (Tofranil; Geigy) or amitriptyline (Tryptanol; Frosst MSD) has been successfully used as part of a total programme to get the child back to school. The medication appears to enhance treatment by its effect on the separation anxiety and helps the child return to school. I have found in my practice a dosage of 50-75 mg at night most beneficial, although higher doses have been used. The child should be on the medication for about 6-8 weeks.

Treatment of adolescent school phobia requires a thorough diagnostic assessment followed by the possibility of a variety of treatment modalities – intensive psychotherapy, medication, and at times hospitalisation. On rare occasions separation from the family may be necessary to achieve success especially in those cases where there is an intense symbiotic relationship with the mother. Admission to an inpatient hospital unit ensures regular treatment in addition to the benefits of a therapeutic environment in mastering anxiety over separation experiences.

It is important to inform parents that once the child returns to school, treatment is not over but rather has just begun. When the child has returned to school the focus often shifts from the child to the marital relationship. Once the child returns to school family therapy sessions should commence and this eventually leads to marital psychotherapy.

It must be emphasised that for a successful outcome of treatment, close cooperation between the therapist, the parents and school personnel is imperative.

Prognosis

The outcome of treatment of school refusal is good whatever the modality of treatment utilised. In most treatment series the success rate has usually been two-thirds or more. The prognosis seems to be related to the severity of the disorder, age of the child and the time between the onset of symptoms and the beginning of treatment. The older the child the poorer the outcome. Children admitted to hospital also tend to be older with symptoms of longer duration and it is also likely that these patients and their families are more deeply disturbed and have not responded to outpatient treatment. Although the prognosis of the return to school has been shown to be good in the short-term, unfortunately the long-term outcome has not been bright. Many of these children and adolescents continue to have difficulty in personal and social relationships and several are still unable to sever ties with their families. It has been shown that a small proportion of children who present with problems of school refusal are at risk for psychiatric disorder in adult life, but most of these phobics will become normal adults.

Further Reading

Atkinson, L., Quarrington, B., Cyr, J.J. School refusal: the heterogeneity of a concept. *Am J Orthopsychiatry* 1985, 55:83-101.

Berg, I. School refusal *Br J Hosp Med* 1984, 31:59-62.

Coolidge, J.C. School phobia. In: Noshpitz, J.D. ed. *Basic Handbook of Child Psychiatry* Vol.2 New York, Basic Books, 1979, 453-463.

Gordon, D.A., Young, R.D. School phobia: a discussion of etiology, treatment and evaluation. In: Chess, S., Thomas, A. eds. *Annual Progress in Child Psychiatry and Child Development* New York, Brunner-Mazel, 1977, 409-433.

Hersen, M. The behavioral treatment of school phobia: current techniques *J Nerv Ment Dis* 1971, 152:99-107.

Hersov, L., Berg, I. eds. *Out of School: Modern Perspectives in Truancy and School Refusal* Chichester, John Wiley, 1980.

Hersov, L. School refusal. In: Rutter, M., Hersov, L. eds. *Child and Adolescent Psychiatry: Modern Approaches* 2nd ed. Oxford, Blackwell Scientific Publications, 1985, 382-399.

Kolvin, I., Nicol, A.R. Child psychiatry. In: Granville-Grossman, K. ed. *Recent Advances in Clinical Psychiatry* No.3 London, Churchill Livingstone, 1979, 305-313.

O'Brien, J. School problems: school phobia and learning disabilities *Psychiatr Clin North Am* 1982, 5:297-307.

Werkman, S.L. Anxiety disorders. In: Kaplan, H.I., Sadock, B.J. eds. *Comprehensive Textbook of Psychiatry-IV* Baltimore, Williams & Wilkins, 1985, 1746-1751.

Opsomming

Langdurige of herhaalde afwesigheid van skool baar ernstige kommer en kan aan die volgende drie oorsake toegeskryf word – ernstige of chroniese liggaamlike siekte, sosiale insinking (weer onderverdeel in huishoudelike redes vir afwesigheid en stokkiesdraaiery) en as deel van 'n ernstige sielkundige sindroom. Weiering om skool toe te gaan kan toegeskryf word aan 'n skeidingsangs, 'n spesifieke vrees vir die skool en skoling, of 'n komplekse neurose. Sindrome met skoolweiering as een simptoom sluit depressie en skisofrenie in.

Dit is belangrik om stokkiesdraaiery van skoolvrees te onderskei. Stokkiesdraaiers se skoolwerk is van 'n swak gehalte, hulle is meer ongedissiplineerd en steur hulle nie aan die swak skoolbywoning nie. Kinders met skoolvrees se skoolwerk is gewoonlik van 'n beter gehalte, hulle het meer gesinsneuroses en is besorg oor hul afwesigheid van skool. Skoolvrees word met ernstige versteuring en 'n onttrekking van die portuurgroep en deelname aan buitebedrywighede, soms saam met somaties klagtes, geassosieer. Omtrent 80 persent van hierdie gevalle word deur die algemene praktisyn gehanteer, terwyl 20 persent na 'n kliniek verwys word. Geslag en sosiale stand speel geen rol as eienskappe van die sindroom nie, maar lg. is meer prominent tydens drie periodes, nl. wanneer die kind vir die eerste maal skool toe gaan tot voor hy 7 jaar oud is, by omtrent 11 jaar oud en by 14 jaar en ouer. Die ouer kinders is geneig om ernstiger psigiatriese afwykings met herhaalde depressie te toon.

As differensiële diagnose behoort stokkiesdraaiery met geen bewustelik gemanifesteerde angs oor skeiding van die huis of skoolbywoning onderskei te word van leergestremdheid en suiwer skoolvrees.

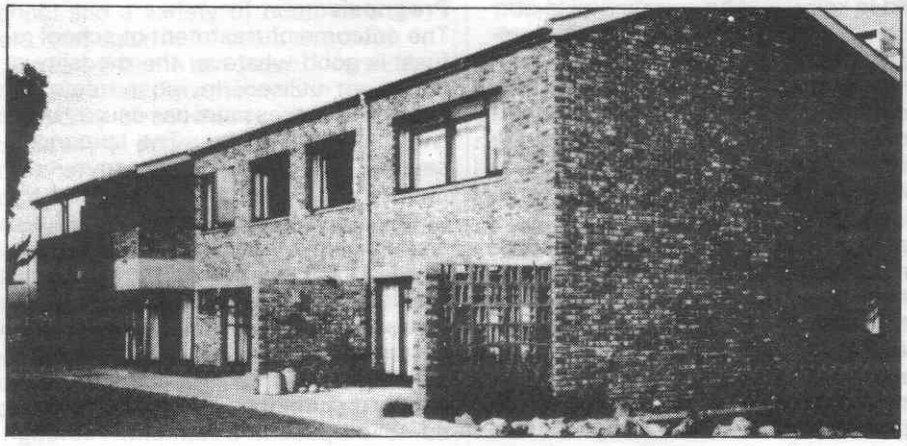
Ten opsigte van behandeling word skoolvrees meestal as 'n psigiatriese noodtoestand beskou. Die kind moet nie van die skool weggehou word nie en die ouers moet verstaan dat dit 'n gesinsprobleem is en die hele gesin moet by raadgewing betrek word. Imipramien is al suksesvol as middelbehandeling aangewend in 'n dosis van 50-75 mg saans vir omtrent 6-8 weke.

Prognosties is die resultaat van behandeling vir skoolweiering goed, afgesien van watter behandeling gegee word, met 'n suksessyfer van omtrent tweederdes of meer, maar die langtermyngevolg is minder rooskleurig. 'n Klein aantal van hierdie kinders loop die risiko van psigiatriese afwyking in hul volwasse lewe.

Parents' Evenings

Margaret Davison

Margaret Davison is a Social Worker at the Friedrich Schweizer Kinderheim in Kenilworth, Cape Town



In February 1986 we held a Parents' Evening so that our new staff members could meet the parents and vice-versa and so that the parents could get to know a little about the running of the home and therefore of the day-to-day activities of their children. The parents attended enthusiastically and a father of two children who had been at the home for about one and a half years requested us to meet on a more regular basis as he had enjoyed it so much. It was the first time he had any idea of what happened within the home.

That really started us thinking! Since then we have been meeting once a month, in the evenings, for about one and a half hours and the meetings have been extremely beneficial to all and we have achieved so much that we can highly recommend the initiating of such a group.

As we are a small home and registered for 16 children, we have children from about 8 families. We seldom have to remind parents of the meetings and we find that they usually contact us if they are unable to attend and it is often for a very good reason. They have even braved some real Cape winter storms to come. Another breakthrough we have had is the attendance at a meeting of a child's biological father and mother, who are divorced, and the mother's fiancé.

We learned very quickly that it was advisable to have an informal agenda and to try to stick to it. Among the staff members, we note topics during the month which we feel we would like to discuss and these have included —

- the adequate supervision by parents of children over weekends and their doing their homework and studying in a suitable place at home over weekends
- ways of spending quality time with their children, and what quality time actually is
- how we use our volunteers which include homework helpers in the home
- some of our different routines and why we have them, e.g. pocket money, chores, and telephone hour
- the importance of extra-mural activities and/or sport.

Parents are also given the opportunity to raise any general matters for discussion.

We are also able to keep the parents up to date on various activities at the children's schools, Sunday schools, etc., like fêtes, sports meetings and festivals and we encourage them to take part or attend.

We find that parents are much more willing to co-operate and to work together with us in the interests of their children once they know the reasons behind our ideas and decisions, or are co-negotiators in some decision-making processes. They also feel less threatened by their children's caretakers once they get to know them and they feel more encouraged to initiate contact with us should they be concerned about any issue regarding their children.

The social worker attached to the private agency who is rendering reconstruction services to the families also attends the meeting and parents can arrange to have an interview with her and/or myself and staff after the general meeting. There is therefore much more contact with everybody concerned than under normal circumstances which is extremely worthwhile and much more is achieved by doing part of the reconstruction service in this way.

The children also eagerly await the arrival of their parents for the meeting and it is felt that they also motivate their parents to attend. The parents spend some time with their children, often in their bedrooms and they can even tuck them into bed and wish them goodnight which in turn means such a lot to the children.

The parents seem to enjoy meeting other parents in similar positions. We have had voluntary offers from parents to assist with the gardening, for example, and often when we have requested assistance in the form of a plate of eats, or marking the children's clothes, this has been forthcoming.

Another factor which has come to our attention is the parents' need for guidance in parenting skills, e.g. we discuss a topic each month like encouraging and listening to your children, not letting your children down and making rash promises, and the importance of physical contact between parent and child. They appreciate a hand-out which they can take home, read and pin up, like 'If a child lives with . . .'. We have had an outside speaker who spoke and showed a video on 'Responsibility' which was very well received and we will plan similar evenings in 1987.

The evening is ended on an informal note with refreshments.

It is a pity that such a valuable group was not started earlier, but we are excited about the prospects for 1987 as the communication between ourselves, the reconstruction social worker and the parents has been increased and extended. This can only be to the benefit of all concerned, especially to the children.

Situations Wanted

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

Child care position sought in Cape Town area by 30-year-old single man. Seven years' experience in child care work as well as administration work. Please contact David Arendse, 12 Barnett Road, Elrichm, Paarl 7646 or Telephone 02211-62-1529.

Child care position sought. Live-in position for me and my dog. Widow, 47, brought up 5 sons, six years private nursing experience. Ring Mrs V. Daniell on 021-72-1801.

Position in child care sought in Natal/Kwa Zulu area. BA(Soc.Sci.) (Potchefstroom), B.Ed. (Unisa) and Teacher's Diploma. Experience in school teaching, work with physically and mentally disabled and school social work. Languages: English, Afrikaans, Zulu. Contact Mrs O.E. Claassens, P O Box 42, Eshowe 3815.

Nuusbrokkies Newsbriefs

Australian Visitor

Sandy van Soelen

Sandy van Soelen (formerly Zabow) was one of the speakers at the first South African Biennial National Conference held by the NACCW in Cape Town in 1977. At the time she was Psychiatric Social Worker on the staff of St John's Hostel, and her paper was on the subject of *Group Therapy in Residential Work.* We were pleased to meet her during a recent visit to South Africa. She is now Assistant Director of the Catherine McAuley Residential Child Care Centre in Wembley, near Perth, in Western Australia. She reports that her agency has recently achieved more autonomy from statutory agencies with regard to reconstruction work and that this has led to a more streamlined service for children. Mrs van Soelen was impressed by some of the progress made with training in this country, and mentioned that this matter was still at a rudimentary and experimental stage in Australia.
Australia had 7 195 children in residential care in 1984, 25 percent fewer than the 9 564 in 1969. Boys and girls are represented in the proportions of 60 percent and 40 percent respectively. Half of the children in care are 13 years or older, though approximately one-third of admissions are under six. Some three-quarters of the children have been in care for two years or less, which suggests some emphasis on short-term care.

Conference

The planning for the Conference is proceeding at a rapid pace. This year our gathering will extend over four days. The first day, Tuesday October 6th, will be devoted to a National Seminar on training in child care. This is aimed at all those who are involved in education for residential care – the NACCW, universities, Technikons, examiners, various government departments, and staff members within institutions who are responsible for in-service training. This is the first time that such a seminar has been convened in the country, and we look forward to a meaningful exchange of views. Our guest speaker Thom Garfat will talk about current trends in training in North America. This will be followed by a number of workshops and several papers will also be presented.
Over the next three days we plan to offer a total of 36 papers or special-interest sessions so that delegates will have the opportunity of choosing those which are of value to them. There is still time to submit proposals for papers, but our deadline is rapidly approaching so that anyone who still has an idea fermenting should communicate with the Conference Organiser, P O Box 8021, Johannesburg 2000, urgently.

Education Think Tank

As part of the current project, jointly undertaken by the NACCW and the Child Welfare Society, to define the educational problems of children in care and to explore possible solutions, a meeting was held at UCT attended by a number of specialists representing practice and academia. Professor Clive Miller, Tony Morphet and Maureen Archer (Education, UCT) and Professor Willem Steenkamp (Child Guidance Clinic, UWC) were joined by Helen Starke and Chris Giles (Child Welfare Society), Mr Gouws (Department of Education and Culture), Patrick Normand (Cape Town School Clinic), Brian Gannon (NACCW), Rose September (Annie Starke Village) and Mr Mike Olivarie (Marsh Memorial Homes School) to thrash out guidelines for the research strategy to be followed.

Wes-Kaap

Course Starts
The National Higher Certificate in Residential Child Care course got off to a good start with twenty students joining the First Year class at the School of Paramedical and Biological Sciences at the Cape Technikon on Wednesday 11 March. Students come from a number of children's homes in the Peninsula – even from as far afield as Durbanville and Simonstown which demands a long trip into the city each week. (Okay, many Pietermaritzburg students travel to Durban each week too!)
The Basic Qualification in Child Care course resumes on 8 April at St Michael's Children's Home in Plumstead. The Department of Health Services and Welfare of The House of Representatives has asked the NACCW to mount the BQCC course for all of its places of safety and detention staff at the same time, so a parallel course will be run with the ability to specialise in this modality of care. An innovation in this course will be a one-day workshop on *Self-awareness* to be attended by all BQCC students on Saturday 11 April. This workshop will be run by Geoff Bestwick and Colin Eng of ISIS.

Welcome Back
Teen Centre in Rondebosch, a 24-bed home for adolescents, has appointed Chris Smith as Principal from 1st April. Chris and Priscilla Smith were houseparents at St Johns Hostel for several years and ar therefore not newcomers to th field. In fact Chris' father was a children's home principal in England before him, so the trade seems to run in the bloo We welcome them to their ne task at Teen Centre.

Workshops and Meetings
Helen Starke ran a workshop o the new Child Care Act on Thursday 19 February where some implications of the new legislation for child care workers were explored and discussed. The first Regional meeting of the year was held a St Michael's on Thursday 19 March, and this was addresse by the National Director. The Principals' Group and Social Workers' groups met on Marc 20 and 26 respectively, and reports of these meetings will be carried in next month's issue.

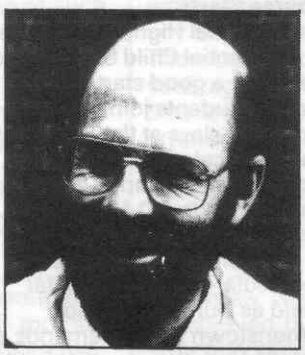
Toespraak aan SA Verpleegsters Vereniging
Op Dinsdag 3 Maart het Brian Gannon die Algemene Jaarvergadering van die SA Verpleegsters Vereniging by Groote Schuur Hospitaal toegespreek. Hy het die goed gevestigde verplegingberoep (met 'n Vereniging van sowat 33 000 lede in Suid-Afrika) vergelyk met die relatiewe klei Vereniging vir kinderversorger wat gesukkel het om samehorigheid te bereik in hul opleiding en praktiese strukture. Hy het klem gelê op die noodsaaklikheid van die ontwikkeling van die kindersorgberoep en gesê dat namate maatskaplike werk en gemeenskapsdienste verbeter, al hoe meer kinders by hul gesinne kon aanbly of in pleegsorg geplaas kon word, met die gevolg dat dié kinders wat nou na inrigtings verwys word die meer uitdagende kinders is, met 'n stygende aantal adolessente. Dr N.S. Louw, Direkteur van Hospitaal Dienste vir die Kaapprovinsie, het die vergadering bygewoon en het die wens uitgespreek om op hoogte gestel te word wat die NVK se werk betref.

Eastern Province

BQCC students from Nerina Place of Safety and children's homes in Port Elizabeth, East London, Mdantsane and Kingwilliamstown.

Forty people came together for a residential weekend at the Eastern Province Children's Home in Port Elizabeth from March 6-8. Two-thirds were students of the Basic Qualification in Child Care (BQCC) course whilst the remaining students attended a number of seminars for senior staff. The BQCC students completed Module 2 on *Child Development* and *Conceptual Models and Evaluation*.
The senior group attended seminars on *Workload Management* and *The Use of the Volunteers in the Children's Home* by Leon Rodriques, vice-Principal of Boys Town Duin-en-Dal in Cape Town, who was one of the visiting lecturers. Seminars led by Brian Gannon, National Director of the NACCW, included *Working with Manipulative Children, Variables affecting the Impact of Residential Environments* and *Androgynous Styles in Child Care Work*.
The course, made all the happier by the splendid hospitality provided by the Eastern Province Children's Home, started with a "fun evening" which included a "trivial pursuits" quiz on the behavioural sciences, and a session during which all participants had to talk for "just a minute" on a given subject.

New Chairman for Eastern Cape Region
At the Biennial General Meeting of the Eastern Cape Region held in Port Elizabeth on 7 March, Barrie Lodge, Principal of Malcomess House, East London, was elected as the chairman of the Regional Executive. Fred Wells was re-elected as Treasurer. Barrie Lodge paid tribute to Roger Pitt,



Roger Pitt

the retiring chairman, who had led the Eastern Province Region of the Association since its inception.

Senior students on the Eastern Province Course

Natal

Sister Madeleine, who as principal of St Theresa's Home in Mayville was responsible for the introduction of many valuable programmes and the creation of a warm living environment, has left the home to assume her new position as Mother Superior of the Augustinian Order. We welcome as the new principal Sister Yvonne Collins who comes from Umgeni Poort.

Staff Programmes
Barbara Robertson, principal of St Thomas' Home reports on a programme which links the staff resources of her home and those of Othandweni Infants Home in Lamontville. An exchange of material and ideas for stimulation and enrichment of the children's programmes has enhanced the services of both organisations. Meanwhile Sister John Mary, principal of St Philomena's Home is experimenting with a shift system for child care staff.

Regional Meeting
The National Director ran a workshop for the Natal Region on Friday 27 March in Pietermaritzburg. The subject he was asked to deal with in the workshop was *Punishment*, and the proceedings might well form the subject of a future article for this journal. He was invited to Natal by the Mary Cook Children's Home, and he spoke at the official opening of their new extensions on 27 March on *The Children's Home and the Local Community*.

Transvaal

Training
The Basic Qualification in Child Care course got off to a good start on the 4th March with a registration of some 100 students in the English language group. The Afrikaans group also started at the same time. This module extends over 10 sessions, has two themes, namely (a) The task of the child care worker, and (b) Welfare Policy in South Africa.
The first theme focuses on what the child care worker is expected to do in the day-to-day situation – the skills needed to manage the routine tasks of child care. The second theme examines the structure of the welfare service in the country – the laws that govern our work, and the place of residential care within the system.

New Leadership Team at SOS
Several new senior staff members have been appointed by SOS over the last few months. The previous Director, Dave Jackson, has resigned in order to start his own consultancy business and has been replaced by Pine Pienaar. Pine is a qualified teacher with extensive experience in the field of advertising. At the Ennerdale Village the principal's post has been assumed by Lindsay Neff. Lindsay worked as a health inspector in the East Rand area and hopes to make a greater contribution to the coloured community through his work with children. Lindsay's wife is employed in the village. The new Deputy Director at Ennerdale is Margo Davids, a social worker with many years experience in the child welfare field. She was previously employed at Boys Town Duin-en-Dal and has also worked for Child Welfare in Durban.

Rita Mabusela

Joining her in the social work department is Ingrid Sinclair, a social worker with experience in community work.
In December the new SOS village in Mamelodi opened. This cottage-style home will cater for 100 children and has a staff of 10 child care workers and three relief staff. Leading that team is Vusi Gumede. Vusi has had an interesting career, moving from teaching to involvement in youth leadership training for the Catholic Church. Vusi has 4 children and his family lives in on campus. Assisting Vusi is his social worker Rita Mabusela. Rita is an experienced social worker, who has been with SOS while the buildings were being erected, and she is keen finally to start working with the children.

A Gardening Tale for Child Care People

Peter Powis

Peter Powis is a Clinical Psychologist at Tenterden Place of Safety

In 2037 in a city somewhere in Africa there was a large park full of tropical plants and trees. Although it was unfashionable to grow tropical plants at that time, the city people were nevertheless quite proud of the fact that they had such a park. As long as they didn't have to grow the plants themselves, they enjoyed strolling through the park among the plants which were not to be seen elsewhere in the city.

In one corner of the park there was a large greenhouse where the seedlings and young shrubs and trees were cared for until they could be planted outside in one of the big gardens. By 2037, the climate of central Africa had changed so much that many tropical plants only survived outdoors if they were first nurtured under controlled conditions. Other plants had adapted to climatic conditions and had therefore been able to survive in the natural environment.

In June 2037, after the resignation of two gardeners, the park manager had to start looking for replacements. As very few people liked working with indigenous plants, it was difficult to find the right people for those posts. Most people grew plants that grew in the natural environment and could not be bothered with plants that needed special attention. Nevertheless, six people responded to the job advertisement in the newspaper. Two of the applicants had exactly the right experience and qualifications for the job. Unfortunately, however, they couldn't afford to work for the low salaries which were being offered. Two other applicants mumbled something about being fond of plants, but were clearly unreliable people and were therefore not considered suitable. Of the remaining two applicants, one (Freddie) seemed to have had some appropriate experience and showed a real understanding of plants in general. He was employed without further ado. Although he wasn't sure about the other applicant (Rick), he needed another gardener quickly and despite his misgivings, the park manager employed him.

Fred and Rick settled down to their new jobs and you wouldn't have noticed anything amiss. However, Freddie, who had a natural feel for working with plants, was a bit concerned about some of the things he saw. For example, he noticed that many of the seedlings and young plants which came into the greenhouse never grew enough to be planted in the gardens outside. Many of these young plants were simply thrown into big black bags and taken off to the rubbish dump outside the city. As he drove past the rubbish dumps on his way home, it impressed him to see that some of these plants had somehow found their way out of the bags and taken root in the soil around the rubbish dumps. They seemed to be growing far better there than in the greenhouse.

Freddie also noticed that Rick was becoming very frustrated. In fact poor old Rick wasn't coping at all. He had previously been a technical inspector on a motor car production line. There his job was very clear – he had to test certain components of the vehicle and if they were not functioning according to technical specifications, he reported the fault and made sure that it was rectified. The plants, however, did not function according to man-made specifications, and he couldn't monitor their growth by using mechanical instruments. Rick nevertheless applied his technical logic to his new job – he looked for obvious problems with the plants and when there were problems, he treated the plants by pouring on extra water, fertilizer and compost. When plants didn't show obvious problems he simply watered them and then left them alone.

As it happened, the additional water, fertilizer and compost made some of the plants perk up their leaves and develop new bright green shoots in the place of their old yellowing leaves. This greatly encouraged Rick. On the other hand, other plants reacted by getting worse and worse. Freddie noticed a whole table full of very sick-looking plants being given yet another dose of water, fertilizer and compost. They looked as though very soon they'd get the "black bag" treatment. He called Rick aside and said "Rick, these plants are getting too much water and they don't like all that fertilizer and compost. They like dryish, sandy soil." Rick was a bit taken aback when he realised that all his efforts had been making the plants worse instead of better. Nevertheless, he appreciated Freddie's advice and wished that he knew more about plants.

He took Freddie to another table of plants whose leaves were dry and shrivelled up, despite all his efforts. "What have you been doing here?" Freddie asked. "The same as with that other lot, I've given them water and lots of compost and fertilizer" said Rick. Looking closely at the plants Freddie said, "Let me tell you about these plants. If you have a close look at these leaves you'll see very tiny spots. That's a fungus and it means that you need to spray or dust these leaves with a fungicide. Secondly, these plants aren't getting enough sun – they shouldn't even be in the greenhouse – they need hot, direct sun and cooler air at night."

Freddie, who had an almost poetic way of talking about plants, went on to explain a whole lot of things, only some of which Rick's technical mind understood. What he sort of understood was basically this: that each plant and every kind of plant is unique, and that therefore what stimulates one plant's growth may destroy another plant. Freddie said something about each plant having its own "spirit" which you could only get to know by watching very closely how it responded to the way you treated it. You had to take time to study shape, colour and texture of the leaves; you had to watch to see how the shoots developed and you had to feel around in the soil to get an idea of how the roots developed. Plants with thin, hairy spread-out roots needed different treatment to plants with thick, deep roots. Freddie said that he even watched to see how different plants responded to light and shade and changes in temperature. Most plants grew towards light, but he said that there were actually some which couldn't process bright light and sun. He said that you had to remember this when planting and transplanting them. Freddie said that it was only when you understood the spirit of plants that you could provide the right conditions for growth. He said people often ignored the spirit of plants and then gave up on them, thinking that they were "dud plants" instead of realising that they

were not receiving the right treatment, or were not planted in the right place. These people would repeatedly plant and pull out plants. They were the kind of people who wanted to grow a delicious monster in the hot, sunny daisy bed just because they thought it would look good. Freddie said that it was amazing how people carried on doing the same things over and over again, even when those things didn't work. Rick felt a bit stupid but he also felt encouraged because he now had more ideas about how to deal with plants.

When Rick went to show Freddie some "weeds", Freddie said something about there being very few real weeds. "Sure, there'll always be some weeds" he said, "but people often call beautiful plants weeds just because they're growing in an inconvenient place – and don't ever tell a tortoise that a dandilion is a weed!", he added.

Freddie carried on talking for quite a while, but Rick couldn't absorb much more. The park manager was rather surprised to hear that some of the plants in the greenhouse should never have been placed there, but after consulting his gardening books he gave permission for them to be planted outside. Freddie and Rick even discovered some non-tropical plants in various corners of the greenhouse, and these were taken and planted in the streets outside the park.

When Rick arrived home after work that night, he couldn't help but notice his own garden. He seemed to see it very differently to the way he'd seen it before. He was more curious about it and went and found some gardening books he'd hardly read. He realised that there were no short cuts when working with plants, and that his work would be more interesting and yet also more demanding from that point on. He closed his book and dozed off into a rather unsettling dream about thousands of plants floating into the greenhouse and floating out all over the place in haphazard fashion. He stood watching helplessly, waiting in vain for the park manager or somebody to take charge and do something. After what seemed like ages, he noticed that an unfamiliar figure arrived who was somehow able to control the flow of plants. Suddenly the park manager and a number of gardeners appeared including Freddie. The unfamiliar figure stopped all the plants before they could float into the greenhouse. He then allowed some of the plants to go inside where the park manager channelled them to one of the gardeners who deftly planted them in neat beds. Other plants were taken by other gardeners and planted in the park, while others were taken outside by gardeners who ran like lightning and planted them all over the city. As this was happening, Rick drifted into a deeper, more restful sleep, and his dream faded away.

Permanency Planning

Helen Starke

A talk given at the Biennial General Meeting of the Western Cape Region of the NACCW in December 1986. Helen Starke is Director of Child Welfare Society in Cape Town

Before discussing the importance of permanency planning, it is necessary to sound a warning. Rooney (1982, 157) writes:

"It is dangerous to represent the permanency planning movement as a panacea for problems related to foster (substitute) care ... (Programs must be) adapted to local conditions and concerned with the full range of children in need of permanent placement ... Permanency planning offers considerable promise for generating constructive programs that are truly in the best interest of the child and end the problem of many children's gradual drift into the limbo of temporary placements. However, the movement must be guided so that a rush toward placing children in inadequate but nevertheless permanent placements does not result. Permanency programs must ... result in more continuous placements that help children feel psychologically secure."

What is permanency planning?

Anthony Maluccio and Edith Fein offer the following definition of permanency planning:

"Permanency planning is the systematic process of carrying out, within a brief time-limited period, a set of goal-directed activities designed to help children live in families that offer continuity of relationships with nurturing parents or caretakers and the opportunity to establish lifetime relationships."

If we accept this definition, we can immediately dispel one commonly held myth – permanency planning is *not* merely a procedure whereby children legally removed from their biological parents are freed for and placed in adoption as speedily as possible.

The underlying philosophy in permanency planning is that children need and have a right to a stable, permanent home. Generally, the child's own home, with his biological parents, is the best home to provide permanency. When outside intervention into the family becomes necessary, the guiding principle should be to maintain and restore the family and, if that is not possible, to make another permanent plan as soon as is possible.

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In any discussion on permanency planning it is important to remember two key issues:

- How intrusive and traumatic it is for children to be removed from their families, and
- How difficult it is to return children to their families once they have been removed.

Therefore, intervention in the family should not be more intrusive than is absolutely necessary.

What has this got to do with children's homes or residential care?

Surely this is the domain of the child and family welfare agencies? After all don't children's homes only come into the picture after the intrusive intervention of removal has been decided upon, or has already been effected?

Maybe they do, but if those of us in the field of residential care are truly committed to the underlying philosophy of permanency planning, then surely we should not just passively accept the children referred to us. We all exercise our right to screen the children referred to us in that we have admission criteria and procedures. Why not take the next step and question whether this child should even be removed from his parents – or if he is removed, whether residential care is the most appropriate placement?

Yes, but perhaps if you do not take the

child because you consider residential care inappropriate, the next children's home will take him anyway. So what is the point? The child will end up in residential care anyway. Probably he will, but by questioning the family welfare agency's plan for this child you will, I hope, get the agency thinking. Maybe this particular child will not benefit from your questioning, but perhaps the next one will. The more children's homes question the appropriateness of applications they receive, the more agencies will be forced to question their plans and interventions on behalf of children.

However, this questioning by children's homes can only be done effectively from a secure base of mutual respect and co-operation: respect from the children's home for the professional ability and integrity of the agency social worker; respect by the agency social worker for the professional expertise of the children's home and the quality of care offered. Co-operation is based on an acceptance that we are all working in child care to provide for our children what the best and wisest parent would want to provide for his children.

Permanency planning starts before a child is ever removed from his family, and children's homes *do* have a role to play at that stage.

Let us now move on to the child who is placed in a children's home. All placements should include: (1) Clear, appropriate reasons for placements; (2) Determination of the type of placement needed; (3) A placement plan; (4) Preparation of child and family. Only two of these will be discussed.

Clear, appropriate reasons for placement

Unless we have absolute clarity on why a child is being placed in our children's home, how can we begin to formulate a treatment plan for him?

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From Children's Court Enquiry reports it is often difficult to define in manageable terms why the child is being placed. There seem to be many problems; where does one begin?

A simple, yet comprehensive framework is provided in a Permanency Planning Guide of the U.S. Department of Health and Human Services, in which it is stated that: "Placement may become necessary due to absence, condition or conduct on the part of parents or child.

- Parental Absence . . . refers to the lack of consistent contact between the parent and child over a period of time
- Child's Absence . . . refers to behaviour on the part of the child resulting in his being away from and without a home . . .
- Parental Condition . . . refers to qualities within the parent which prevent adequate nurturing. These qualities should have a diagnosis and prognosis.
- Child's Condition . . . refers to qualities within the child which prevent him from receiving the care and nurturing he needs in his home. These qualities should have a diagnosis and prognosis . . .
- Parental Conduct . . . refers to parental behavior which is detrimental to the child.
- Child's Conduct . . . refers to a child's behavior which is disruptive to the family."

A placement plan

All placements should be planned. If a written plan is not done prior to placement, it should be the first priority after placement. A placement plan must include:

- The goal of placement.
- Identification of the specific circumstances which necessitated and caused the separation of the child and his family.
- Identification of the specific actions to be taken by *the agency, the children's home, the parents and the child* in correcting the conditions which led to separation and the date by which each of these activities is to be accomplished.
- Anticipated length of placement stated in *months*.
- Plan for visiting stating frequency, location and participants.
- Specific procedure for review and revision of plan.

Placement review

We all talk a lot about case reviews, but are these reviews focussed and goal-directed? What questions should we be asking at placement reviews?

- What was the reason for placement?
- What is the long-range permanent plan for this child?
- What specific tasks were assigned to agency, (children's home), parents and child to achieve the long-range plan?
- Of tasks completed: (a) Are achievements documented? (b) Will these tasks lead to the desired goal? (c) What child or parent strengths are apparent now that were not at the time of placement?
- Of tasks not completed: (a) Are failures documented? (b) Are tasks reasonable, appropriate? (c) Why were tasks not completed?
- Did visiting occur as planned?
- What is the expected length of placement (in months)?
- What changes need to be made in the long-range plan, specific tasks and visiting schedule?

Permanency plan

Mention has been made of the long-range or permanent plan, but what are the options?

- Return home – first choice in all cases and must be explored and ruled out before selecting another permanent plan.
- Placement with relatives.
- Permanent foster care.
- Adoption.
- Emancipation.

Conclusion

We are all afraid of making decisions, especially decisions which change the course of children's lives. Our rationale for postponing these decisions is that we want to be sure that we are doing what is best for our children – what is in their best interests. But by *not* making these decisions we are acting against the interests of the children in our care. We are inevitably going to make the wrong decisions sometimes. The only person who doesn't make a wrong decision is the person who never makes a decision. Most of us have personal experience of children in our care whose parents had been missing for years or had been "written off" and lo and behold one day – after the child had been with us for 5, 10 or even 15 years – he was happily returned to his parents.

The only person who doesn't make a wrong decision is the person who never makes a decision.

What if we had created another permanent home for this child in the meantime and thereby "deprived" him of this return to his own family? If I can answer this question with a question: What have we done to this child in the meantime by not making a decision and keeping him in limbo for 5, 10 or 15 years?

Here I speak from personal experience. I had in my foster care a child who was in a children's home from the age of three to nine years and after 18 months in foster care with me he returned to his mother. A success story? Some might think so, but why was this child deprived of permanency for more than seven years?

How many children do we have in limbo in our children's homes?

Notes and References

Jones, M.L., Biesecker, J.L. *Permanency Planning Guide for Children and Youth Services* U.S. Department of Health and Human Services, 7-8.

Maluccio, A.N., Fein, E. *Permanency Planning: A Redefinition* Child Welfare LXII (May/June 1983) 197.

Rooney, R.H. *Permanency planning: boon for all children?* Social Work (March 1982) 157.

Management Principles in Children's Homes

Ernie Nightingale

The second of two articles by Ernie Nightingale, National Chairman of the NACCW and Principal of Ethelbert Children's Home in Durban

Much has been written about management styles and management systems. However, each manager develops a style unique unto himself and brings his experience, training and knowledge into his practice. It is this blend of ingredients which has led to the identification of certain aspects of management which become concerns or issues to the internal management structure of a children's home.

The very nature of residential work creates situations which are different from those experienced in most places of work. By and large the majority of the work force is itself residential and professional managers need to understand the dynamics at work in such situations. It is easy for staff to see themselves as not being "at work" and the inherent dangers of this are obvious.

Internal management (principals, social workers, case managers, supervisors, senior child care workers) need to have an understanding and knowledge of forces at play within a residential staff team. This article draws attention to four such areas: group dynamics, communication, conflict and stress, and power.

Group Dynamics

There is no one definition of a group and no agreement on what is meant by group dynamics. A popular definition by Joe Kelly describes group dynamics as being viewed from the perspective of the internal value of groups, how they form, their structure and processes, and how they function and affect individual members, other groups and the organisation.

Individuals form themselves into groups and affiliate with one another because of spatial or geographic proximity. Another element of group formation is interaction. Persons in a group interact with one another, not just in the geographic sense, but also to solve problems, reach goals, plan together, reduce tension and achieve a balance. Rewards from such group interactions gratify needs while costs incur frustration, anxiety, tension and fatigue. There are naturally also some very practical reasons for joining and/or forming groups. Employees may for instance, form a group for economic, security or social reasons. The most important practical reason why individuals join or form a group is, however, that groups tend to satisfy the social needs of most people. These groups tend to be fairly formal, but informal groups also develop in an organisation. Interest and friendship groups are common examples. Common interest groups range from sport to hatred of management! Friendship groups are formed to satisfy needs for affiliation.

Group dynamics within the context of a children's institution would also include the formation and functions of committees and sub-committees. This should be noted as committees do not fall within the perimeters of this article.

It is easy for staff to see themselves as not being "at work" and the inherent dangers of this are obvious.

It is important for professional managers in children's institutions to have some knowledge of the forces at work when a group of people assemble. Managers spend a great deal of time giving and receiving information which is disseminated to/by people. Employees adopt a variety of informal roles best described by Bertram M. Gross as follows:

- Regulars: those who are "in", who accept the values of the group and are accepted by the group.
- Deviants: those who depart from the values of the group – the "mavericks".
- Isolates: the true "lone wolves", they are further from the group than deviants.
- Newcomers: they know little and must be taken care of by others; they are "seen but not heard".
- Old timers: those who have been "around" a long time and "know the ropes".
- Detached: slackers who either "go along for the ride" or "call it quits".
- Involved: those who are fully immersed in their work and the activities of the organisation.
- Tehnique-orientated: the masters of procedure and method.

Other types of employees include nay-sayers, yea-sayers, rule-enforcers, rule-evaders and rule-blinkers.

One of the greatest attributes of a group is the combined and integrated judgement which it can offer.

The task of the manager is to recognise, understand and better utilise each of these different persons. Group meetings, i.e. staff meetings, training groups, etc. take on a different meaning when the leader has been sensitised to the dynamics at work within the group. Group activities need to be structured in such a way as to allow for maximum participation and involvement by members.

Function of groups

In order to have a better understanding of organisational behaviour, managers should have some knowledge of the functions that a group can serve for both the organisation as a whole and the individual organisational participant. The impact of groups on organisational effectiveness includes:

- accomplishing tasks that could not be done by employees themselves.
- bringing a number of skills and talents to bear on complex, difficult tasks, i.e. combined integrated judgement.
- providing a vehicle for decision-making that permits multiple and conflicting views to be aired and considered.
- providing an efficient means for organisational control of employee behaviour.
- improved communication network.
- effective device for reducing conflict and promoting co-operation.

The impact of groups on individual employee effectiveness includes:

- aid to learning about oneself.
- provides help in gaining new skills.
- obtaining valued rewards that are not accessible by oneself.
- satisfying important personal needs, i.e. social acceptance and affiliation.

Groups can be a very effective organisational device to help reduce conflict and promote co-operation and co-ordination within the institution. One of the greatest attributes of a group is the combined

and integrated judgement which it can offer. From a personal (human) point of view, the biggest advantage of group formation may be the increased motivation and commitment derived from participation. A group provides the opportunity for the personal development that individuals would never achieve on their own.

Communication

Again, one of those much discussed and written about topics. Easy to understand and yet so difficult to apply. Attention will only be focused on two aspects of this vast subject – the grapevine and the need for a communication policy.

The grapevine

If an institution does not accept its responsibility to communicate down the line, or if some managers in the chain of communication cause a blockage because they don't want to or cannot communicate the things people want to know about, then people will find a way to get answers to their questions. Rumours will begin to fly: those who know a little will pass it on, as the story is passed from person to person, it will, as usual, get more and more distorted and exaggerated until the message people finally get is completely wrong. The institution will suffer because the rumour leads to uncertainty, uncertainty leads to anxiety and fear, which in turn leads to the inability to work effectively. If people are anxious about their future, their need to know and find out exactly what is happening will become more important to them than their jobs.

Management must realise that if they won't, or don't communicate, someone will. The *grapevine* is the fastest, most efficient form of communication in any organisation, especially in an organisation which fails to communicate in an open and honest way.

Every manager should recognise the existence of the grapevine in his institution. This informal system of communication can be used to spread false rumours and destructive information. The grapevine cannot be ignored because: it exists; it cannot be switched off; it is old but immortal; it has a high degree of distortion; it has a high degree of credibility; it exaggerates; it spreads and like any underground movement, if it says the opposite of the official line, it will be believed, even if it is wrong.

The existence of a grapevine in a children's institution causes many problems and usually operates at two levels – the staff and the children.

The management must learn to beat the grapevine at its own game. It must develop a consistent communication policy which, like the grapevine, spreads throughout the institution.

The grapevine can effectively supplement the formal channels of communication. It can quickly disseminate information that assists to attain goals. As useful as this may be, it is not a permanent solution to the problems of communication. Each institution needs to develop a policy of communication,

Management must realise that if they won't, or don't communicate, someone will.

which will obviously differ from institution to institution, in order to ensure a constant accurate flow of information.

A communication policy

The following points may need to be considered in arriving at such a policy:

- inform all employees about institutional goals, plans and objectives.
- inform all employees (and children) about current activities of the institution.
- inform all employees of various sensitive, negative or controversial issues affecting the institution.
- encourage two-way communication.
- ensure regular supervision meetings for employees to discuss their performance.
- encourage free expression of thoughts and ideas at all meetings.
- communicate important events and situations as quickly as possible.

Key words in such a philosophy are "all employees", "regular", "two-way communication", "quickly" and "free expression". This will help managers in all departments of the institution to know what, when and how to communicate. The following check list may even be more specific: be frank, be timely, be clear, be constantly aware of your employees' needs and wants.

Often managers and supervisors are guilty of isolating themselves from the rest of the staff team.

There are a great number of different methods of communicating to employees. Some of these are:

- Two-way – upwards and downwards: Briefing groups, interviews, 'walking the floor', consultative committees, induction programmes, the grapevine, response system.
- One-way – downwards: Mass meetings, notices, posters, bulletins, personal letters, briefing meetings, institutional handbook.
- Horizontal or sideways: Meetings, reports, memos, telephone.
- One-way – upwards: Suggestion scheme, response to surveys, absenteeism and lateness.

Walking the floor

In its simplest form this means getting out to where employees work and meeting with them. Often managers and supervisors are guilty of isolating themselves from the rest of the staff team. Meaningful communication cannot take place if the only form of contact is that which is made in an office setting.

Induction programmes

Induction is not in itself a form of communication, but it plays a crucial role in communicating with the new employee.

One aim of induction or orientation is to familiarise or teach the new worker about the work, but, a greater aim, often neglected, is *to establish* clear, open lines of communication between the worker and his superior, which will form the base of all future working relationships.

Nicki Stanton says, "People speak and listen to satisfy personal needs, to establish relationships, to understand the same things, to believe what is understood, and occasionally to entertain. If we consider the reasons why we communicate we will also gain insight into the effects of communication."

The task of internal management is to understand this and to communicate effectively.

Conflict and Stress

No one likes or enjoys conflict. It must be the most misunderstood and mismanaged aspect of organisational management. Conflict is not inherently bad or good, but must be evaluated in terms of its individual and organisation function and dysfunction. Conflict can, if understood and managed correctly, lead to innovation and change. It can energise people to activity and can be managed to work for, rather than against, goal achievement.

Conflict has been defined as the condition of objective incompatibility between values or goals, as the behaviour of deliberately interfering with another's goal achievement, and as hostility in terms of emotionality.

Stress has some of the same characteristics as conflict but is usually associated with more physiological outcomes. Stress is defined as the outcome of a set of circumstances under which an individual cannot respond adequately or instrumentally to environmental stimuli, or can so respond only at the cost of excessive wear-and-tear on the organism, for example, chronic fatigue, tension, worry, nervous breakdown or loss of self-esteem.

Principals and supervisors generally rely on formal authority and classical organisation structures to solve their "conflict problems". They develop all sorts of delaying tactics to avoid conflict. An understanding and acceptance of the

following basic assumptions about conflict will help the manager to deal more effectively with it. Some of these assumptions are: conflict is inevitable; conflict is determined by *structural factors* such as the physical shape of the buildings, or the design of a career structure; conflict is integral to the nature of change; a minimal level of conflict is necessary to maintain a correct balance between complacency and innovation.

A minimal level of conflict is necessary to maintain a correct balance between complacency and innovation.

There are various ways of managing conflict, e.g. groupwork or bargaining, but, from a practical point, effective management requires the application of one or more of the following steps:

- Perceiving/experiencing unacceptable conflict;
- Diagnosing the sources of conflict;
- Intervening.

Intervention can take several forms and once again the manager is required to acquire skills in this area. Some practical suggestions include:

- Erecting buffers between parties until the problems can be sorted out;
- Helping the parties to develop better insights into themselves and how they affect others;
- Redesign the organisation structure in order to reduce tension.

Managers/supervisors in any residential setting should be aware of the many stress producing factors within their organisation and actively work towards the proper management of this component of human relations. Although conflict management rests largely upon the shoulders of the manager, each employee should be made aware of the importance of identifying and dealing with the early symptoms of conflict or stress. The National Training Laboratory recommends seven guidelines for providing feedback for effective interpersonal relations:

1. be descriptive rather than judgmental;
2. be specific rather than general;
3. deal with things that can be changed;
4. give feedback when it is desired;
5. consider the motives for giving and receiving feedback;
6. give feedback at the time the behaviour takes place;
7. give feedback when its accuracy can be checked with others.

The purpose of this discussion is merely to draw attention to the importance of this aspect of personnel management. Principals and social workers are urged to acquire more knowledge and skills in the handling of conflict and stress in their particular institution.

Power

In our work much attention has been paid to groups, informal organisation, communication, conflict and stress, and leadership skills. These have been recognised as important dynamics of organisational behaviour. Power and politics, however, have been largely ignored. Yet it is becoming clear, and can surely be verified by many, that organisations are highly political and power is the name of the game.

Power and politics must be "brought out of the cupboard" and recognised as an important dynamic in organisational behaviour.

Robbins supplies one of the most detailed, and perhaps most understandable, definitions of power as follows:

"When we discuss power, we mean the ability to affect and control anything that is of value to others. If A has power over individual or group B, then A can influence certain actions of B so that the outcome is preferable to the self-interest of A. Therefore, power requires two or more people – an exerciser and a subject. Power also disregards intent. Whether A *wants* to have control over B is irrelevant . . . Finally, power may exist but not be used. It is a capacity or a potential."

Power is not authority. Authority legitimatises power. Authority is the *right* to manipulate or change others. Power need not be legitimate. The person who possesses power has the *ability* to manipulate or change others.

There are two major types of power, one negative and one positive. The commonly used term "power-hungry" reflects the negative feeling about power. Power that is associated with personal gain tends to produce the most negative consequences.

One form of positive power is also referred to as social power. This form of power has been defined as "a concern for group goals, for finding those goals that will move men, for helping the group to formulate them, for taking some initiative in providing members of the group with the means of achieving such goals, and for giving group members the feeling of strength and competence they need to work hard for such goals." This definition given by David McClelland seems to be closest to the ideal use of power in a residential setting.

In order for managers to give effective leadership, time needs to be spent identifying the types of the current uses of power in the institution. Leaders have power to influence their followers (employees) and caregivers have tremendous power in influencing children's lives – but that's a topic for discussion on its own.

The art of management is to help people to grow, to become competent and skilled at their work and to develop as individuals in their own right. The greatest impact on the development of emotional competence is the use of life experiences, those reinforcing events that serve to point a person in the direction of change.

For if behaviour is to be changed, learning must take place. Sometimes this learning facilitates a change in beliefs. Skinner emphasises the importance of changing a person's behaviour toward something different. The problem with this, he continues, is to induce people not to be good, but to behave well.

The task of the residential manager is not to induce people to become submissive and compliant, but rather, to do their work well.