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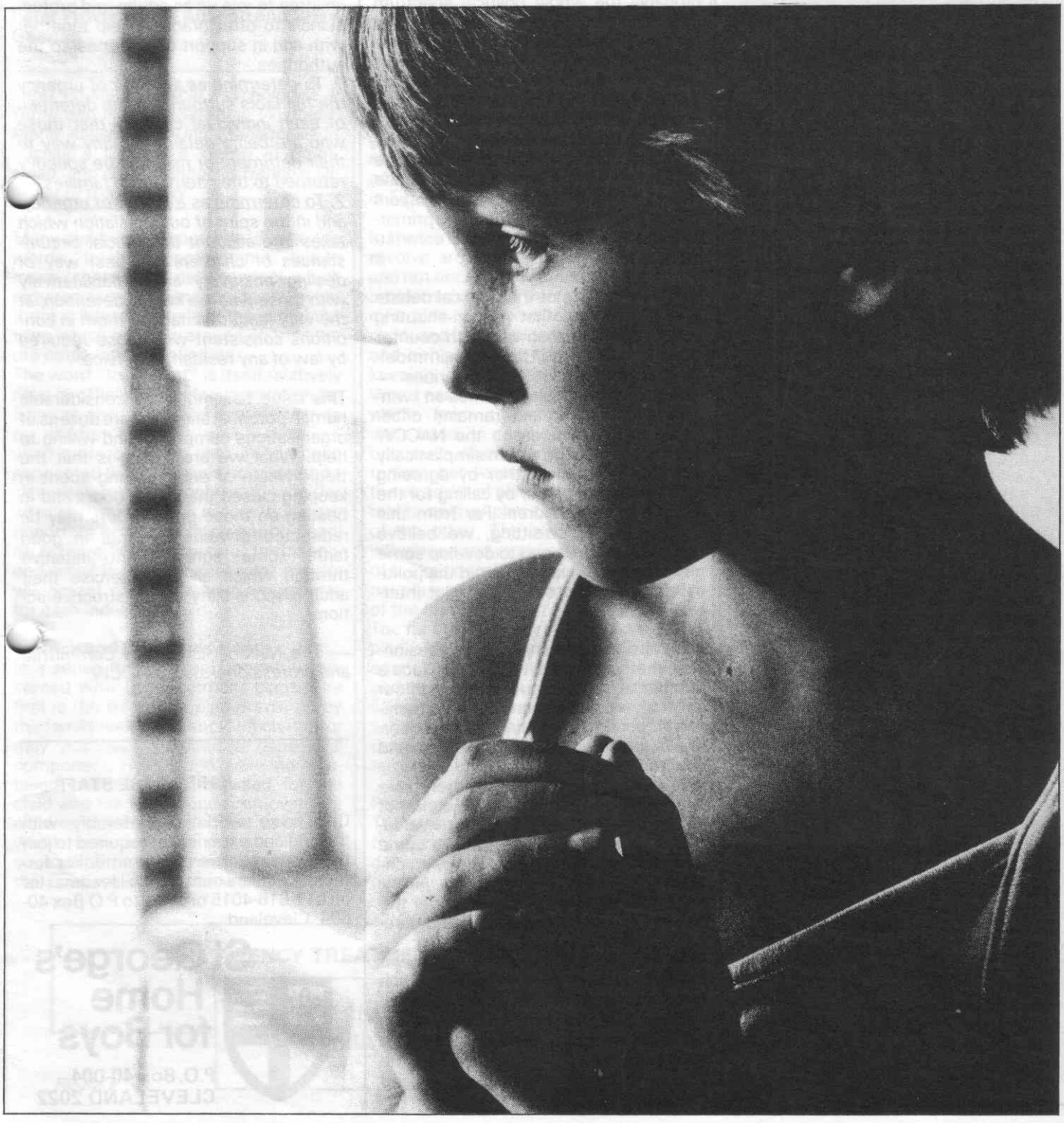
Die kinderversorger



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NASIONALE VERENIGING VAN KINDER-VERSORGERS

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POSITION STATEMENT

Children in Detention

The NACCW is a non-political organisation. Its members, who represent all race, language and religious groups and probably the whole political spectrum from far right to far left, share one major concern: the well-being of children and specifically those who must be cared for apart from their homes and families.
Just as doctors in a civil unrest or even a war situation commit their skills primarily to healing and the alleviation of suffering, so, when a situation like the detention of children arises out of the political arena, child care workers should seek a way of responding primarily in terms of their professional commitment.

Such is the state of the political debate in South Africa that slogan-shouting does little more than call forth counter slogans and we adults are then immobilised in our own political polarities — while an urgent issue becomes an I win/you win contest and remains unaddressed. For this reason the NACCW does not want to be drawn simplistically into the stalemate either by agreeing with the detentions or by calling for the release of the children. Far from this being mere fence-sitting, we believe that as adults we need to develop some new initiative which will avoid the political deadlock and serve the best interests of children.

As adults, as parents and as professionals, whether we like it or not, we face a number of critical issues relating to our children and our responsibility to them.

- A large number of children have been drawn into the cycle of violence and counterviolence.
- A whole generation of children have been polarised through an inversion of values where ideas like authority, education, loyalty and freedom have come to mean radically different things to different people.
- A large number of children under the age of 18 have been detained under security legislation.
- There is no doubt that some of these have committed acts of violence which have not left them unaffected as developing youngsters.
- There is no doubt that some of these have been wrongly detained and are being unnecessarily exposed to risk and separation.

More than all of this, those of us whose work is connected in any way with the rising generation who are to be the adults of tomorrow, quite apart from the already daunting challenges presented by poverty, rapid urbanisation and economic under-development, have a massive rehabilitative and reconstructive task ahead of us in South Africa, which becomes more difficult for every day that these issues remain under political wraps where the adults and professionals can't get at them to help.

We invite all whose concerns lie with children to join us as adults and professionals to offer practical help together with and in support of an appeal to the authorities:-

1. To determine as a matter of urgency the full facts surrounding the detention of each individual child so that those who are being detained in any way to their detriment or risk may be speedily returned to their homes and families.
2. To determine as a matter of urgency, and in the spirit of our legislation which takes into account the special circumstances of children, the best way of dealing positively and rehabilitatively with those who are kept in detention, at the very least maintaining them in conditions consistent with those required by law of any residential service.

This issue has mobilised considerable human potential and there are dozens of organisations competent and willing to help. What we are asking is that the tragic waste of energy being spent in keeping closed the prison doors and in beating on those prison doors may be redirected towards seeking, in good faith, some agreed joint initiative through which all can exercise their adult responsibility for constructive action.

— The National Executive Committee and professional staff, NACCW.

Regulation 33(2)(f) under the new Child Care Act (No.74 of 1983) for the first time requires children's homes to have on file a "treatment programme" in respect of each child. In this series of four articles the authors explore the purpose and nature of such a document.

The Treatment Plan

Peter Powis, Merle Allsopp and Brian Gannon

Peter Powis is Clinical Psychologist at Tenterden Place of Safety in Wynberg, Merle Allsopp is a Unit Manager at St Michael's Children's Home in Plumstead, and Brian Gannon is National Director of the NACCW.

Many children's homes already use the words "treatment programme" but to many others it is a new concept which requires some explanation. In any event there is little unanimity in the use of the term which has now arrived on the statute book with no definition.

The word "treatment" is itself relatively new in official state documentation relating to child care, and confirms a role for children's homes which goes beyond mere custodial care. It has been suggested that children's homes need a clear statement not only as to why (for what reason) a child is in care, but more important as to why (for what purpose) he is there, and the answer to the second *why?* is the foundation for the development of a treatment programme for each individual child.

Agency and Children's Home

In a sense the children's home is concerned with *two* treatment plans. The first is the treatment plan drawn up by the family welfare agency which may or may not have included a residential component. The second is the more detailed treatment plan devised for the child and his family once removal to a children's home is decided upon and which now includes the specific resources of the residential agency. From this point we seem to be working with a composite treatment plan for the child and his family in which the referring agency and the residential facility to a greater or lesser extent share roles and responsibilities. Schematically the composite treatment plan may be viewed as in Fig.1.

In theory the referring agency's plan will revolve around the family as a whole, and not uncommonly this will be a multi-problem family. The residential agency's plan will focus on the individual child, and his developmental, emotional and behavioural problems and growth keeping in mind the family context. While each of the two agencies clearly works from its own knowledge and skills base, in practice the task should become a shared task, and then the interface between the agency plan and the residential plan becomes critical. In reality neither plan can be independent of the other. The agency plan will be influenced and modified by the inclusion of the residential resource; the residential plan cannot operate independently of the family.

The fact that we work with a composite plan which is mediated by two separate agencies creates its own set of tasks, and the residential social worker is a key liaison agent between the two. At the same time this partnership widens the resources available to the child and his family.

Planning Priorities

The demand for treatment programmes to be included in the children's home's documentation forces us to look at a number of issues related to the service we provide.

Permanency planning: We have a responsibility to subscribe to and work towards the principle that children have a right to live in families which offer durable and predictable relationships. This means that having children just *living* for indeterminate periods in institutions is no longer tenable practice. It also means that when the door opens to admit a child to a children's home, we should already be thinking of the doors we will have to open to discharge him. Permanency planning is a planning priority.

Regarding children as in transit: If children are in children's homes so that we can help them towards permanent normative placement, then their stay is time-limited and whatever work we have to do must be begun. How sad that our legislators saw fit to water down the new Child Care Act by including Section 16(2) to the Draft. It would have been good for us to have to go to the trouble of a whole new Children's Court Inquiry after two years and to have to explain why we needed more than this period of institutional care to help a child. Urgency is a planning priority.

Cost effectiveness: 24-hour services are expensive. A children's home spending, not uncommonly, R500 per month per child is accountable for what the public and private sectors get for their money. At this rate we spend R12 000 over a two-year period. It would certainly be hard to justify the expenditure of R30 000 over a five-year period. Children's homes cannot continue to spend such amounts without offering planned and goal-directed services together with some demonstrable results — and at the same time the state has to accept some realistic financing responsibilities if it wants the services. It is astonishing that the state is still prepared to condone the expenditure of R60 000 on one life over a period of ten years and get at best a doubtful return, instead of spending say R20 000 on that same life over two years with the probability that this will produce a healthy-functioning contributor to society and the economy. The Americans spend twice that amount in one year, and they have something to show for it.

What is a Treatment Plan?

A treatment plan is essentially a systematic set of steps followed by an agency in order to define what treatment tasks need to be done, how they should be approached and by whom, in order to reach agreed objectives within a given time frame.

The above discussion emphasises the need for individual treatment programming so that not a day is wasted in the pursuit of defined goals.

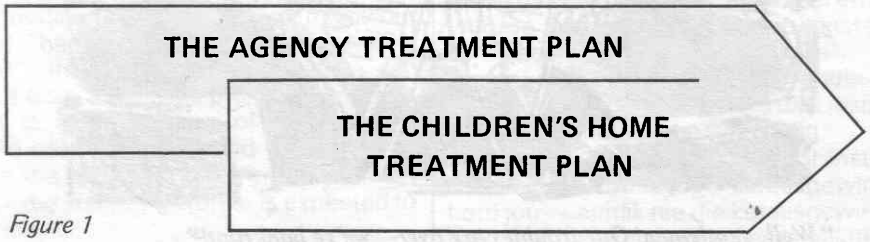

Figure 1

An assessment of the child, together with past and present significant relationships and events, leads to the formulation of a diagnosis, as well as recommendations for the child's future placement and management.
The diagnosis should indicate problem areas in the child's and family's functioning, as well as strengths which may be used to facilitate change. On the basis of this diagnosis the treatment plan is drawn up with the child's future in mind.
The treatment plan gives guidelines to specific people working with the child (eg. case manager, child care worker, therapist, reconstruction worker, teacher), and also where appropriate, to significant others (eg. the child's family).

The treatment plan should include an estimate of the time required to work on specific goals.

While guidelines are given concerning how goals should be approached, team members should not merely be prescribed to. What is important is that each member of the treatment team sees his role as a part of a larger co-ordinated effort. This also implies that someone co-ordinates the treatment plan.
The treatment plan should include an estimate of the time required to work on specific goals. The plan should however allow for the fact that change often occurs in its own time and in unpredictable ways.

Why a Treatment Plan?
The advantages which flow from having a treatment plan for each child are numerous. Some of these are:
- Every team member knows what to work on and can see how his involvement fits that of others. This prevents team members from working at cross purposes with each other. It also ensures that each team member forms a contextual view of the problem areas.
- It creates structure and security for both the team and the child. When significant others are involved, they are also provided with structure and a sense of purpose.
- It ensures that important decisions are made systematically and that the purpose of a child's placement is constantly borne in mind.
- It keeps everyone's mind on the *child's* problems which encourages the team to act in a child-centred and not an institution-centred style.
- It encourages both staff and child as interim goals are reached and visible gains are made.
- It facilitates the estimate of a time period for the child's stay.
- It reassures the child that all are working on his problems and ensures that the treatment the child receives fits into the plan for his future.

A lot of the anxious and destructive behaviour observed in children's institutions results from children's feelings that they are forgotten, that their needs are not being met and that their hopes and dreams are unimportant to others. When this happens, staff are tempted to develop strategies to counter the anxious and destructive behaviour, and without realising it the team is working at full-steam solving problems which have nothing to do with individual children's development. Without treatment planning, staff find themselves working *in vacuo*, they become discouraged, and a vicious circle gains momentum as we all, staff and children, lose our way.

The Treatment Plan

Joe took his car to garage. "I've got a problem here", he said. "It's not going too well and it's using a lot of fuel — and I need a reliable and efficient car for my work".
"Okay, let's have a look and see what's wrong", said the garage man. "It will take me an hour or so to find the problem and then I'll call you".
An hour later the garage man 'phoned Joe to say that he had a leaky fuel pump which he would have to send out for repair and that the car needed a new set of spark plugs. He would get on with the job and the car would be ready by 4 pm. In fact it was only ready at 4.30, but Joe was pleased to have his car back on the road in good shape.

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Susan went to the doctor with a severe pain in her elbow. She had fallen during a tennis game and the next morning could hardly use her elbow. She wanted to be fit in time for the summer championships. "We'll have to take some X-rays and we might get an osteopath to have a look at you", the doctor said.
Two hours later Susan was back in her doctor's office. "Luckily there's no sign of a break or anything" he said. "It looks like a case of old-fashioned tennis-elbow. You've injured a tendon and it's very painful".
"What can we do about it?" asked Susan.
"I shall have to give you an injection which will relieve the pain. You will have to rest that arm for a good two weeks and then do some exercises I'll set for you. It will take six weeks altogether, but you'll be as right as rain after that".
That summer Susan was runner-up in her club championship and never gave her elbow a second thought.

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The social worker took Chris, aged 7, to the local children's home clutching a court order and report which told the unhappy story of his troubles at home. The principal said "Okay, just leave him here. I'm sure in time he will settle down".

"Well, gentlemen! Our troubles are over—we're bankrupt!"

Practice Hint

Happy People Don't Behave Like That

Selma Wastell

"I don't want to go home, my mother is an even bigger bitch than you are!" It was an eleven year old's response to a polite enquiry about the coming weekend and it reminded me of when I first heard the words in the title of this article. They were said to me by a young man when we were witness to very uncalled for, unfair rudeness. I wondered why some people behave that way. "I don't know" he said, "but one thing is sure: happy people don't behave like that."

We learn in child care courses that we must separate the deed from the doer, but even more than that we must keep ourselves out of the conflict and not add to the unhappy wrong-doer's misery. This is the most difficult part, but in actual fact, by returning anger with anger, injustice with injustice, rudeness with rudeness, we are indulging in the same wrong activity instead of trying to improve how the other person is feeling. "Condemning wrong behaviour, certainly includes refraining from it". This is another statement that had an impact on me recently when I felt I had been unjustly treated. My first reaction was one of self-pity and revenge. It took a lot to try to see why the other person had done what they had, and then the "happy people don't behave like that" quote sprang to mind. This made it easier for me to see the other side and to start working on a constructive solution.

It is difficult when a child (or anyone else for that matter) treats us with rudeness or unkindness, to respond with love. The child who loses control and attacks is probably on the point of losing a massive inner struggle. He is resorting to his most primitive defences, and is at his most vulnerable. To be attacked from outside at such a time is the last thing he needs.

The children we care for have been hurt by society in general and their families in particular. When their feelings are aroused or simply bubble up, they tend to hit back at the people who (probably for the first time in their lives) care for them or, more primitively, they take it out on the walls, furniture and fittings of the children's home.

If one can remember in face of spiteful, aggressive and destructive behaviour that "happy people don't behave like that", the focus of our response can shift from the child's provocative acting out to an awareness of the unhappy child behind the act, and there we will find the real (and much more difficult) task the child care worker is expected to tackle.

KENNISGEWINGBORDE

J. Pelcher

Kobus Pelcher is 'n maatskaplike werker en is tans Hoof van die Alta du Toit Nasorginrigting in Bellville. Hy was voorheen adjunkhoof by Kinderoord MTR Smit in Ugie waar hy ook die hoof van die Departement Behandelingsdienste was.

Wat ookal van hierdie woorde u mag tref — ek bedoel die stuk afgebakende area waar kennisgewings en 'n magdom ander inligting aan 'n ieder en 'n elk beskikbaar is.

Rondom ons is daar orals kennisgewingborde: by stasies, kafees, bioskope, kerke, sportgronde, skole, woonbuurtes, staatsdienskantore en selfs kinderhuise!

Ek het die afgelope jaar die voorreg gehad om verskeie kinderhuise te besoek. Dit sluit in Natal, Vrystaat, Noord-Transvaal en selfs die Kaapprovinsie. Die opvallende kenmerk van al hierdie kinderhuise se kennisgewingborde is dat dit saai, oninteressant, formeel en oorlaai met amptelike kennisgewings/omsendbriewe is. Sommige hiervan erg vergeel en dan ook nog op outydse "foolscap" papier.

Ag nee mense, komaan, ons leef in 1987! Word wakker, kry lewe, of nog erger, probeer dit waarmee u voortspartel op u kennisgewingbord uitspel en by woorde van Martino, kulkunskunstenaar: siedaar! Nog 'n nuwe toertjie!

Mag ek u vertel van een kinderhuis se kennisgewingbord? Dit kan u dalk inspireer om ook hul voorbeeld te volg.

Wanneer jy die dubbel voordeur instap oorheers 'n reusagtige kennisgewingbord jou — eintlik nie die kennisgewingbord self nie, maar die massas inligting wat vir almal beskikbaar is. Heel bo-aa is drie groot kalenderbladsye langs m kaar: 'n kwartaal- en maandbeplannir ineen. 'n Veelheid inskrywings in ver killende kleure en handskrifte sê my d hierdie beplanning voortdurend op d tum gehou word. Van naderby bek sien ek dat die skool, jerk en verske ander organisasies se aktiwiteite hierc ingeskryf is. Saam hiermee dan ook ve gaderings van die beheerraad, kom tees, 'n inspeksie (deur d Departement), diensbeurte van perso eel, 'n huiskomiteevergadering en da natuurlik (in rooi omsirkel) die begin e einde van die skoolkwartaal. Naby d einde het iemand ingeskryf: "ten mo to go".

Ek merk half skeef onderaan die kenni gewingbord ook 'n netjies geteken raam en bo-aan die sjabloon-opskri "Verlore Goedere". 'n M16H sleut hang aan 'n skuifspeld tesame met sakdoek met 'n groot "B" op geborduu 'n mooi Bybelteks en dan, o so kenme kend, 'n ongemerkte huiswerkboek.

'n Ander groot stywekarton plakka met netjiese sierskrif vang my oog ook die lagwekkende prentjies daarb Die opskrif, Wie, Wat, Waar, Wanne Hier sien ek die hart van die kinderhuis Die washuisbeurte, dorpsdae, winke beurte, snoepwinkeltye, biblioteekty en nog 'n magdom interne reëlings, ewe netjies, dog in telegraaf-styl besk ryf.

'n Netjies getikte verjaarsdaglys van di personeel en kinders is half weggestee onder 'n gemaakte plakkaat wat 'n sok kiejol adverteer. Toegang: 20c. Te oo deel aan die getekende disko-ligt beloof dit beslis 'n treffer te wees.

Die groot stapstewel, kompleet met ir

gerygde skoenveter, trek die aandag van die voornemende stappers. 'n Staptoer langs die Wildekus met relevante inligting. Klink baie interessant. My knie pla ongelukkig.
Verder is daar 'n rooster vir bus- en treintye, en 'n gewraakte dag-vir-dag eksamenrooster vir alle skoolstanderds. Hierby dan ook nog 'n uitnodiging na 'n CSV kamp op 'n mooi gedrukte kaartjie, maar effens versteek in die middel, 'n foto van die hoof en sy vrou wat 'n simposium oor kinderversorging bygewoon het.
Twee los plakkate sê "Welkom" en "Totsiens". Slegs een foto van 'n dogter wat die kinderhuis verlaat het pryk hierop, dog 'n hele lys getikte name en opvolgadresse is beskikbaar. Heel onderaan het (seker 'n kinderhuisverlater) geskryf: "Cheers".
My oë val verder op verskeie kleiner, maar ewe interessante kennisgewings: dié van 'n koffiedrinkaand by een van die dogtershuise (hulle beloof skuim bo-op die koffie en 'n malvalekker vir diegene wat hulle gedra) en ook nog daarna musiekteoriepapier met regop en onderstebo note en 'n handgeskrewe uitnodiging tot 'n musiek- en liriekaand by 'n ander huis.
Met belangstelling kyk ek na 'n ander kinderhuis se brosjure — hul sportapparaat en speelkamer val my op. Wonder waar kry hulle die geld?
Ag, en dan die kunswerke: 'n groterige waterverfprent met 'n seun se naam en ouderdom onderaan; 'n gevoude gedoente van papier; 'n potloodskets van 'n ruiter op 'n perd met twee pistole op sy heupe en dan die blomme op 'n stuk kladpapier geteken met inkleurkryt.
Ek sien ook 'n "word gou gesond" en bedankingsbrief naas 'n troukaartjie van 'n oud-personeellid (die uitnodiging aan die kinders en personeel). Wonder hoe sy dink ons almal op Rietbron gaan uitkom?
'n Spotprentjie uit die Landbouweekblad versier 'n ruilkolom — en word daar nie baie aangebied nie?! Dit wissel van 'n vergrootglas, PM9 radiobattery, jong groep budjies en dan ook nog 'n drie-in-een flits waarvan die gloeilamp makeer (eerlike ou dié). Ek sien dan ook dat iemand 'n stel fiets-sleutels (spanners) aanbied in ruil vir "wat het u".
En dan, die nimmereindigende en altydteenwoordige "Gesoek" — 'n swart masker met vae waterige oë versier hierdie papier waarop daar die volgende op staan: horlosie (dames, silwer) sonder band, VIRO-slot en sleutel, lessenaar, potloodsakkie en koorlêer. Shame, ek wonder hoe hierdie ou nou koorsing.
In Gotiese skrif tref ek die gedagte van die week aan: "Hou jou glimlag vir jou vyand, jou traan vir jou medemens en jou gewete vir jouself." Langenhoven.
Die uitslag van 'n tuinkompetisie is ook bekendgemaak: Eerste: Huis so en so, Tweede: Huis so en so, en Derde: Huis so en so. Iemand het Budget Rent-a-Car se advertensie uitgeknip en by die derde plek geplak. Die woorde van "Soon we'll be number one" weerspieël beslis hul motivering.
'n Rekenaardrukstuk met 'n groot simbool van die bloedoortappingsdiens spoor ons aan om bloed te skenk en sodoende 'n lewe te red. By die datum onderaan het 'n opmerksame kind (of was dit 'n personeellid?) bygeskryf: "dis dan Bles Bridges en Joanna Field se konsert in die stadsaal." Klaar, uit en gedaan. Wonder wie nou nog bloed wil skenk en aan die red van 'n lewe gaan dink?
Bo-aan die lysie is daar 'n parmantige toktokkie plakkertjie en 'n Biblia 50 plakstrokie. Onmiskenbaar staan daar op rooi geskryf met 'n swart koki-pen: "Stilte in die wagkamer".
Ek merk ook 'n netjiese lys, redelik opmekaargetik op: "Verhoging van sakgeld soos vanaf 1.6.1987 in werking". Hieronder die ouderdomsgroepe en die bedrag sakgeld wat elkeen op geregtig is. Die matrieks se R25 per maand is met 'n sterretjie gemerk, wat onderaan verduidelik dat hul hieruit alle toiletware self moet aankoop. Skielik is dit nie meer sakgeld vir spandeer nie.
'n Groepfoto wat half uit fokus is wys vir ons die Kinderhuis Junior Bestuur. Wonder hoekom hul die ou vaal togas moes aantrek? Die sekretaresse se oë lyk vir my toe — moontlik geknip vir die kamera, of dalk in diepe bepeinsing oor die notules wat sy moet skryf?

Wat is die doel van 'n kennisgewingbord?

Vir my is dit belangrik dat 'n kennisgewingbord die wese van die kinderhuis uitbeeld. Dit omsluit aspekte soos:
- organigram
- funksionering (administratiewe-, behandelings- en versorgingsdienste)
- amptelike kennisgewings
- informele aktiwiteite wat dienste aan en vir die kind, en dit wat deur die kind self geskep, georganiseer en aangebied word.

Bowenal moet dit gesonde tweerigting kommunikasie bevorder. Laasgenoemde bring my by die volgende punt. Waar moet 'n kennisgewingbord dan wees om in sy doel te slaag?

Waar?

Vir voor die hand-liggende redes is 'n kennisgewingbord by die hoofgebou of administratiewe gedeelte onontbeerlik. Elke kantoor van die personeel het gewoonlik ook 'n kleiner kennisgewingbord waarop die meer formele omsendbriewe en kennisgewings is. Dit sluit natuurlik nie uit dat hierdie kennisgewingborde ook met kunswerke en ander items versier kan word nie.
Die kombuis, wassery of magasyn en selfs 'n speelkamer kan ook 'n funksionele kennisgewingbord hê, maar die ander belangrike plek sou seer sekerlik in elke huis/wooneenheid wees.
Elke huis het gewoonlik sy eie interne organisasie, roetine en pligte wat tesame met 'n verjaarsdaglys en enkele ander stukke die kern van die tersaaklike inligting uitmaak.
Op die terrein kan ook 'n muur of onderdak-kennisgewingbord wees waar die onmiddellike daaglikse gebeurtenisse uitgespel word. Ek dink hier aan "Pannekoekverkoping: Mowgli House, 18h00, of "Kaskarwedren: 10h00 parkeerterrein" of "Sokkiejol: 20h00".
Om in die doel van 'n effektiewe kennisgewingbord te slaag, sou ek oordeel dat dié in die hoofgebou of ontspanningslokaal die meeste inligting sou omvat en die duidelikste tot elke toeskouer behoort te spreek.

Wie?

My oorwoë mening is dat die Departementshoof: Behandelingsdienste die aangewese persoon is om —
- inligting deur te gee
- nuwe inligting aan te suiwer en programme op datum te bring
- verbygaande uitgediende inligting te verwyder, en waar nodig, te liaseer.

Dit sluit natuurlik nie ander personeellede en kinders uit wat iets snaaks het om mee te deel (spotprent) of 'n gepaste byskrif ("Cheers") om die vrymoedigheid te neem om ook tot die potpourri van 'n kinderhuiskennisgewingbord by te dra nie.

Hoe?

Waar beplanning deesdae 'n uiters belangrike komponent van elke kinderhuis is, sou 'n kwartaal-, maand- en weekbeplanning onmisbaar wees. Ondervinding het geleer dat groot kalenderbladsye hiervoor onontbeerlik is.
Ruimte moet beskikbaar wees vir ander afgerolde of getikte of handgeskrewe kennisgewings asook dié ekstern aan die kinderhuis wat van belang is.
Ek sou dink dat 'n minimum vervelige en uitgediende reëls en regulasies daarop moet wees. Onthou: kleur, vorm en skrif is belangrike komponente vir suksesvolle kommunikasie.
Met 'n skêr, tydskrifte en 'n sjabloon kan wondere verrig word — en laat gerus die kinders met 'n kunsaanleg toe om self mee te help om die inligting aantreklik aan te bied. Saam met een of twee kinders kan die kennisgewingbord voortdurend verfraai word.

Slotgedagte

Persoonlik sou ek oordeel dat 'n kennisgewingbord 'n spieëlbeeld van die pols-ende lewensgang van die inrigting in een oogopslag vir die oningeligte moet kan bied. Dan slaag die kennisgewingbord in sy doel en funksie.
Hoe lyk u kinderhuis se kennisgewingbord?

Nuusbrokkies Newsbriefs

Eastern Province

er Supervision
The children's homes in the Border Region of the Eastern Province, the social workers and principals of Malcomess House, King Williams Town Children's Home, Khayalathemba and Mfasane Organisation have been meeting on a monthly basis for peer supervision. At their last meeting, which was held on 13th May, they were also able to include the Woodlands Mission and Sister Mathilde, who is assistant to the principal, and Sister Theodore, the principal, attended for the first time. Woodlands Mission has been in existence for 60 years and the Border Region of the Eastern Province was pleased to have been able to include them for the first time in their meetings.

Weekend Course for Eastern Province Region
56 students attended the residential weekend course held at King Williams Town Children's Home from Friday 15th to Sunday 17th May. Newcomers were staff from the Woodlands Mission and St Thomas' School for the Deaf near Stutterheim in the Ciskei. Woodlands accommodates 117 children in a hostel situation of whom 50 are there on children's court orders — interestingly none of them from the Ciskei, all from other areas in the Republic. St Thomas' School, whose principal attended with two child care workers, has 170 children. Selma Wastell, who was until recently vice-principal of St Michael's Children's Home in Cape Town, shared the lecturing in the Basic Qualification in Child Care course with Lesley du Toit.

Students of this course are at present studying Module 3 of the BQCC which deals with Public Welfare Policy and (in the practical sessions) with Daily Routines. On the first evening of the weekend Selma Wastell ran a workshop entitled "The Trap of Experience" which challenged staff members who thought they "knew it all" as a result of experience and therefore deprived themselves of the stimulation of new experiences and new learning.

Selma Wastell

There were four seminars for principals, social workers and senior staff: Selma Wastell ran a workshop on "Reshaping Today's Organisations for Tomorrow's Needs". Barrie Lodge presented a session on *Children's Homes Looking Outward* which explored the functions of the children's home in the context of the wider community. Lesley du Toit spoke on *Teaching Competence through Activity Planning*. There was a session introduced (*in absentio*) by Brian Gannon on the use of films in staff development which included the viewing of the video *The Loneliest Runner* followed by discussion.

International

NACCW invited to join International Network
The NACCW has been invited by the Child Welfare League of America to become part of the newly established International Network of Child Welfare Affiliates sponsored by the CWLA whose motto is "Guarding Children's Rights : Serving Children's Needs". The Executive Director of CWLA, David Liederman, whom our National Director met while in North America in 1985, points out that "since children and families around the world face similar problems, it makes sense to pool the globe's resources, solutions and expertise in facing the challenges ahead". The CWLA publishes a regular journal together with other handbooks which have been of considerable use to us in South Africa, and in turn has regularly received our own journal *The Child Care Worker* at their Head Office in New York.

A Basic Appeal
Pastor and Mrs de Jager who run the Manhinga Village near Mutare in Zimbabwe end their April Newsletter with a simple appeal as the highveld winter draws on: "We are in short supply of clothes and will appreciate your used clothing". A parcel sent to P.O. Box 213, Mutare, Zimbabwe would be put to good use.

National

National Executive Committee Meets in Cape Town
On Thursday 23rd April the National Executive met in Cape Town where major issues discussed included NACCW staff, publications, child care training, welfare policy and international links. The National Director and Treasurer each presented their reports, the latter report leading to considerations of fund-raising and membership subscriptions to be raised at the Biennial Conference later this year.
It was noted that the NACCW has 282 students enrolled in the Basic Qualification in Child Care (BQCC) course countrywide and that altogether 211 were enrolled at technikons for the National Higher Certificate in Residential Child Care (NHCRCC) course. The fact that 160 of these were in their first year and only 51 in second year demonstrated a disturbing fa off rate of almost 70 percent. Plans were considered for additional staff training specifically for more experienced and senior staff.

Regional Director Appointed
At the recent National Executi meeting in Cape Town it was agreed to appoint a full-time Regional Director for the Nat and Eastern Province areas. The appointment of Lesley d Toit, presently Programme Director at the King Williams Town Children's Home, as fro 1st August 1987 was confirme Elsewhere in this issue is an interview with Lesley regardi her new post.

Natal

Regional Meeting
A Regional NACCW meeting was held at the Browns Scho in Pinetown on 22nd May. Th Speaker was Duncan Davids who spoke about Alcohol an Drug Dependency amongst Adolescents. He highlighted t pressures that are brought to bear on young people.

Liaison Committee
The Department of Health Services and Welfare: House Assembly have formed a Regional Liaison Committee children's homes. This committee will be used to de with administration functions and procedures concerning t management of homes.

Kathy Mitchell, one of the tutors on the BQCC course

Training
56 child care workers recentl completed Module I of the Ba Qualification in Child Care course. The students look forward to the appointment the Regional Director so as to provide further training opportunities this year.

Rebuilding
The NG Kinderhuis in Malver is a hive of activity since the arrival of the builders. More about their redevelopment ne month.

Transvaal

Mollie Painter with audience at Regional Meeting

The concept of regional meetings is relatively new to the Transvaal. Last year one such gathering was held. The first one for 1987 was held on Wednesday, 29th April at the Maria Kloppers Kinderhawe. This meeting was attended by children's homes from as far afield as Mamelodi and Germiston. Our meeting was advertised as "A good gossip" and consisted of a humorous look at the way the child care workers perceive the principal, and the way the principal perceives the child care workers. Jonathan Pearce, principal of Epworth, and Jean Wright, principal of Guild Cottage, role played two child care workers meeting in the supermarket and having a good gossip about their principals.

Jonathan Pearce

Their remarks had us all laughing heartily. Not only were they very funny, but they also made some excellent observations about the way child care workers see their principals.
The next role play was done by Jenny Stafford and Tracey Nurick, both child care workers at Johannesburg Children's Home. They role played two principals meeting for a gossip about their child care workers, and their remarks threw light on this subject from the opposite point of view. After this similar role plays were presented in Afrikaans. President Kruger Kinderhuis kindly agreed to do the presentation, and the role plays were done by Miss B. Smit and Mr Oosthuizen representing the principals and Jenny Oosthuizen and Ella Fitzcharles representing the child care workers. At the end of the meeting the various threads of the discussion were put together and presented to the group. A successful meeting enjoyed by all!

BQCC Course Programme
June 3rd —
Forms of substitute care.
Adoption — Maureen Lang, former Manager, Adoption Services, Child Welfare Society.
Foster care — Lecturer to be announced.

June 10th —
The Residential Care System.
The Places of Safety, Schools of Industry, Reformatories.
Lecturer: to be announced.
Cottage Homes, Dormitory Systems, Group Homes.
Lecturer: Di Levine

June 17th —
The Children's Home — How it works.
1. The role of the Management Board — Lecturer: Di Levine.
2. The Role of the Principal — Lecturer: Joan Rubinstein, Principal, Johannesburg Children's Home.
3. The Role of the Social Worker — Lecturer: to be announced.
4. The Role of the Child Care Worker — Lecturer: to be announced.

June 24th —
Test.

Principals' Meeting
The date of the next meeting has been changed and we will now meet on Thursday, June 4th, at Firlands Children's Home at 10h00. The address is 4th Avenue, Linden. Telephone 782-5556/7.
Topics for discussion include discipline, pocket money, smoking. We will also analyse the new departmental manual on management boards in the children's home, so if you have a copy, bring this along. Another suggestion is that we start a journal club. Members of the group will be given an up-to-date journal or article to read and then report back to the group on the special points of interest. The journal club will be started at this next meeting.

Social Workers' Meeting
The next meeting of the social workers will take place at 09h00 on Thursday, May 14th at St George's Home, Healey Road, Malvern East. This group will be led by the St George's Home social workers, who have kindly agreed to present their programme on hosting for the group to discuss. The possibility of standardisation of these programmes will be examined. Here too, a journal club will be started and journal articles will be presented at this meeting.

Executive Committee
The next meeting of the Executive Committee has also been delayed and will take place on Thursday, 4th June at Firlands Children's Home at 08h30.

Wes-Kaap

Nuwe Aanstelling
Johannes van Staden is pas aangestel as Hoofversorgingsbeampte by Tenterden Plek van Veiligheid in Wynberg. Hy is vanaf 1973 by versorgingswerk betrokke en was senior personeellid by die Witrivier Rehabilitasiesentrum vir Alkoholiste in die Transvaal. Hy is vandaar met bevordering na Kaapstad verplaas. As nuweling in die Kaap en in kindersorg sal die aanpassing vir hom 'n uitdaging inhou. Hy en sy vrou woon naby en het vier volwasse kinders.

New Facilities at Bonnytoun
On 19th May Dr Gamieldien, Director of Health Services (House of Representatives) was the guest speaker at the opening of the trimpark and gymnasium recently added at Bonnytoun Place of Safety in Wynberg. The principal, Ashley Theron, expressed the gratitude of his staff and children at the way in which the Department had responded to the real needs of an institution like Bonnytoun. Present were Engela van Dyk, head of the Department's Wynberg office together with Messrs Broderick and Rossouw of the Department, as well as many representatives of children's institutions in Cape Town.

Mr S. Broderick, Mrs M. Hendricks and Engela van Dyk with principal Ashley Theron

New Appointment
Newly appointed Principal of Leliebloem House, a cottage-style home for 72 children in Belgravia, Athlone, is Peter Campbell. After matriculating in Johannesburg, Peter served two years in the Navy and then spent five years as a wild life guide in the Kruger National Park. Then, while supporting himself as a child care worker in Cape Town, he studied at UCT for his B.Soc.Sci. degree. Peter was born with a child care spoon in his mouth — he was born in Pietermaritzburg at the Baynes Memorial Home where his parents were in charge at the time.

Situations

Experienced child care worker required to develop residential programmes for 140 children in special school. Leadership of 20 child care staff. Enquiries to the Principal, Dominican School for Deaf Children, P.O. Box 18, Wittebome 7840

Resident, experienced child care worker required for small children's home in Durban. For further information contact the Principal on 031-21-0837

Vice-Principal: Programme Director

Senior appointment for a person experienced in residential child care to manage programmes. Resident post in cottage style home.

Further information from the Principal, Eastern Province Children's Homes, Lenox St, Port Elizabeth.

Psycho-somatic Illness and Symptoms in Children

Stanley Levenstein

Dr Stanley Levenstein is a Cape Town General Practitioner

Psycho-somatic illnesses (also known as psychophysiological disorders) are certain conditions in which structural changes in the body are attributed mainly to emotional disturbance. Common examples of psycho-somatic illnesses in children are bronchial asthma and certain skin conditions such as neurodermatitis (hives) and eczema, while less common (but not rare) examples are diabetes and stomach ulcers. Psycho-somatic symptoms refer to complaints such as stomach pains, headaches, dizziness and tiredness which are attributable to emotional causes, but without any structural changes in the body tissues.

The emotional — physical link

How can emotional disturbances cause physical illnesses or complaints? The various organs of the body e.g. the skin, lungs and stomach and intestines, which are not under voluntary control, are especially sensitive to changes in the individual's emotional state. By "voluntary control" is meant the individual's ability to control the functioning of an organ or organ-system by an act of conscious will. Readers will know from their own experience that they are unable to control their own heart- (pulse) rate, but that they have been aware of their hearts beating faster after physical exertion or when experiencing intense anxiety. The same applies to other bodily activities such as sweating, blushing, and narrowing or widening of the pupils of the eyes. The reason for the lack of voluntary control over these activities is that the organs concerned receive their nerve supply from a part of the nervous system known as the "autonomic" nervous system which regulates all involuntary bodily functions. The autonomic nervous system is under the control of a part of the brain known as the *hypothalamus* which in turn is very sensitive to any changes (external or internal) that may affect the individual's emotional equilibrium. The autonomic nervous system is intended to help maintain the effective functioning of the body as a whole, but in cases of psycho-somatic illness, the nature of the stresses and the nervous responses to them produce a pathological reaction.

It is not only the autonomic nervous system which plays a part in the production of psycho-somatic disorders. Hormones such as cortisone, thyroid hormone and insulin which are produced by various glands in the body and secreted directly into the blood-stream, can and do play an important part in the development of psycho-somatic disorders. The glands, known as *endocrine* glands, which produce these hormones also receive their nerve supply from the autonomic nervous system and are therefore influenced by, and in turn influence, the individual's emotional state. The activity of the endocrine glands is also regulated by the hypothalamus which has been described as "the conductor of the endocrine orchestra".

These factors are likely to render the child in residential care more susceptible to psycho-somatic disorders as well as to illness in general.

It can thus be seen that there is the most intimate connection between the individual's emotional state (psyche) and the functioning of his/her body (soma). This inter-connectedness is so great that many people have argued that the term "psycho-somatic" is an artificial one, implying as it does a separation between the functioning of the psyche and the soma. In fact it is increasingly being shown that there is an interplay between psychic and somatic factors in virtually all "physical" illnesses and not only in "psycho-somatic" disorders. An example of this is the study of bereaved spouses in the United Kingdom where it was shown that the individuals concerned not only showed a higher incidence of emotional and "psycho-somatic" disorders than controls, but also a markedly increased incidence of "physical" illnesses, such as arthritis, infections and cancer!

Coping with distress and loss

Perhaps the Bereavement Study would be an appropriate starting point from which to consider the problem of psycho-somatic disorders in children in residential care. In a sense all children in residential care could be regarded as bereaved, if not in the literal sense then certainly insofar as they have all experienced major losses of important parental and other figures in their lives. Furthermore, unlike adults, they have usually not yet been able to develop adaptive ways of coping with the considerable stresses in their lives, nor have they yet acquired the verbal skills to express their distress in words. Both these factors are likely to render the child in residential care more susceptible to psycho-somatic disorders as well as to illness in general.

Where does the child care worker fit into all this? Firstly, he/she needs to recognise physical ailments in the child in residential care as being, to a greater or lesser extent, a manifestation of the child's emotional suffering. Secondly, although the care worker may be aware that a child's physical complaints are largely of emotional origin, the child himself will *not* realise this. As mentioned earlier, the activities of the organs concerned are not under voluntary, or conscious, control. The child will therefore (usually) not be *aware* of the emotional origins of his/her physical symptoms. Thirdly, although a child's symptoms may be emotionally induced, this does not make them any less real. An attack of asthma precipitated by emotional causes can be just as severe as one due to allergic irritants, and a headache or stomachache is no less painful for the fact that it may be tension-related. It must be extremely vexing for a child clutching his stomach or head to be told that he is "imagining" the pain when he is painfully aware that this is not true.

Malingering

How does a care worker know whether a child is malingering or not? This question is perhaps an unfortunate one because of the perjorative connotations of the word "malingering", with its moralistically loaded undertones. The child is thus seen as bad rather than sad. Objectively speaking, malingering suggests a conscious falsification of complaints as opposed to the predominently unconscious origins of psycho-somatic illness. It may be difficult to assess to what extent, if any, somatic complaints are de-

liberately fabricated by a child. A more important consideration is what purpose is to be served by such an assessment. If the aim is to identify "malingerers" in order to expose them as liars and frauds, then the care worker will be embarking on an exercise which is not only futile but also counter-productive. Much more important questions for the care worker to consider are "if this child is malingering, why has he/she found it necessary to adopt this maladaptative way of dealing with his/her problems" and "how can I find ways to try to understand this child better and help him/her to cope more constructively with his/her problems?" This approach does not imply that malingering should be encouraged or reinforced by the care worker. It does, however, suggest that the care worker's suspicion that a child may be fabricating or exaggerating his/her complaints should not form the basis of a power struggle between the care worker and the child with the child's body as the arena for the contest. The outcome of such power struggles can only be a defeat for the care worker, the child, and their relationship, with the child who has been upbraided for "putting on an act" either feeling unjustly accused or else believing that he/she will have to try to be more convincing next time. In either case, any possible chance of helping the child with his/her problems will have been lost. On the other hand, if the care worker can indicate to the child that he/she is not unduly concerned about the severity of the child's complaints without adopting a critical or punitive attitude, the child may gradually come to the realisation that there might be better ways of coping with life's difficulties than producing physical symptoms. In cases of persistent suspected malingering, it may be necessary for the care worker to adopt quite a firm approach to the child and state clearly that the child will not be allowed to stay away from school, for example. However, even then the card$_0$worker's firmness should not turn into hostility, and at a later stage the opportunity should be created to discuss with the child the circumstances e.g. unhappiness at school, which gave rise to the malingering.

Medical advice

When should the care worker ask a doctor to see a child with possible psychosomatic complaints? As in the case of parents with their children, this will depend on the judgment (and anxiety level) of the care worker. The care worker has a responsibility to ensure that the child's health is not neglected (asthma attacks, for example, can be extremely dangerous and a doctor should always be contacted if the attacks do not respond to inhalers or other asthma medication). On the other hand, it would be very unwise to call the doctor every time a child complained of a stomach- or headache. The care worker has to steer a middle course which avoids any harm to the child's health as well as preventing the "medicalisation" of all the child's complaints. The latter situation could have the effect of reinforcing somatisation as the child discovers that every complaint is rewarded by special medical attention, and the even worse effect of convincing the child that he *must* be physically ill if he has to be seen so frequently by the doctor.

The care worker should listen attentively and empathetically and not rush in with advice or admonitions.

Of greater importance than the question of whether or when to ask for medical help is the co-operation between the care worker and the doctor. If the care worker is in doubt as to whether a child's symptoms are of physical rather than emotional origin, then the doctor is also likely to be uncertain. Doctors, because of their training which is heavily loaded towards physical rather than emotional problems, tend to be biased towards diagnosing organic (physical) rather than psychological causes for patients' symptoms. The care worker can be of great assistance to the doctor by providing him with essential information about the child's background, personality make-up, relationships with other children, school difficulties, etc. This input from the care worker may well prevent any unnecessary investigations and drug treatments being carried out by the doctor. The doctor in his turn can assist the care worker by advising her/him as to when medical intervention may be necessary with a particular child, and when not. The importance of the 'team approach' between care worker and doctor cannot be stressed highly enough: if they are not working together, the stage is set for "splitting" of care worker and doctor by the child e.g. "the doctor says my pains are due to worms, so you were talking nonsense when you asked me if I was upset about anything!", or "the doctor thinks there's something wrong with me and I've got to go for X-rays". Of course there will be times when such situations are unavoidable, but generally speaking, an over-organic approach by the doctor, unchecked by discussions with the care worker, can only be to the detriment of the child.

Children at risk

What children are more likely to develop psycho-somatic symptoms and/or illnesses? There has been much research and literature published on this topic. Only a few of the findings will be mentioned in this article.

Minuchin, in his study of Psycho-somatic Families, found that the families of children suffering from such illnesses e.g. anorexia nervosa, asthma, diabetes, were characterised by "enmeshment" (family members are over-involved with one another and over-responsive), rigidity,and a marked inability to resolve conflicts. A psycho-somatically ill child may help the parents to avoid facing the conflicts in their relationship by apparently focusing all their attention on the child. In other words, the child is unconsciously encouraged to remain sick in order to help the parents avoid having to face their mental problems. For the child this is preferable to the trauma of being exposed to his parents' marital problems coming into the open, so he continues to have psycho-somatic symptoms and the system is maintained. In other cases a psycho-somatic illness or symptom may be used to maintain a dependent role in the family, while in others it may be an expression of frustrations, anger, or deprivation.

These findings have important implications for care workers. The setup in residential care is of course not identical to that of a nuclear family but there are important similarities. The individuals concerned form part of a system which in some cases may be "enmeshed" and rigid, with poor conflict resolution. Psycho-somatic illness in children in residential care could be a response to tensions among the children and/or staff members or a reaction to an over-protective (or insufficiently protective) care worker (the latter representing a parental figure in the eyes of the child).

Other studies have focused on the personalities of children with psycho-somatic illnesses. Asthmatic children, for example, showed heightened dependency on the mother, fearful concerns about rejection, suppression of resentment reactions, and ultimately efforts to control and regain the relationship.

John Apley, a prominent British pediatrician, conducted a detailed study of 1 000 children with abdominal pains. In over 90 percent of cases, no organic (physical) cause for the pain could be found. Apart from the fact that children with organic causes for their pain (e.g. kidney infections) tended to experience their pain towards the sides of the abdomen rather than in the centre (around the navel), there were no reliable distinguishing features (e.g. severity, duration of pain, accompanying signs like fever, vomiting, or diarrhoea) between abdominal pain of physical and that of psycho-somatic origin.

The children with psycho-somatic abdominal pains (as compared with con-

trols) were found to be highly strung, fussy, excitable, anxious, timid, or apprehensive. Most gave an impression of over-conscientiousness, as did also many of their parents. Often they were 'bad mixers', but aggressive behaviour was uncommon, and the children were described as 'indrawn' rather than 'outgoing'.

Another important finding from Apley's study was that in a large proportion of cases of psycho-somatic abdominal pain, a distinct time relationship between a causal precipitating factor and the onset of the abdominal pain could be established. The commonest causal precipitant was found to be stresses related to the school which the child was attending.

Management

Apley found that "informal psychotherapy" was effective in a large proportion of the cases of psycho-somatic abdominal pain he attended. This approach included allowing the child (and parents) to verbalise their fears about the child's pain (e.g. appendicitis, cancer), encouraging the child to "blow off steam" about topics which he/she felt strongly about including apparently irrelevant details about everyday life, at home and at school; and modifying harmful aspects of the child's environment.

What can the care worker do to help the child with psycho-somatic ailments? From what has been discussed thus far, it will be clear that in the first instance the care worker needs to *observe* children under her/his care closely. Is this a child who expresses his feelings easily, or is he inclined to "bottle up" a lot (and thus be more prone to psycho-somatic disorders)? Has this child been subject to any particular stresses recently, e.g. school problems, separation from a friend, physical or sexual abuse?

Having ascertained any precipitating factors, e.g. poor relationship with school teacher, the child should be encouraged to talk about his feelings about the matter (compare the "blowing off steam" which Apley referred to). The care worker should listen attentively and empathetically and not rush in with advice or admonitions. It is possible that the child may express anger towards the care worker — this should be regarded as a positive development as the child who is verbalising such feelings is less likely to express them with bodily symptoms. The care worker should therefore avoid reacting defensively to such criticisms whether or not he/she feels there is any substance to the child's allegations.

In cases where school difficulties exist, the care worker should make contact with the child's teacher and school principal. Much tact may be needed to avoid creating the impression that the teacher is being criticised or that the care worker is teaching her her job. The care worker can indicate that she wishes to assist the teacher by providing her with background information about the child and his progress. She can ask the teacher to assist her by offering suggestions as to how the child can be helped with schoolwork and why the child seems to be struggling. The teacher can also be asked about the child's relationships with other children at the school, etc. Approached in this kind of way, the teacher's attitude towards the child may change from a hostile to a more sympathetic one. As in the case with the medical attendant, the care worker's coordinating role may be pivotal.

Having suggested some approaches to the child with psycho-somatic problems, it must be stated that the most important factor which will determine the care worker's success with these children is the *relationship* which she/he establishes with the child. It goes without saying (but nevertheless has to be said) that in the absence of a safe, trusting relationship, a child is unlikely to share his innermost fears and feelings with a care worker. In the case of children in residential care such relationships are particularly difficult to form as the children's previous experiences have considerably undermined their capacity for trust. Nevertheless, the care worker should persevere, and be prepared for self-examination as well as discussions with supportive colleagues in an attempt to improve her/his relationship with the children under her/his care as far as possible.

Conclusion

The problem of children with psycho-somatic illness poses a special challenge to the care worker. While it is understandable that children in residential care are likely to be particularly prone to these illnesses, it remains true that illness is a maladaptive way of coping with stresses, and if allowed to progress can only have the effect of further disadvantaging already disadvantaged children (Apley is convinced, for example, that children with recurrent psycho-somatic abdominal pains are at greatly increased risk of developing peptic ulcers in adult life). The care worker's difficult task is to help the child to find ways, other than illness, to cope with the many stresses he will have to contend with.

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Dimensions of Helping

Ram Dass and Paul Gorman
How Can I Help?
Alfred A. Knopf, New York, 1985

Child care workers whose constant daily responsibility it is to find answers to calls for help will be enthused, inspired and centered by these "stories and reflections on service". Considered by Elizabeth Kubler-Ross to be "a must for anyone in the field of service", this book takes a broad metatheoretical and spiritual look at the issues raised when human beings attempt to assist one another in the business of life. Leaving aside current academic theory, *How Can I Help?* looks at natural innate human ability to be of service. Concentrating on the depth, consistency and responsibility of our own existence, the authors develop thoughts and ideas around the fact that it is not *what we know* but *who we are* as people that determines the extent of our ability to help others. As child care workers we will identify with the questions this book will put to us about service; we will read about the issues that we ourselves struggle with regarding the meaning of our work, the "what is all of this for" questions.

We will be challenged to look at ourselves in these pages, to look within . . . "can we see that to be of most service to others we must face our own doubts, needs and resistances". Instead of attempting to prescribe an elaborate means to do this *How Can I Help?* is simply written and interspersed with vignettes of genuine experiences of ordinary human beings, offering an experience for the reader rather than yet another how-to-do-it manual.

"We can seek to identify certain basic inner obstacles to the expression of our caring instincts. As these rise to the surface in familiar concrete situations, we can bring them into the clear light of awareness: we see how their resistance is affecting our ability to hear people's needs; how this habit is shaping our attitude to social action; how this expectation is contributing to burnout. By carefully observing these hindrances we can strip away some of their hidden power and reduce their influence over us. With a certain amount of perspective, in fact, we can come to see them not only as problems to overcome but as information leading to a deeper understanding of service. We can make use of them, helping ourselves help others."

Not something to be read once and set aside, this book contains the kind of lasting wisdom and inspiration that elevates it to the realm of compulsory reading for those in child care . . . to be returned to again and again and again.

M.A.

INTERVIEW

Lesley du Toit

Newly-appointed Regional Director for the Natal and Eastern Province Regions of the NACCW, Lesley du Toit, introduces herself . . .

CCW: Tell us about the job you are leaving in order to join the staff of the NACCW.
LdT: I have been at King Williams Town Children's Home for the past three and a half years. I was appointed as social worker and over this period we have attempted to build a strong team and a workable programme in a relatively isolated situation. King Williams Town isn't exactly in the middle of nowhere, but it's not far from there! We have not had the advantage of many child care professionals and models on our doorstep as metropolitan children's homes have, and staying in touch with contemporary practice has involved quite a lot of legwork. At present I am Programme Director at the children's home and there is another social worker on the team. We have also built up a useful middle management structure, making use of experienced child care workers as supervisors and leaders, and we have had the advantage of additional professionals such as Occupational Therapists on the staff.

CCW: In spite of being isolated, you nevertheless have an advanced programme at King Williams Town Children's Home.
LdT: The home has a good range of services. On campus we have four cottages together with good communal facilities. Also, in the town we have two group homes. But we also offer a number of non-residential services to the local community. We run a counselling service for parents and children, and local doctors, parents and schools make a lot of use of this. We have also run parenting courses and parent support groups as part of a preventive service. We are linked with the local SASPCAN child abuse team in King Williams Town which operates a telephone-in-service for parents and children.

CCW: Your experience hasn't been limited to child care work?
LdT: For the two years 1982-1983 I was involved in a very interesting job with the Methodist Church in Queenstown which involved several roles. One was working with shut-in elderly people, and another was as a counsellor and youth worker for the 300-odd Methodist children who were boarders at Girls' High School and Queens College. The job also involved community work in the local coloured township and much of this was developing self-help projects as well as self-care for senior citizens.

CCW: Where was your first contact with child care work?
LdT: For three years I was social worker at the Strathyre Girls' Home in Johannesburg. Here I was involved in ordinary residential social work tasks, and I had the benefit of contact through the Social Workers' Group with such figures as Joy Hansen and Jacqui Michael who were significant teachers for me. In turn I also did some supervision of social work students. One highlight for me at this time was helping in the production of a video presentation entitled "Let the Children Speak" to the 1981 NACCW Biennial National Conference.

CCW: For how long have you been associated with the NACCW?
LdT: My first links with the NACCW were in 1979 when I was at Strathyre. I found membership of the Residential Social Workers' Group was a very helpful and stimulating contact for me. Then, I have been involved in the Eastern Cape Region for all the time I have been here — and was in fact secretary of the Regional Executive Committee from its inception until March 1987.
In the Eastern Cape I have enjoyed strong links with NACCW. We have had the benefit of Residential Weekend Courses four times a year, I have been able to attend Biennial National Conferences, was asked to speak at a Western Cape Regional Conference, and attended national seminars in both Cape Town and Port Elizabeth.

CCW: How do you view your new job with the NACCW?
LdT: Today I was at a peer supervision meeting with colleagues from East London, King Williams Town and two institutions in the Ciskei, and I was made all the more aware of the size of the task ahead. There are enormous needs in child care. I am very challenged by these, and quite excited about being able to tackle them on a full-time basis. Natal where I shall be based is, of course, an unknown to me, but I have heard a lot about the enthusiasm of the NACCW in that Region, and I look forward to getting to know the Natal folk. It's always hard to move away from one's known base, and especially to leave a team one has worked with so closely. But I identify strongly with the vision of the NACCW and I think the next few years, so far as the Natal and Eastern Cape Regions are concerned, will be good years.

Substance Abuse in Adolescents

C.F. Ziervogel

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Substance abuse is receiving increasing publicity as a world-wide problem. Epidemiological studies indicate that the increased exposure is due not only to greater media coverage and public awareness but also reflects a real increase in incidence. An alarming fact is that the peak occurs in late adolescence and early adulthood. In the task of quantifying the extent of the problem there are a number of difficulties, for example, defining what is meant by use, abuse and dependence, as well as gathering accurate data. Society disapproves of the use of certain substances (alcohol and to a lesser extent tobacco) in people under 18 years of age. The use of other substances such as cannabis, heroin, or cocaine is illegal. This means that young people, parents and schools are often reluctant to encourage research that would reveal the true extent of the problem. This arises (a) partly out of a fear of legal action; (b) partly out of a fear that it will reflect poorly on the individuals and institutions concerned; and (c) partly out of a sense of helplessness and powerlessness in dealing with the problem. This last point may be particularly relevant in the case of health professionals who very often neglect to enquire directly about substance abuse.

To adequately discuss the problem in context it is necessary to first simply list the substances that may be abused. Drugs used by adolescents include the following:

- Alcohol — perhaps because this is a serious and widespread problem in society at large, especially in South Africa, its abuse in adolescents does not attract great attention. Furthermore, its use is not illegal.
- Tobacco — known to be a health hazard but socially acceptable.
- Cannabis — this is the commonest 'illegal' drug to be used in South Africa. According to the literature, this drug does not usually cause physical dependence although it may cause marked psychological dependence. Recent experience has shown that this is not always true and withdrawal states may be encountered.
- Amphetamines — act as central nervous system stimulants.
- Hallucinogens — best known is lysergic acid diethylamide (LSD).
- Barbiturates.
- Other non-barbiturate tranquillisers such as benzodiazepines and methaqualone (Mandrax), Methaqualone is increasingly used in combination with cannabis ('white pipe').
- Solvents (glue sniffing).
- Heroin, cocaine and narcotics (hard drugs).

Clinical significance of substance abuse

It is important to understand that substance abuse in adolescents is a symptom and not a clinical entity. This fact is borne out both by theoretical considerations of aetiology and by clinical experience.

Often it is difficult to categorise the symptoms in a clear and unambiguous manner, so the differences in significance may be best represented by Fig. 1.

Experimentation

In the process of establishing identity as an independent human being many adolescents engage in experimentation. For most healthy adolescents their core values, attitudes, morals and ambitions approximate closely those of their parents and families of origin. However, teenagers are influenced by their peer group in other areas, usually in matters of taste, such as clothing, fashions and music, and possibly also in the sphere of social behaviour.

Adolescent tasks

As an aid to coping with the tasks of adolescence, some of these tasks will be discussed under aetiology.

Conduct disorder

In this case the young person will have a history of other forms of behaviour in which the basic rights of others or major age-appropriate societal norms are violated. Some examples are: lying, stealing, playing truant or precocious sexual behaviour.

Symptoms of an underlying psychiatric illness

Incipient adult-type mental illness is not common in adolescence but must be excluded.

Established addiction

Chronic, established addiction may be

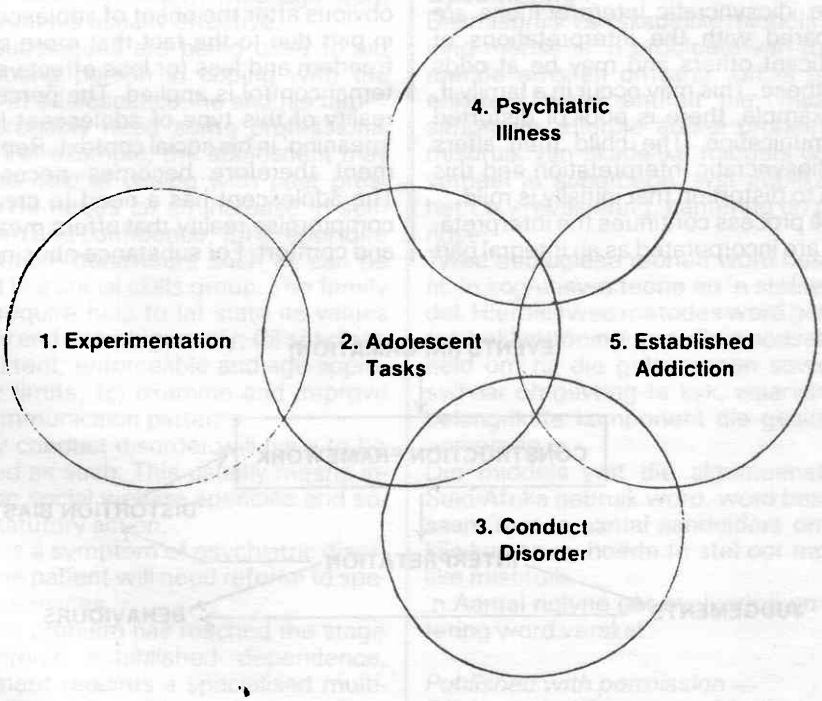

Fig. 1. The significance of the symptom of substance abuse.

the end point reached through any of the above routes.

Aetiology

Two theoretical models will be outlined. The first, a cognitive model, can be termed an intrapersonal model while the second is a family or systems model. These two have been chosen because the clinician will require some framework for understanding both the affected individual and his support system, the family.

Cognitive model

Adolescence is the developmental phase that marks the transition from childhood to adulthood. In successfully negotiating this transition a number of tasks must be learned or accomplished:

- To establish 'self identification', such that the self is seen as an independent, decision-making human being.
- To incorporate into one's emotional and behavioural repertoire actions that support close emotional bonds.
- To adopt emotionally and attitudinally appropriate sexual roles within a sexual relationship where one's sexual identity becomes established for the rest of one's life.
- To develop abstract thought and an emotional understanding of this, which enables one to responsibly integrate with and participate in society.

To achieve the above tasks the child must develop a basic understanding and a sense of meaning from his world — external events and his experiences. This is the individual's 'interpretation' of his situation and takes place from birth onwards. The most basic requirement for this process is raw data or concrete experiences which lead to the individual making idiosyncratic interpretations.

These idiosyncratic interpretations are compared with the interpretations of significant others and may be at odds with these. This may occur in a family if, for example, there is poor or distorted communication. The child then alters his idiosyncratic interpretation and this leads to distortion that initially is mild.

As the process continues the interpretations are incorporated as an integral part of the information network that in turn is used to assess and modify other information. This is known as a 'distortion bias'. Information, then, is processed through a construction framework and leads to interpretations being made. On the basis of the interpretations, judgements are made and behaviours undertaken (Fig. 2). The judgements made are cumulatively built into the individual's belief system or world view.

The initial perceived reality is developed in response to interactions in the family at home. This can be called 'perceived reality' No.1. It allows the child to feel comfortable with his experiences at home.

The child then reaches school-going age and is subjected to a new environment, the school. He then proceeds to interact with these new stimuli and to develop 'perceived reality' No.2. If these two perceived realities are at variance with one another, a dilemma is created. The solution to the dilemma lies in creating 'perceived reality' No.3, that is a compromise. It is important that the child is able to feel comfortable in, or at least find tolerable all three perceived realities.

If the discrepancy between 'perceived realities' No.1 and No.2 is too great, the child is not able to find one of them tolerable and emotional detachment occurs. In other words there is a divorce between the perceived event and its emotional significance. An extreme of this is in child abuse where a state of emotional 'numbing' is reached.

Distortion bias may be corrected during childhood or it may continue. If it continues it is often not very noticeable until the onset of adolescence. The behavioural manifestations become more obvious after the onset of adolescence, in part due to the fact that more social freedom and less (or less effective) external control is applied. The perceived reality of this type of adolescent loses 'meaning' in his social context. Replacement therefore becomes necessary. The adolescent has a need to create a compromise reality that offers meaning and comfort. For substance-abusing adolescents, then, perceived reality No.3 is the 'drug scene' where the 'drug culture' provides meaning and interaction with peers and the group provides comfort. Belonging to any group is more important than belonging to none. This process is aided by the fact that perception is altered by the substances used.

A secondary process occurs in which new behaviours are learnt. These behaviours are functional within the substance-abusing context but dysfuncitonal in the context of normal development. If the youngster remains in the 'drug scene' for a prolonged period, he will increasingly learn new behaviours appropriate to that context but increasingly miss out on the behavioural and emotional repertoire that his normally developing peers are acquiring. Furthermore, he will start 'unlearning' or losing through disuse those adaptive skills that he previously had. The practical implication of this is twofold:

- He will increasingly feel ill at ease with the perceived reality that corresponds to the range of normal development.
- In treatment he will have to relearn his old skills (rehabilitation) as well as learn new skills (habilitation).

Family/systems model

In their experience with established drug addicts, Stanton and co-workers have noted certain patterns emerging in the addicts and their families:

- A close, dependent relationship between the addict and one parent, the other parent often being distant and excluded.
- In 50 percent of cases at least one parent had a drinking problem or some form of addiction such as compulsive gambling.
- There was a lack of constructive pressure by the family on the addict to give up his habit.
- The addict was discounted as a person.
- The family felt powerless or used blame (for example, on peers, the neighbourhood, etc.).
- The addict was the focus. He was overprotected and treated as helpless and incompetent.

Their postulate was that the role of the addict was to maintain the family's stability at his own expense. Restated in these terms the central problem can be seen as the difficulty the family and the young person have in disengaging from one another. The addict and the family can avoid facing this reality by pointing to the addict's close involvement with substance-abusing peers. This involvement is rationalised as being evidence of independence, whereas in reality it is a pseudo-independence. The young addict then is dependent not only on the psycho-active substance but also on his family of origin. Furthermore, in time he

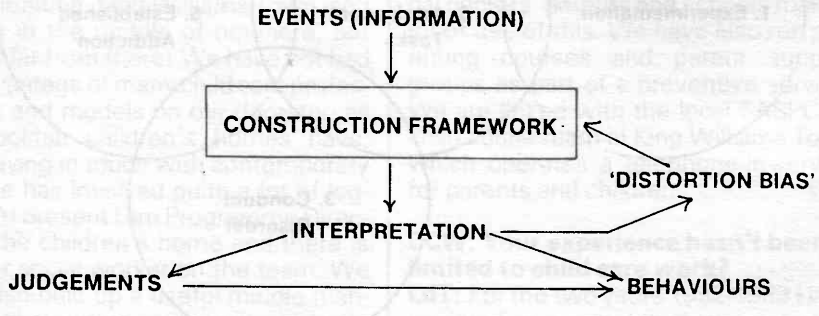

Fig. 2. A cognitive model of perception.

becomes dependent on the care workers and institutions provided by society. The clinical significance of these findings is that it is important to assess both the index patient and his family.

Assessment

Drug history

An adolescent will rarely volunteer information about substances abused unless asked directly. The inquiry should be made in a matter-of-fact non-judgemental manner. It may be necessary to use colloquial terms to find a vocabulary understood by both the clinician and the young person. Inconsistencies in the history must be clarified. Collateral information is vital in establishing a realistic clinical picture.

Clinical signs

Some of the indicators suggesting substance abuse are:

1. Change in behaviour from previous characteristic patterns, for example increased isolation, irritability or moodiness.
2. Change in functioning, such as a drop in school performance or loss of interest in sport or hobbies.
3. Episodes of intoxication, manifest as disinhibited behaviour, slurred speech or unsteady gait.
4. Specific signs from specific drugs:

- Cannabis (dagga): bloodshot eyes, giggling episodes, increased appetite ('munchies'), dreaminess, stains on the palms or the characteristic smell;
- Stimulants (for example appetite suppressants): 'getting high', elation alternating with depression, loss of appetite, insomnia;
- Sedatives: drowsiness, appearing drunk without alcohol intake, loss of inhibition;
- Inhalants: slurred speech, confusion, staggering gait or irritability;
- Hallucinogens: markedly abnormal behaviour, for example confusion, excitement, hallucinations, rambling speech, paranoid delusions, or 'flashbacks'.

Associated features

- Complications such as physical addiction, psychological dependence or physical side-effects.
- Evidence of conduct disorder.
- Any features of psychiatric disturbance that may be a result (a toxic psychosis) or a cause (underlying formal psychiatric illness, for example schizophrenia or an affective illness). People suffering from schizophrenia or manic-depressive illness not infrequently use substances in the early stages of their illness in an attempt at self-medication.

Assessment of functioning

This must be done on a number of levels.

1. Individual —

- Extent of dysfunction. To what extent does functioning deviate from what is normal for the individual's developmental stage? It is useful to remember that there are developmental differences between early, middle and late adolescence. This assessment is particularly relevant to the points discussed under aetiology. The specific behavioural and physical changes are discussed under the section on clinical signs.
- Strengths and resources. These factors play an important part in gauging prognosis and planning management.

2. Family —

The functioning of the family must be assessed in such areas as communication, behaviour control, boundaries, problem-solving and the ability to prepare the young person for age-appropriate tasks such as independence.

The role models provided by the family often play a vital part. An example is a family in which the parents are horrified when they discover their child has been abusing cannabis yet the father regularly abuses alcohol. The adolescent is then receiving two messages; the verbal message is: do not use/abuse substances; the non-verbal message is that substance abuse is a valid behaviour within the family.

3. Environment —

An assessment of the school and leisure environment (for example disco's) as well as available peer groups.

Management

Using the categories outlined in the section on clinical significance of substance abuse:

- If substance use is a form of experimentation, counselling by the clinician and a clear consistent message from the prents is usually effective.
- If substances are being used to aid the young person in coping with the tasks of adolescence, he and his family will probably need some professional help. For example, the adolescent may require help in coping with peer pressure. He needs (a) an increase in self-esteem and confidence; (b) a repertoire of suitable behaviours such as can be learnt in a social skills group. The family may require help to (a) state its values clearly and unambiguously; (b) set clear, consistent, enforceable and age-appropriate limits; (c) examine and improve its communicaion patterns.
- Any conduct disorder will have to be treated as such. This usually means involving social welfare agencies and social/statutory action.
- If it is a symptom of psychiatric disorder, the patient will need referral to specialist services.
- If the problem has reached the stage of chronic established dependence, treatment requires a specialised multidisciplinary approach.

Some of the resources available are listed in booklet No.5 in the set *Your Child and Drug Abuse* published by the South African National Council on Drug Dependence. Examples of these resources are: (a) the psychiatric emergency unit at the local hospital, if such a unit operates; (b) drug counselling centres, now being established — the local Life Line service in various centres may be able to offer more information about these; (c) SANCA (SA National Council on Alcoholism and Drug Dependence) offices in various centres.

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Opsomming

Die misbruik van skadelike middels deur jong mense is 'n probleem van toenemende erns en omvang. Dit is nie 'n enkele kliniese entiteit nie, maar 'n simptoom. Hierdie artikel probeer die misbruik van skadelike middels onderverdeel in subgroepe, wat implikasies het t.o.v. evaluering, hantering en prognose.

Twee etiologiese teorieë word beskryf, nl. 'n kognitiewe teorie en 'n stelselmodel. Hierdie twee metodes word gebruik ter beklemtoning van die noodsaaklikheid om na die gidspersoon sowel as sy/haar omgewing te kyk, waarvan die belangrikste komponent die gesin van oorsprong is.

Die middels wat die algemeenste in Suid-Afrika gebruik word, word beskryf, saam met 'n aantal aanduiders om die klinikus op sy hoede te stel oor moontlike misbruik.

'n Aantal riglyne oor evaluering en hantering word verskaf.

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The Residential Environment:

Making a House a Home

The writer is a second year student of the National Higher Certificate in Residential Child Care course at the Cape Technikon.

The task of providing "real experiences of good care, comfort and control" is made complex by group living. We must find a way of "living, not just existing", a way of giving the children these basic things so that it "feels *given* and not provided". The difficulty is that, though in theory we are providing a base for these children for a short while, in reality we must approximate a home for several years and not just "a place in which one marks time".

To create a home environment on a domestic scale while "living in a noisy fishbowl" is extremely difficult. The large numbers and lack of funds, plus the ugly buildings of the larger institutions, all militate against this. But there are ways and means. It needs imagination, energy and motivation. A can of paint and a vase of bright flowers can work wonders to change the atmosphere. The physical surroundings do affect the mood in general, so the child care worker should look at communal space as she would her own living space at home, and add those little touches that turn any dreary room into a home. A clean, warm, cheerful room with table set and hot lunch waiting for the children when they get back from school, a little bunch of flowers for the girl who is feeling down, being available for and aware of each individual's needs, checking and showing an interest in arrangements to ensure a successful outing or home visit, window-shopping, walks in the neighbourhood — all things a normal family would do for its members without thinking.

If at all possible, blanket rules and "absolute time-tables" must be avoided so as to cater for individual needs and to avoid the apathy which a monotonous routine sets up. Ideally the group home seems to fulfil most of the needs of normal family life. For one thing the home is part of the neighbourhood, the ages and sexes of the children approximate the normal family situation where age-appropriate behaviour becomes obvious and sex role identification easier. Here too the simple tasks like shopping for the kitchen and the joy of preparing and cooking the family meal can be shared by all and individual tastes and fancies catered for. In the institution a simple hot plate can do wonders in creating a warm feeling — flapjacks on a rainy afternoon or popcorn to fill those ever-hollow tummies. The oral needs of these children have on the whole been neglected and food becomes a vitally important means of providing care.

Since learning to make choices is one of the chief steps in gaining personal independence, it is vital for the children to help in the formation of the structure for the smooth functioning of the home. They must help decide on rules, consequences, chores. In the household running one can provide for different roles which meet individual strengths and weaknesses. Joe is the best vacuum cleaner while Sally loves setting the table. They must also share in decision-making when it comes to things like choosing a new colour scheme for communal space or moving the furniture around. So many useful skills for adult life can be given in this informal manner.

Personal space must be separate from communal space. We all have a need for privacy and the child coming into care must feel very exposed and vulnerable in this "noisy fishbowl" environment. We must take great care to ensure privacy of person and possessions. Keys and lock-up facilities should be provided. One of the problems in institutions is trying to teach a child respect for his/her property and that of others. For this to develop healthily one needs a sense of ownership and pride in one's personal space. We must guard against the assumption that all children want a room of their own — for some this may be seen as punishment rather than a privilege. So a quiet corner somewhere may be preferable for some. In his/her room the child should have some freedom of choice as to colour and decor to express his/her individuality. Clothing too should be, where possible, a matter of individual choice. Here the child care worker can assist in showing the children how to use imagination with second-hand clothing — a sewing machine is an essential at any time.

The normal family provides lots of informal education, e.g. in the use of tools and appliances, how to fix a broken plug or window pane, the practical use of the everyday world, how to send a parcel or telegram, the encouragement of hobbies, all the little things we take for granted in our own homes but which an institutionalised child may never be exposed to.

Our job then must be to try and personalise our caring for the child in care, to create that priceless commodity we have taken from him/her — home. We can never replace his/her home, but we can try and make him/her feel at home.

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