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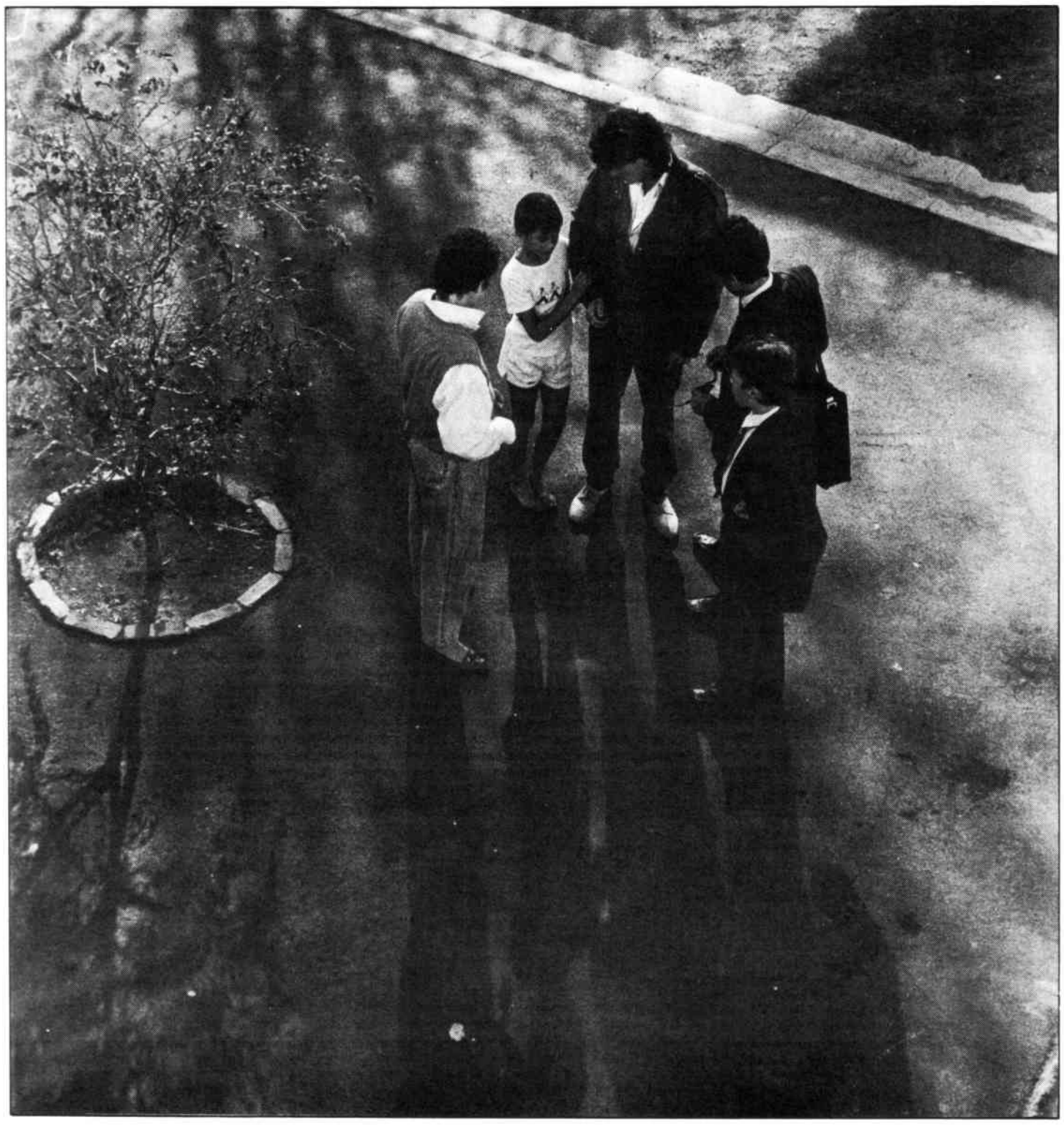
The child care worker



Kwaliteit of Kwantiteit?

Die NVK is daarvan bewus dat ons uitgawes 'n hoofrol speel sover dit inligting en betrokkenheid van ons lede en kollegas betref. As gevolg van die wye verspreiding van kinderinstansies in Suid-Afrika, is *Die Kinderversorger* dikwels die enigste verbindingsmiddel waardeur inligting, menings en opvoeding verwissel word. Die Nasionale Uitvoerende Komitee van die NVK bly daarby dat hierdie tydskrif die hoogste voorkeur onder ons verskillende dienste geniet, en dat gereelde publikasie staande gehou moet word.
Terselfdetyd styg druk onkoste toenemend, en die direkte koste vir 'n enkele uitgawe, wat drukwerk, koeverte en posgeld insluit kan R2 000 beloop. Om dié rede het ons besluit om ons druk metodes effens te verander deur ons setwerk op ons eie rekenaar te doen. Dit sal tot gevolg hê dat ons formaat voortaan ietwat moet verander word hoewel dit hoofsaaklik herkenbaar sal bly.
Deur kwaliteit minimaal toe te gee, word onafgebroke publikasie van *Die Kinderversorger* verseker.

Quality or Quantity?

The NACCW is aware that publications play a major role in informing and involving our members and colleagues. Because of the wide geographical dispersion of children's institutions, *The Child Care Worker* is often the only linking medium we have through which to share news, opinions and education. The National Executive Committee of the NACCW remains convinced that this journal should enjoy highest priority amongst our various services, and that regular publication should be maintained.
At the same time printing costs continually rise, and the direct costs of a single issue, including printing, packaging and postage, are as much as R2 000. For this reason we have decided to change our printing process slightly by doing our typesetting on our own computer. This will result in a slight change of format from now on, though the journal will remain eminently recognisable. Through a minimal sacrifice in quality, we can ensure uninterrupted publication of *The Child Care Worker*.

GUEST OPINION

A Group for Child Care Workers

One of the most difficult problems faced by children's homes is the finding, supporting, keeping and upgrading of the child care personnel.
Child care workers are "on the firing line", they are vital if any programme is to succeed beyond the mere provision of food and a place to sleep for troubled youngsters. The efforts of the child care workers in any organisation can either promote health or hinder it.
What is alarming is that child care workers, the ones from whom so much is expected, are poorly understood and nurtured.
It is important for child care workers' needs to be met to a reasonable degree before they in turn are able to meet the needs of socially and emotionally disturbed children.
Because child care workers enter the field with a wide variety of experiences, but few with any formal training, it is important for them to participate in in-service training programmes, which contribute to the formation of a health-promoting milieu. This sets up clear expectations and a shared pool of knowledge and wisdom, and removes much of the anxiety of new people coming into the field.
As child care workers, we need to form a network of on-going training; we need to become each others' teachers; we need to welcome newcomers as allies rather than seeing them as intruders.
We need to increase our knowledge and skills, and further our formal studies, equipping us better for our work. We need recognition for the knowledge and experience we have, and which is worth imparting to others, and which enhances our view of ourselves.
If child care workers' needs are met, this raises the level of effective performance. We need to develop an identity of our own, a kind of cultural blueprint (beliefs, values, patterns of behaviour) which can be passed on to subsequent child care workers. This too will modify and change over time, for change is continual, depending on the worker and the environment.
We need help in acquiring tools for our work. Since coming into the field, I have always missed the link between child care workers, and I find myself asking whether it is not necessary for us to come together more often as a group? Such a group would offer not only support but also on-going development oppor tunities, promoting growth and enquiry, offering a chance for us to review, check and balance our perceptions and attitudes – and thus enhance our efforts in helping troubled children.
We need to become responsible for our own continuing growth and development so that we may face the challenges of our work with knowledge, wisdom and support.
I have put the idea of a closer group for child care workers forward at a recent Regional Meeting of the NACCW, and the response encourages me to go ahead with the plannning of a first meeting.

Nicole van Rensburg

Adolescence and the Drug Trap

Sylvain De Miranda

Dr De Miranda is Director of Clinical Services at SANCA in Johannesburg, and this paper was delivered at the October 1987 Conference on Adolescence organised by the Association for Child Psychiatry, Psychology and Allied Disciplines

The drugs, or chemical substances, which tend to be abused by people are known as *psycho-active chemical substances*. These drugs, regardless of their origin, legality or nature, all have the ability to change moods, feelings and perception.
In a society where "escapism" is actively practised by young and old alike, it is not surprising that "mood changing" drugs have become part of that society. To feel relaxed if one is tense; to feel sleepy if one can't sleep; to feel happy if one feels sad; to feel strong if one feels weak; to live in a world of unreality if reality is too painful; these are but some of the effects achieved by the mood changing drugs.
To review these trends and patterns in any country is to review the customs, values, mores and cultural differences of that country. It goes even further in that geographic position, regional interaction, existing legislation and control measures, as well as local production and cultivation of a variety of psycho-active substances (both natural and synthetic) all play a significant part.
South Africa is no exception. If anything, with its mix of different population groups, different cultural values and extreme differences in socio-economic development, it represents even a more complex pattern than most other countries.

The meaning of drug dependence (addiction)

It is clear that a large number of our population periodically abuses one or more of the mood changing drugs. However, a percentage of these drug abusers develop a progressive, insidious condition known as dependence (addiction) to their drug(s) of abuse. The process of drug dependence is a complex one, involving an interaction of bio-genetic, neuro-chemical and psycho-social factors. For these reasons its onset is unpredictable and therefore no one who uses, and at times abuses, psycho-active drugs (including alcohol) is ever able to say, "this cannot happen to me".
The process of dependence entails an uncontrollable urge to satisfy a need and can be said to exist if, as a result of the repetitive (not occasional) use of a chemical substance, there is impairment of functioning (physical and/or emotional and/or social) of the affected individual.
The physiological or bio-chemical component of drug dependence usually, but not always, consists of the development of *tolerance* to the drug (i.e. increasing amounts are needed to experience the required effect) as well as *withdrawal*, with signs of shock and physiological deprivation on the discontinuation of the drug of dependence.
It is to be noted that such discontinuation withdrawal can occur for a number of reasons, e.g. during treatment for drug dependence, imprisonment or admission to hospital for whatever reasons.
The psychological or emotional component of drug dependence will consist of an agonising, all embracing *craving* or longing for the mood altering effect of the drug of dependence. This craving may lead to extremes of behaviour, where the need of the drug defies all norms of control and social barriers. This uncontrollable need to obtain the drug of dependence "at all costs", regardless of consequences, is probably the saddest and most agonising symptom of drug dependence.
Whilst the abuse of a drug with its resultant intoxication, or even over-dosage, is an incidental, instantaneous occurence, the development of drug dependence varies considerably in its length of time.
For example, dependence on alcohol usually develops after a number of years (except in youngsters and populations unaccustomed to high percentage alcohol beverages, where dependence develops at a much faster rate) compared to some six weeks in reported cases of cocaine dependence (especially after smoking cocaine-base known as "Crack").
Dr Robert L. duPont, in his book *Gateway Drugs*, describes what he calls the "Four Downward Steps to Drug Dependence". This pattern is commonly observed in the youthful drug dependent.

1. Experimentation and first-time use

This stage is crucial to our current problem with adolescent drug use. Too many of our youth apparently believe that experimentation with drugs is safe and even normal. Experimentation with drugs in South Africa occurs usually between the ages of 12 and 16 years.

2. Occasional or social use

Here, the person does not actively seek out the drug, but passively accepts it when offered by friends as being part of "acceptable peer group behaviour".

3. Regular use

A drug abuser now actively seeks out his drug and makes sure he can maintain ready supplies. Use is typically once or twice weekly on a regular on-going basis.

4. Dependence (addiction)

At this stage, the drug(s) will constitute the major part of the person's life and any effort to separate the person from the drug(s) will be met with substantial resistance. Drug dependence, unless treated, is a fatal, progressive, illness. It has well been described as a "journey into nowhere". Much still remains unknown about the etiology of drug abuse.
On the basis that much of our behaviour is orientated around the simple principle of maximising pleasure and minimising pain, one can visualise the effect of the psycho-active drugs as supplying almost instant gratification in maximising pleasure.
Recent research has established furthermore that indentical pathways and neurotransmitters are involved in both the natural pleasure/pain relationship as are in the extrinsic pleasure stimulus induced by the psycho-active drugs.
The adolescent, who is just beginning to learn how to adapt his behaviour to the natural, but at times difficult, pleasure/pain equation of life, will therefore become most susceptible to the lure of drug abuse. The effect of these drugs can almost be seen to pre-empt the process of the adolescent's adaptive behaviour development. It is this seductive trap of "easy solutions" which accounts for the fact that initial drug experimentation occurs maximally during adolescence.

Classification of drugs
From a practical point of view, the best classification is to consider the primary effect of the drug on the vital functions of the central nervous system, i.e. on the brain. Using this classification, all drugs fall within one of three groups.
- Drugs which primarily depress the vital functions of the central nervous system.
- Drugs which primarily stimulate or excite the vital functions of the central nervous system.
- Drugs which primarily distort the vital functions of the central nervous system by eliciting hallucinations.

Central nervous system depressants:
This group probably contains the largest number of drugs both used and abused in the world. The generalised symptoms these drugs produce are a slowing down of all systems (for these reasons drugs in this group are often referred to as "downers"). There is a slowing down of pulse and heart rates, shallow breathing, lessening of consciousness (drowsiness), slowing and, ultimately, slurring of speech, diminishing reflexes, impaired co-ordination leading to staggering gait and abnormal eye movements (nystagmus). The pupils of the eyes react sluggishly to light.
Dependence on these drugs invariably causes tolerance and, consequently, severe withdrawal symptoms may be encountered. Withdrawal symptoms include tremors and shakiness which may lead to convulsions, vomiting, sweating, abdominal cramps, diarrhoea, intractable pains in legs, muscular aches and restlessness. In extreme cases, mental confusion, delirium and collapse of the heart and circulation system may occur.
Long-term dependence on these drugs ultimately leads to organic deterioration of the brain resulting in chronic personality changes, memory impairment and a variety of abnormalities of the nervous system. Similarly, there is a high incidence of both liver and kidney failure, of which alcoholic cirrhosis of the liver and analgesic (anti-pain preparations) kidney failure are some prime examples.
The commonest drugs of abuse in this group are:
- Alcohol
- The narcotics, e.g. Heroin, Morphine, Pethidine, Wellconal, Codeine and other synthetic narcotics.
- The hypnotics (sleeping tablets), e.g. Barbiturates, Mandrax (non-barbiturate).
- The tranquilisers, e.g. Diazepam, Oxazepam, Lorazepam and Nitrazepam.
- The analgesics, anti-pain medication.
- The inhalants, e.g. Amyl Nitrite and Isobutyl Nitrite, Anaesthetics.

The central nervous system stimulants:
The general effects of this group of drugs are a "speeding up" of all systems. For this reason these drugs are often referred to as "uppers". There is an increase in pulse and heart rates, rapid breathing, extra alertness and insomnia, i.e. inability to sleep, rapid and incessant speech, irritable reflexes and rapid continuous movements with restlessness, often leading to exhaustion and collapse. There is a marked loss of appetite leading to progressive weight loss (frequently mis-diagnosed as anorexia nervosa). The stimulant drugs are popular drugs of abuse.
In spite of present debate about the degree of physiological addiction which stimulant drugs can cause, it is known that the chronic abuser develops a marked tolerance. Conversely severe withdrawal symptoms occur on discontinuation. Withdrawal is often hallmarked by attacks of very severe depression, during which the patient becomes a serious suicidal risk.

This uncontrollable need to obtain the drug of dependence at all costs, is probably the saddest and most agonising symptom of drug dependence.

Chronic abuse frequently leads to psychotic episodes. These psychotic states manifest serious paranoid delusions, where even close friends are thought to be plotting to harm the abuser. Visual hallucinations which appear real to the abuser, and the feeling of "insects" crawling under the skin, are frequent. These people often become violent and are potentially homicidal.
It should be noted that many stimulant abusers often resort to the use of hypnotics and tranquilisers to counter the unpleasant side effects of sleeplessness and agitation.
Stimulant drugs are used medically in the treatment of some cases of hyperactive children (usually due to minimal brain dysfunction); narcolepsy (a rare sleep disturbance), and for controlling excessive appetite leading to gross obesity.
The commonest drugs of abuse in this group are
- Amphetamines.
- Appetite suppressants, e.g. Obex, Tenuate, Nobese, Minobese, Thins and Redupon.
- Ritalin (methylphenidate).
- Cocaine.
- Caffeine.
- Ephedrine.
- Nicotine.

The central nervous system hallucinogens:
A wide variety of both synthetic products and naturally occuring plants throughout the world make up this group of drugs.
The intoxication effect of these drugs is manifested by a general disturbance of perception, resulting in either illusion or true hallucinations. The concurrent hallucinations induced by these drugs are visual, i.e. seeing things which are not there; auditory, i.e. hearing things which are not there; and tactile, i.e. feeling things which are not there. Occasionally hallucinations of smell and taste can occur. An interesting phenomenon is the occurrence of "synesthesias", which is the blending of two different senses, e.g. music can be "seen" and colour can be "heard".
The duration of this state, depending on dosage and the type of drug abused, may vary from half an hour to twenty-four hours. Most of the hallucinogens have atropine-like properties, so that physical signs such as very dilated eye pupils, dry mouth with dry cracked lips, as well as flushing of the skin are additional features of some hallucinogens abuse. Distortion of time, space and body image frequently occur. There is a marked disturbance of thought process and an impatient short-term memory, i.e. memory for recent events. These individuals frequently believe they are experiencing a profound mystic or religious experience.
Individual reactions to the effect of hallucinogens vary greatly. The hallucinatory experience can be pleasant (described as "good trips" or extremely frightening and unpleasant ("bad trips").
Another phenomenon encountered with these drugs is the occurrence of "flash-backs". This occurs long after the drug's presence in the body is gone, and is manifested by a sudden, intense hallucinatory experience of short duration (a few seconds or minutes). Most commonly "flash-back" experiences occur after LSD abuse. Flash-backs in LSD abusers can occur spontaneously or can be triggered by emotional tension, loud music or the use of alcohol or dagga. There is no tolerance to the hallucinogens and physiological dependence has not been demonstrated except with dagga, where there is

evidence of some physiological addiction. The urge to repeat the hallucinatory experience, however, makes these drugs psychologically dependency-forming.
The earliest recorded history of the use of hallucinogens is found in Indian religious writings dated 1600 B.C. Similarly there are recordings of religious and ritualistic use of marijuana and hashish in ancient Chinese and early Greek writings. The intense and bizarre alterations of awareness which the hallucinogens can produce, have occasioned their use for mystical, religious and ritual purposes in many cultures throughout the world, including Africa.
The commonest drugs of abuse in this group are:

- Dagga (Marijuana).
- Hashish.
- LSD.
- South African plants and seeds, e.g. Datura Stramonium (stinkblaar), Morning Glory, Atrophine Scopolamine and Hyoscyamine.
- PCP, e.g. Mescaline, Psilocybin and Nutmeg.

Treatment approaches
Only some general guidelines will be explored, as it is evident that the process of chemical substance dependence is highly complex and its effective treatment therefore has to give attention to these complexities.
Experience has shown that individual variables play a determining role in prognosis. For this reason the individualisation of therapy cannot be overemphised.
Bearing in mind the intense psycho-activity of the abused chemical substances, it must become an axiom of therapy that any treatment approach must commence with the total and complete discontinuation of the drug(s) of dependence. It is the non-recognition of this axiom which has led to some of the therapeutic disasters in psychological medicine.
The appropriate treatment modality in terms of out-patient, in-patient, day care and the duration of treatment, requires individual assessment, evaluation and continued re-assessment.
In the same way as family involvement and subsequent family therapy plays a vital part in the treatment process, the whole socio-economic environment of the drug dependent plays a significant part in the selection of the correct treatment modality.
The treatment methodology is to provide the appropriate blend of individual, group and family therapy, with an emphasis on exploring drug-free lifestyles and providing drug-free coping skills. The need for a multi-disciplinary approach in this field is generally well recognised but not always properly implemented. It is only in this kind of structured milieu that the skilled psycho-therapist can function optimally in the treatment of the drug dependent patient.

Prevention strategies
With the increasing incidence of chemical substance abuse worldwide, we recognise that existing preventive strategies have not been very successful. For various reasons most present-day preventive measures are based on some form of control, e.g. legislation, law enforcement, prohibition of substance, age restrictions and sales restrictions. Students of human behaviour will agree that such control measures, whilst necessary to promote some form of organised and structured society, will not materially influence long-term behaviour or attitudes. In order to achieve such human behavioural and attitudinal change, an educational process is required.
Suffice it to state that in the same way as the successful psycho-therapist will endeavour to get the drug dependent patient to internalise the concepts of drug-free coping skills, the successful primary prevention model will have to devise a successful education programme that will successfully reverse negative and destructive drug-related community behaviour into a positive, constructive drug-free lifestyle community attitude.
Our Johannesburg Centre for Alcohol and Drug Studies has successfully designed such a preventive education model over the last few years. It has been implemented in a number of primary and secondary schools and is undergoing final evaluation. Hopefully the design and contents of this Preventive Lifestyle Education model, which is generally based on Erikson's theory of development psychology, will be the subject matter at one of your future conferences.

"Hey Grandpa, Remember Me?"

Hey Grandpa, remember me?
That short little blond-haired kid?
The one you used to give stale lifesavers
off the bureau.
My little grasping hand held tight in yours,
Making me feel safe and secure.

Hey Grandpa, remember me?
You used to call me your baby,
And parade me around your office
like I was the most precious thing,
telling everyone all my accomplishments,
and bragging on my every action.

Hey Grandpa, remember me?
I was the one you took to all
the local playgrounds to play.
The one you took to the pool and clapped
on my every dive.
I was the one you took to the library
and read stories to daily.
And the one you took to the toy store
to spoil everytime I visited.

Hey Grandpa remember me?
I was the one who was too scared
to fly to see you,
but you understood,
and you made me feel okay,
like it was alright to be scared.

Hey Grandpa, remember me?
I had my birthday in your hospital room.
I stood by your side,
and held your hand telling you
it was going to be okay
like you used to tell me.
Your frail, sick body in pain,
just lying there motionless,
emotionless,
and your whole family,
gathered around your hospital bed,
reading to you
singing to you
and praying for you.

Hey Grandpa, remember me?
I was the one who wasn't there
When the breathing machine stopped
and you left me.
I was crying across the miles between us,
Hot tears streaming down my face.

Hey Grandpa, remember me?
I remember your deep chuckle,
and your scruffy white beard,
and your musty golf clubs.
What I would not give
to smell those musty clubs again.
But most of all,
I will always remember your love,
like I hope you will remember mine.

Kathryn Stallings (age 13)
Journal of Child Care, Canada

Handling a Sexual Incident in the Children's Home

Sharon Bacher

How should we handle this incident?
At about 10.00 p.m. one night, a care worker walked into the room of two boys. To her shock and embarrassment, J aged 15, and T aged 16, were engaged in oral sex. The care worker says she was completely taken aback and did not know what to do. Her immediate impulse was to leave the room quickly. This is what she did.
Now she wonders whether this was a helpful way to respond to the boys. She is uncertain about what the boys behaviour means. She is worried in case this means the boys have become homosexuals.
She asks for help in understanding what this is all about so that she can consider some alternative and perhaps more appropriate ways of responding.
Before looking for answers let us discuss the incident and the worker's reactions. We can look at what happened from various perspectives. We can ask the questions: in what way and to whom is the boys' behaviour a problem?

The incident from the perspective of the worker
Is the problem one of shock and embarrassment at walking in on the boys while they were engaged in an intimate act?
Is the worker feeling confused about how she handled the incident? Can she now not face the boys? Is she disappointed or guilty about her reaction?
Is the worker facing a values conflict? Is oral sex between boys anathema to her? Is it against her religious beliefs? Is there a concern that the boys were sinning?
Is the worker uncomfortable about being involved in a sexual experience with adolescents?
Since sex is an area about which most of us feel sensitive and confused, it is likely that the worker does feel some sensitivity about the children's sexual behaviour. Part of growing into adulthood is learning to keep our own sexuality under wraps, and we may be uncomfortable in the sexually charged atmosphere of adolescence. Some of us may have had upsetting experiences of a similar nature or of a different kind which colours the way we respond to an incident such as the one described.

The incident from the perspective of the children
Is their behaviour part of the normal experimentation of youth?
Is this behaviour developmentally appropriate to boys of this age?

The care worker needs to look at her personal attitudes and feelings about sexual behaviour

Since the children were 'caught' can one infer that they wanted an adult to see them? Were they trying to tell the care worker something?
Are there other reasons to fear that these particular children are developing distorted sexual identifications? In other words, is this an isolated incident or do we have good reason to be concerned about the boys becoming homosexuals?
Is this sexual interaction an alternative for the warmth, loving and mothering that the boys need but the care workers cannot provide?
What about the children's immodesty? Do they need to learn that sexual interaction is a private affair?
Is one concerned in case one of the boys is being coerced or bullied into complying with the other boy's domination? Do we fear that a child is being abused?

The context in which the incident has occurred
Should one have a special concern because this behaviour has taken place in a children's home or institution?
Should one not consider what the children will think if there is or is not a strong adult reaction to such behaviour? Will the children conclude that sexual acting out is condoned? Will there be uncontrolled sexual acting out?
Could this incident be communicating something about the mood of the children and the general state of affairs in the home? Apart from an individual communication, could this then be understood as a symbolic group communication?
Many questions can be asked about the incident the worker has described and it should now be evident that one is dealing with a fairly complex situation. How the worker could intervene must take into account her own concerns as well as the overall needs of the boys and of the home.

The worker's personal anxieties about the incident
The care worker needs to look at her personal attitudes and feelings about sexual behaviour. She needs to recognise that this is a value-laden issue and to become aware of how her own values might be colouring her reactions. While one's own anxieties are usually one's own business, as a care worker she needs to develop some professional objectivity so that she does not use only her own biases as a standard for measuring what is normal or abnormal in the children.
Open discussion of her feelings in supervision could help her become more self-aware and develop some objectivity about the issue. In addition, talking about sexuality could lessen her sensitivity to such discussions, and reading about child and adolescent development could broaden her views.
In discussions with children, the care worker should acknowledge her own values and show respect for the children's values if these are different. In this way one could help the children to make reasonable choices about their lives. Respecting the children's values does not, however, mean one has to condone anti-social behaviour. While children have a right to their views, they still need to be socialised and helped to conform to the standards of society.
If deep conflicts about sexuality among children underlie the care worker's own anxiety, she will need to deal with her problem. In the sexually charged atmosphere of a children's home one is confronted with daily manifestations of the children's sexuality. To the extent that one is uncontrollably afraid, or embarrassed, or anxious, or disgusted, or even stimulated by this, one is handicapped in responding appropriately to the children.

The children and normal sexual development
One's opinions about this sexual acting out between two adolescent boys should also take into account what is known about normal sexual development.

In the course of this development, it should be noted that boys do go through a stage of homosexual attachment to other boys. This usually occurs in early puberty, i.e., between the ages of 9 to 13. As they grow older their male peer group becomes an important base from which they can make their tentative flirtations with the opposite sex. Sexual behaviour between boys of 15 and 16 is not ordinarily developmentally appropriate. However, many children in a children's home are emotionally younger than their chronological age, especially institutionalised children, and one's baseline for assessing whether their psychosexual development is normal or not, must necessarily alter.

Child care worker intervention

The meaning of the children's behaviour is not self-evident. While this is a 'homosexual' interaction, one should be cautious about labelling the boys 'homosexual'.

The boys may be attracted to girls while not having yet moved clearly out of their homosexuality. In other words, their orientation may be normal (heterosexual) but because they are shy, or lack confidence, or for other reasons, they may be afraid to make approaches to girls. Helping the boys, then, should focus on building their confidence and sense of 'okayness' about being desirable males, and helping them to take initiatives with girls. Their male peer group may give them a secure base for making tentative approaches through group dates, etc.

The particular boys in question may have been giving other clues in their behaviour, perhaps that they are confused about themselves sexually. Their past experiences with females may have led them to fear female domination, or they may have idolised women and have deep conflicts about heterosexual acts. Learning more about the particular boys will enable the worker to assess whether there are deeper problems involved. If this is so, and the child appears to be asking for help, the caregiver could think about referring him to a professional therapist especially competent in dealing with problems related to sexuality.

The fact that the boys' behaviour was so blatant suggests that they may be uneasy about what they are doing. Whether the boys are stuck in an earlier phase of development, or whether they are experimenting with themselves in different sexual orientations ("Am I a homosexual?) there is bound to be confusion, anxiety, and possibly feelings of guilt. The boys are most surely aware that what they are doing is 'shocking' and they may feel disgusting, sick, or 'queer'. If they are left alone with their thoughts, they may retreat further into a homosexual peer group to seek validation for their feelings and a sense of social acceptance.

It is important for the care worker to acknowledge and speak to the children about the act she has witnessed. This discussion needs to be handled sensitively. While conveying that sexual acting out in general is not acceptable, and that their specific acts are of concern, she must try to convey acceptance and understanding of the boys as people and of their sexual needs. The care worker must take care not to increase the boys' sense of self-disgust, guilt, or confusion. If a meaningful level of discussion can be reached the care worker could support and reassure the boys in a helpful way.

One should also take into account the context in which the behaviour has occurred. With many adolescents in the home, the boys' normal sexuality may be constantly stimulated. The care workers may be young and attractive and the boys may be highly aroused. The care workers may even enjoy their capacity to arouse the boys, and may unwittingly act provocatively and seductively. In this case the boys' behaviour may be an acknowledgement of their mutual excitement, and also a way of seeking relief from their anxiety about their feelings.

One needs to be alert to clues of sexual exploitation of one boy by another. This could have serious overtones. For the exploiter, one would have concern about his use of sexual domination to coerce and bully other boys. The exploited boy, on the other hand, will need the care worker's protection. Unfortunately one has usually got to be very perceptive in order to pick up clues of such exploitation from the boys, since most often the victim will protect the bully because he fears retribution.

Finally, what are the boys communicating by flaunting a socially unacceptable act? If one looks at what is going on in the home at the time, their behaviour may be fairly understandable. For instance there may be a feeling of general insecurity in the home. Or there may be new care workers and the children may be testing out their fear: "Will these people know what to do when I'm afraid, or confused or out of control? Will they be able to keep me safe and to look after me properly?"

The children's home

As a care worker one will not only be concerned with the behaviour of the two children. In addition, one needs to consider whether something is being communicated about the state of affairs in the home itself. Is this behaviour becoming a group norm in the home? What is the effect on the other children likely to be.

And again, are children being molested and coerced into traumatising acts? The care worker needs to convey strongly that homosexual acting out, indeed sexual acting out between children, is not permitted. Nor is promiscuous behaviour acceptable. A sense of modesty needs to be encouraged. A value system in which sexual behaviour is seen as part of a committed relationship needs to be transmitted. Where sexual behaviour is used to shock or to 'thumb one's nose' at the system, it should be discouraged. Where promiscuity is the result of the need for affection and comfort, other means of getting these needs met should be encouraged. The children need to discover that their entering into a sexual liaison in order to gain popularity will be doomed to frustration. And they need to be reassured that they are not emotionally mature enough to handle the responsibility of committed emotional and sexual relationships. As can be seen there are many dimensions to the problem the care worker has described. Not least is the fact that the incident emphasises only one aspect of dealing with child and adolescent sexuality in general. One should avoid over-reacting to the children's behaviour. One should refrain from labelling children as being this or that type of person. On the positive side, one should become knowledgeable about sexual issues of importance to the children one cares for. One should become aware of one's own 'hang-ups' and values and attitudes and use these constructively to help the children develop their own sound value systems. One should avoid harming them by clumsy, insensitive discussion. And one should work towards being able to help them in a mature adult way.

ESSAY: THE YEAR OF THE CHILD CARE WORKER

The Paradoxical Journey: Some Thoughts on Relating to Children

Gerry Fewster

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Sharing the Road

Through relationships, children learn about who they are and about the worlds in which they live. Through relationships they come to experience their separateness, their uniqueness and, ultimately their relatedness. The pathway is laden with discoveries and beset with hazards but the process is as compelling as life itself ... for that is precisely what it is.

Child and youth care workers appear as fellow travellers along that pathway for an increasing number of children in our society. For brief periods of time they share part of their respective journeys, eventually choosing to part company to pursue their own purposes and destinies. The encounters are as varied as the wayfarers themselves but they all offer their own unique opportunities for each individual to learn from the shared experience of the others.

The caring adult, as the more seasoned adventurer, has much to offer in the sharing of past struggles and discoveries. Along with these experiences there are also fears, hopes and aspirations about what lies ahead. Those who journey with calm confidence and courage know that the possibilities and potentials are endless and that each person must learn to steer his or her own course and make his or her own choices along the way. They do not attempt to "show the way" or assume that they, themselves, walk the path of righteousness, for they know that their struggling companions have all that it takes to seek out and discover for themselves. For a time they may walk together, hand in hand, or with arm laid gently around the shoulder. They may allow the young traveller to follow behind but they are always teaching from experience, pointing out the options and examining the terrain. Occasionally, the wiser companion may step in to protect the other from danger but the teacher knows that their association will be short and that the student must quickly learn to walk alone. Then, of course, there are times when the youngster makes a decision that imposes upon the freedom of the teacher. Here the student must attend to the other's experience and come to know that there are rules of the road and that "freedom" for one cannot be expressed as a suppression for another.

Eventually, at the parting of the ways, the older companion, who is truly wiser, will know that the teacher learns from the student. Even students who are angry and resentful, mistrusting and evasive, or quiet and withdrawn, have much to offer. Each has a special story and a unique set of experiences that will be shared if the teacher has the necessary patience, strength, tenacity and commitment to learn. In listening to the young person's story, the adults learn more about themselves and about the fascinating and provocative journey that confronts us all. Then, as they part and go their separate ways, there are no debts to be paid and the appreciations are for what has been shared. The sadness is good, for both companions know that they are now stronger and that in some way their shared experience will continue to link their separate journeys.

In my experience, very few child and youth care workers actually take this perspective when looking at their relationships with young people. More often than not they seem to believe that it is their task to "get to know" kids as quickly as possible and then proceed to "point them in the right direction" by whatever skills or methods are made available. Very few practitioners seem prepared to accept the notion that a relationship based upon shared experience is worthwhile as an end initself. In most designs, it is seen to be a means to an end. The irony is that an open relationship cannot be "used" in this way for such intentions would inevitably produce closure and separation.

In the thoughts that follow, I will attempt to place the child care relationship in a particular framework; i.e., one that is detached from all of the projects and intentions inherent in producing change in others through the various forms of "intervention" or "therapy". This is not to suggest that adults should not have definite expectations of children or that there is no place for discipline or control in the adult/child relationship. In what follows, such contingencies are not discussed, although I would suggest that they could be readily and appropriately built into the perspective presented. The intent behind this article is simply to encourage the reader to "take another look".

The Only Child is Me

To truly understand another person is an impossible task since we have only our own experience to work with. However sensitive, brilliant and insightful we are, we can never really "know" the experience of the other. So, in responding to the other person, we are actually responding to our Selves. From this perspective, our impressions and judgements reveal much about our Selves and very little about the other person. The feelings of joy, sadness, fear and security that we experience as we listen to another person's story are feelings that actually relate to our Selves and our own stories. Think about this the next time your are quietly emoting in the protective darkness of your local movie theatre. Consider how "self-conscious" you would feel if the house lights were to be put on and you were to be seen by the rest of the audience in your state of vulnerability and self-indulgence. In child and youth care work, ask yourself why the story of a particular child will produce anger in one person, condemnation in another, sympathy in another, despair in another and so on. The child and the story remain the same but the experiences of others are quite different, along with their direct responses to the youngster in question. The primary response is always to the Self.

Hence, relationships are essentially connections with the Self and not with the worlds actually experienced by others. It is the quest for Self discovery that constantly draws us toward others. Some writers and philosophers have argued that beyond Self discovery there lies the more mystical world of trans-personal understanding but, for most of us struggling through our daily lives, we have only tantalising glimpses of this realm of evolved consciousness. For the most part, the experiences of others help us to experience our Selves. The more others share their experiences with us, the more we learn about our Selves. Conversely, the more we share our experience with others, the more we offer potential for learning and growth.

When taken seriously this perspective offers some fascinating paradoxical learning opportunities for child and youth care workers. Some examples of such paradoxes are discussed in this article but readers are certainly encouraged to develop their own. However bizzare they might appear at first blush, the chances are that their further consideration and analysis will help practitioners to take a fresh look at their most critical professional issue ... relating to children and young people.

The More I Can Explain, the Less I Understand

As I listen to child's personal story, expressed in either present or past experience, my senses are inextricably bound up with my own present and past experience. In order to make full use of what my senses have to offer I must begin by allowing them to be as open and receptive as possible. This means that I must be prepared to abandon, at least for the time being, all of the feelings, thoughts, ideas, theories and judgements that do not belong in the immediate project of attending to the young person who is sharing my physical space. Any pre-established attitude will undoubtedly limit my openness to the experience. Hence, a feeling, thought or judgement brought in from some theory or belief will adversely affect the learning potential of the encounter to the degree that it restricts me from moving freely with what is occurring from moment to moment. In this process the explanations which emerge from theory, hypothesis-testing or even past experience, are inhibitory to the task of learning.

As I learn from the story of the child as it unfolds in the immediacy of the moment, so I open up to my own direct experience of myself at that point in time. As I move toward the experience of the other person, as a child, the only threads of my understanding are drawn from my own experience of childhood. This is not a regressive process of drawing upon images of the past. In growth and development we never simply "move on" from one period to another. Rather we incorporate our experiences from moment to moment and from year to year in an ever-expanding sphere of consciousness. So the child that we contact is not the child that was but the child that is. It is not the child of another world but the child within.

When we open up to our own experience in this way, we prepare ourselves for sharing that experience with others. In this case, we are creating the most vital and stimulating arena of learning for children and their care-givers. We are not concerned with explanations that tell us what to do next, give us potential control over others or promote our status as experts in child care. These are desires and intentions which take us in a different direction and while they might be perfectly valid

in themselves, they have no place within the project being considered here. The more such explanations are sought or imposed, the less will be the learning potential for the two selves involved. While the search for empirical generalisations and scientist-practitioner methods may be laudable, there is clearly a distinction to be made between knowing a particular child through personal experience and knowing about a particular child through theory and prediction. They are mutually exclusive perspectives of course but it is possible, and probably desirable, for both to be incorporated into child and youth care practice.

The More I Succeed in My Role, the Less I Relate to the Child

When we are concerned about the roles we play, professional or otherwise, we are concerned about our "performance" in accordance with some prescribed set of expectations or aspirations. We are interested in presenting our Selves to others in a particualr way and attempt to evaluate this impression by looking back at our performances "as if " through the eyes of others. Most successful people are very adept in this process and most professionals have a great investment in creating and maintaining a specific or idealised image in the minds of colleagues, clients and the general public. There is absolutely no doubt that successfully meeting the role expectations of others is a significant factor in the development of social competence and the enhancement of self-esteem. On the other hand, it can inhibit personal growth and be diabolically destructive to relationships in the helping professionsgenerally and child and youth care specifically.

A role is essentially an idealised presentation of the Self within a given context. It is an object created by our Selves for the benefit of others based upon what we believe their expectations to be. In professioanl roles such prescriptions are carefully established through the "ethics" of particular associations and through the job descriptions of particular organisations. More pervasively, however, they are subtly created through the informal encounters and exchanges of people involved in their daily activities and routines. As most seasoned residential workers know only too well, it is the people who work together day by day who determine what good child care work is all about and which practitioners deserve and receive the "real" status and approval.

While such roles might reflect the person in some ways, the Self is primarily involved in evaluating performance while directing its energy toward meeting external expectations. In a sense it has turned the person into an "object". In this process it is not readily available to become openly involved in relationships. Among human service professionals, the more the Self directs its energies toward meeting external expectations, the less it is involved in its own learning, growth and development. Deprived of such nutrients the experience to the person is often one of fatigue and "burn out" as the Self and the role become increasingly detached.

To make matters worse, the concern with role performance and evaluation makes it necessary for the person to place others into reciprocal roles. While this is obvious in the case of formally prescribed roles such as those of supervisor or administrator, it is the informal prescriptions which are the most influential in determining the quality of relationships. In child and youth care, the role-objectification of the young person places an invisible and impersonal barrier between the youngster and the caregiver.

In order to be successful in the role of child and youth care worker it is not sufficient to simply respond to youngsters in certain ways. It is also necessary for practitioners to be able to describe them in particular ways and reflect values prescribed within the formal and informal role structure. This may invoke the use of some formalised assessment or classification system or the informal assignment of roles which inevitably occurs in staff rooms or through case conference.

Finally the role of child and youth care worker is assessed through the behavioural responses of the kids themselves. Here the youngsters become active objects in the role performance game. This is a depersonalised arena of action in which open relationships become virtually impossible to attain. The best that can happen is that practitioners can practise their professional roles and youngsters can practise their "disturbed", "alienated", "hostile" or "adolescent" roles.

The More Responsibility I Take For Kids, the Less Effective I Become.

Since it is not possible for me to "know" the experience of another person, I cannot take responsibility for that experience. Moving a step further, it is not possible for me to assume responsibility of the options perceived or the choices made on the basis of this personal experience. This is a difficult proposition for us to accept in relation to any person we care about and particularly in situations where we assume that the person in question is suffering from some form of diminished responsibility. Among child and youth care workers there are powerful internal and external expectations that practitioners are responsible for the experiences, options and decisions of the children and young people intheir care. This misdirected working hypothesis is distinctly hazardous to the health of relationships

Once we stop believing that we can actually change people through psychotherapy, conditional love, coercion or manipulation, we give our Selves permission to be who we are and grant the same degree of freedom to the other ... even where the other happens to be a child. This makes it possible to establish a relationship with another person as a separate and unique entity. This does not mean that we should not do our utmost to assist the youngster in becoming personally responsible or that we should not exercise our adult responsibilities as teachers or even protectors. In the early developmental years we should acknowledge that children must first learn to separate themselves as individual entities in the world and support them through this process of experiencing and learning.

The point is that within their own worlds, however restrictive or expansive, all human beings are alone, coming to their own conclusions and making their own choices for their own reasons. As outsiders, we have no access to those worlds, however much we believe that we "know" the person and however knowledgeable we believe our Selves to be in the human sciences. Of course we can attempt to influence experiences and choices by meddling with the external environment but even children will continue to make their own decisions and there is no way that we can really connect with the experience that actually influences this process. The more we believe that the experience of others parallels our own experience of the world, the less we accept the uniqueness of their experience and unless we have experienced some shared state of "intimacy", we are most certainly deluding ourselves. If we move one stage further and actually take responsibility for the experience of others, we have taken the ultimate step in denying their very existence.

However obvious this might appear, child and youth care workers often assume this responsibility as part of the "caring" mandate. Those who do will never be in a position to develop relationships with young people since, for the practitioners, such youngsters are not more than extensions of them Selves. There is nothing else to relate to.

The More I Relate to Others, The More Alone I Become

Developmental psychologists have consistently suggested that a critical period of growth takes place as the child begins to form a concept of self as separate from the world in which the child lives. This process takes place in direct interaction with the world. By the same token, children become aware of their personal uniqueness as they develop a sense of Self that is separate from that of their parents and other people in their lives. Moving through adolescence and into adulthood, the more we are able to share our experience with others and the more they share their experience with us, the greater becomes our sense of individuation and separateness. Developmentally speaking, then, child and youth care workers will probably have very different needs and experiences in their relationships with youngsters from the youngsters themselves.

The "healthy" adult, possessing an integrated view of Self as a competent, autonomous and worthwhile entity, is free to move in and out of relationships while maintaining an on-going sense of personal integrity. This personal sense of Self does not require the daily support of the evaluations of others and the person may choose to move to those places where the opportunities for personal growth and self-discovery are the greatest. Personal inadequacies or deficiencies are taken as tolerable "givens" which can be addressed without having to be propped up bythe strengths or attributes of others. As people continue to relate from this perspective, they become increasingly "sure of them Selves", establish a sense of comfort with who they are and move in the world with a state of grace and independence. They are separate, unique and free to explore themselves further through relationships with others.

Children and young people, particularly those who come to the attention of child and youth care workers, are generally not at this stage of development. Frequently they have a poorly integrated sense of who they are, their perceived inadequacies are experienced as irrevocable failures and they move clumsily in a world that is intrusive, oppressive, hostile and overpowering. While some of them might choose to withdraw from this world, they are unable to separate their Selves with any sense of integrity and, when hiding fails, strike back with anger and resentment. Alternatively, the youngster may recognise the power of the world.

Whatever response a particular youngster decides upon, a relationship with an adult who recognises the state of aloneness, and who is prepared to share in this experience, offers the ideal learning opportunity. Through such a relationship, the young person may come to understand that being alone is not the same as being lonely; that autonomy is not the same as alienation and that loving another person is an act of freedom and not an expression of dependency.

American workshop on
Positive Peer Culture

Lynette Rossouw

At the recent Inter-Association Child Care Conference at Valley Forge, Pennsylvania, Lynette Rossouw attended a workshop on the positive peer culture model (PPC) presented by Dr Larry Brendtro.

During the 1950's there were major new directions in work with troubled persons. Maxwell Jones started a war against the "patient model". He believed that patients should be empowered to participate in their own treatment ("therapeutic communities"). Professionals like Bettelheim and Fritz Redl promoted milieu therapy. Prisoners in army camps had formed groups to talk. These were successful, and when the war ended the Highfields Project was started in New Jersey. Harry Vorrath did his social work internship at Highfields, where the group home model had been implemented. He learnt "guided group interaction" there and when there was a riot at a state training school, Vorrath was hired to go there. He selected the thirty worst children and locked himself, the children and the staff in. The outcome was so successful that he was given a contract with the state correctional facilities. Specially trained consultants can be hired to live in at agencies for a year in order to implement the PPC programme. Vorrath used problems to change values in an aggressive way. He challenged the "tough young people" to be "smart and have guts". Vorrath is the co-author of *Positive Peer Culture*.

Some concepts of the PPC programme

The power of peers. "How many things, which for our own sake we would never do, do we perform for the sake of our friends?" – *Cicero.*

The rewards of giving. "Help thy brother's boat across and lo! Thine own has reached the shore." – *Hindu Proverb.*

If you always have to be the recipient, it makes you feel helpless and your self-confidence tends to be poor. Helping someone else helps your own self-concept. For this reason the intake officer at Starr Commonwealth asks the adolescent what he can do for *someone else* and not what he expects should be done for him.

Empowering youth for responsibility. "Our society deprives youth of opportunity for responsibility and then blames them for their irresponsibility." – *Ruth Benedict.*

Trust and openness versus invasion and exposure. "Trust not in him your secrets, who, when left alone in your room turns over your papers." – *Johann Lavater.*

Members should be allowed to share with the group because they trust each other, *not* because others "stripped them of their defences". For example, a new member may decide that he is not ready to share his life experience with other group members. Members then wait until he is ready to do so. He may then ask for a group meeting to tell his life story. After hearing this, the group then assigns to him problems to work on problems such as "substance abuse" or "low self-image".

Our society deprives youth of opportunity for responsibility and then blames them for their irresponsibility.

A climate of change versus a climate of security. Never apply "non-therapeutic" programmes with young people. "What man actually needs is not a tensionless state, but rather the striving and struggling for some goals worthy of him." – *Victor Frankl.*

If people seem satisfied with their actions, we should *create* anxiety so that they would want to change.

ology of service. "The emerging generation is more than hinting, now almost screaming to be used in some demanding cause." – *George Gallup, Jr.*

Young people's "great idealism" should be recognised. They need to be drawn into striving towards a better situation. They also have the following characteristics: optimism, altruism (concerned about others), problem-solving is seen as a challenge, positive self-esteem, creativity (in an unpredictable situation young people often come up with novel ways of handling it).

More responsibility should be given to adolescents. Adults often find the idea of having to "step back" very scary. Underinvolvement is seen as uninvolvement.

The groupleader's role in the PPC programme is to:

- step in when it is obvious that communication is not authentic;
- intervene when there is abuse of confrontation in the group;
- address the issue when a young person who is estranged from his family is more responsive to peers than to family;
- teach group members listening skills. Adolescents know how to "preach" – they learn it from their parents, but they have poor listening skills;
- avoid a lack of individualisation in the group;
- sanction. Group members do not have a licence to punish and thus cannot ask a member to leave the group, etc.

The basic goal of the PPC programme is to create caring environments and to teach responsibility.

Group structure

The groups normally consist of nine to eleven members who meet five days a week for 90 minutes per session. In a bigger group cliques would easily form. Two helpful techniques are:

1. *Reversal technique*: The groupleader should spot denial, projection and excuses and cut right through them. The end result will be that the adolescent will own the problem. For example, the adolescent may say: "Nobody cares about me, so why should I try" or "Alcoholics' children get bad anyway".
2. *Relabelling technique*: For young people "hurting is cool", "helping is sissified" and "being nice is not fashionable". In their culture hurting behaviour is romanticised. The groupleader must never label the adolescent, but should confront him and build him up at the same time. An example of this would be: "That's very childish (confront) for someone so mature as you (positive feedback)".

Conclusion

The "Peer Culture Model" utilises peer involvement to foster change. The underlying philosophy is that peers have power and that they have much to offer. They should be helped to identify problems in the group, take responsibility for themselves and also help each other. By "giving" they improve their self-image and decrease their helplessness.

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Street Children: The Nature and Scope of the Problem in Southern Africa

Linda M. Richter

Linda Richter, a clinical psychologist, is Assistant Professor in the Institute for Behavioural Sciences at the University of South Africa in Pretoria. This is the text of her Keynote Address at the recent National Workshop on Street Children, given on 7 July 1988.

What is the problem?

The "problem" as I confront it is perhaps a little different to the one that most directly affects the participants of this workshop. I assume that most of you are concerned with the practical issue of what *to do* about the children. The "problem" for me is being able to describe, as fully as possible, the historical and contemporary forces, and the social and the psychological factors, involved in the phenomenon of homeless children living and working in the streets of towns and cities in South Africa. Indirectly, my problem is your problem too, because only by understanding the current situation and the historical context of the children, will we be in any position to respond constructively to their situation.

The numbers

I'd like to start with an estimation of numbers, even before attempting any definition of street children. I do this mainly because, paradoxically, it is easier to deal with estimates of street children as referred to colloquially within the ranks of people working with the children, than to first try to limit the meaning of the term and then to make guesses at the numbers of something which may be different from what my sources were referring to in the first place.

The only guess at the number of street children in South Africa that I have seen is the one given by Jill Swart in 1987 (Swart, 1987). She reported that an anonymous government official had estimated the number of street children to be about 5 000 countrywide. This figure was based on informal feedback received from welfare organisations throughout the country. However, there seems to be general agreement, in some popular media and amongst those involved with street children, that this is an underestimation of the size of the problem.

Nonetheless, I believe that dramatic and sensational overestimates should also be avoided. It is very tempting to speculate that there could be "hundreds, even thousands" of street children, and that we are seeing but the tip of the iceberg. The alarm implied by such statements may be useful for alerting the government and the public to the urgency of the situation, or for reassuring ourselves that we are working on major and significant social problems. However, in the end, dramatic forecasts can have negative effects by blinding us to the actual nature of the issues involved, and by making us feel important in the face of what seem to be insuperable obstacles.

I also think that we should learn from the experience of South Americans. Sensationalistic overestimations of the numbers of street children in South American countries handicapped efforts both to understand the problem and to design responses to cope with the issues. For example, both Ennew (1986) and Sanders (1987) have drawn attention to the fact that some media estimates of street children in Latin America included 30-80 percent of all the children in those societies within the relevant age range, and that these figures were clearly absurd.

Both authors have also pointed out that it was readily assumed that the phenomenon of street children was due to the breakdown of family life on a massive scale. While family dysfunction and abandonment was clearly involved in the histories of some of the children, two thirds of street children have been identified as "working" children of needy families. Of this situation, Sanders says: "In a valiant and admirable struggle to improve their situation, the poor turn to various alternatives, one of which is to have their children work or beg to supplement the family income".

I will reconsider this issue, that is, what children might be doing on the streets in South Africa, later in my paper. Right now, however, I will turn my attention to making an educated guess at the number of street children in South Africa.

In all my calculations, the population figures I have used are those from the 1985 Census, adjusted upwards for underestimation by the Bureau for Market Research at the University of South Africa. In general, the Bureau's adjustment consists of increasing the figures by about 25 percent depending on the area. The only *actual* figures with which I could work were the estimates of the number of street children in Cape Town (between 300 and 600) made by Scharf, Powell and Thomas (1986) and a guess at 600 as the number of street children in Johannesburg and Lenasia made by Father Bill MacCurtain.

I used several other findings in making the calculations, based on information gained from our own studies and from that of Scharf *et al*:

- In general, the age range of the children to whom we are referring is from seven to sixteen years of age;
- Between 80 percent and 90 percent of the street children we studied in Johannesburg came from the surrounding Witwatersrand areas (statistical regions 72, 73, 74 and 75). We made the assumption that the same principle would apply to the Cape Peninsula (statistical region 1).
- Although barely visible, street girls comprise about 10 percent of the population of street children.
- The greatest majority of street children in Johannesburg are black children, but in Cape Town the numbers

TABLE 1	WITWATERSRAND Street Children = 600	CAPE PENINSULA Street Children = 450 (300-600)	
	Black males 7-16	Black males 7-16	Coloured males 7-16
Reference Population Group (adjusted)	178 958	31 048	101 160
10% are females but not subtractedfrom the Johannesburg numbers	600	405	
80-90% are from the metropolitan areas	510	344	
In Cape Town 70% of Street Children are coloured, 30% are black	510	103	241
Percentage Street Children of Reference Population Group	0,285%	0,332% (AVERAGE = 0,285%)	0,238%

are split between coloured children (roughly 70 percent) and black children (30 percent).
The rationale for the calculations are shown in Table 1. By the methods used, I estimate that street children comprise about 0,3 percent of the relevant reference population groups. In this context, the relevant population groups are black and coloured males and 10 percent of all females between seven and sixteen years of age. I am quite sure this percentage is not an underestimation as the comparable figure for Brazil, where the problem is supposed to be immense, is 0,1 percent (Sanders, 1987).
We can estimate the total number of street children in South Africa by applying this percentage to the rest of the country. To do this, however, we have to assume that the pull to urban centres from all areas is the same as that to Johannesburg and Cape Town. That is, children will migrate to Cathcart, Pietersburg, Mafikeng, Port Alfred, Umtata, Worcester and so on, with the same ease as that which governs the movement to the major metropolitan areas. I am sure this does not in fact apply, but it is easier to assume that it does, than to weight the "pull" of some centres relative to others. It may also be better to overestimate, rather than underestimate final numbers. The estimates for the total number of street children in South Africa, including the independent states, are shown in Table 2. By the method I have used, I estimate that there are over 9 000 street children in South Africa.

TABLE 2
TOTAL NUMBER OF STREET CHILDREN in RSA and Independent States

Coloured and Black, Urban and Rural, Boys and 10% of Girls aged 7-16 years
TOTAL = 9390 (0.285% of 3 294 707)

DISTRIBUTED BY AREA IN RSA
Western Cape = 813 Natal = 367
Northern Cape = 222 OFS = 640
Eastern Cape = 528 Transvaal = 1 827

BY AREA IN INDEPENDENT STATES
Bophuthatswana = 559 Ciskei = 303
Transkei = 977 Venda = 128

The numbers of children in the independent states were extrapolated from the percentage of children in this age range amongst black people in South Africa (21 percent). We also assumed that there are approximately 51 percent females and 49 percent males in the population. The population figures for the independent states were taken from the South African Institute for Race Relations Handbook for 1984).
These figures clearly do not include so-called "veld" children and "dump" children. However, there are no informed estimates of the numbers of such children, although the indications are that there are, relatively, very few children living in this way.
The figures I have estimated are, I think, lower than many of you might have suspected. I am neither an epidemiologist nor a statistician, but I felt compelled to make some kind of reasoned estimate of the size of the problem. I certainly believe that at every point of decision, I opted for over- rather than under-inclusion, and that the figure I have arrived at is probably the upper limit of the number of street children in South Africa.
Essentially, however, the matter of arriving at good estimates hinges inextricably on what we accept as our definition of street children. Without going into the issue, I would support Annette Cockburn's definition, which I have altered slightly. That is, for our purposes, street children are those who have abandoned (or have been abandoned by) their families, schools and immediate communities, before they are sixteen years of age, and drifted into a nomadic street life.

Working children

Before we settle estimates of the number of street children, I would like to introduce a distinction made by Judith Ennew, between children *of* the street and children *on* the street (1986). By "children of the street", Ennew intends to refer to homeless children who *live* on the street. It is this condition, I believe, we all mean to indicate when we refer to "street children" in South Africa.
On the other hand, "children on the street" refer to children who go into urban areas in order to earn or beg money and who then return home. These children contribute all or most of their earnings to their families. Importantly "children on the street" are attached to, and integrally involved with, their families.
As with the majority of the Brazilian street children referred to earlier, these "children on the street" are a response to the problems of poverty, unemployment, and marginalisation which affect their families.
The idea of "working" children, which is what "children on the street" are, is supported historically, by custom and by need, amongst the poor and the working class (Zelizer, 1985). It need not depict less caring or less cohesion on the part of families.
On the other hand, without careful investigation, there can be no certainty that the children are not being exploited by their families. As Sanders (1987) argues, children working is a response on the part of desperate and sorely pressed families to generate funds in whatever way they can. The fact that parents may be powerless to earn wages whereas their children are successful at begging, earning or eliciting money, is an indictment against underdevelopment and social injustice.
That children are working, says Sanders (1987) of Brazilian street children, is not a manifestation of family disintegration, but an affirmation of unity and solidarity; it is part of the family's solution to survive under conditions of poverty.
The question arises regarding the number of children seen on the streets in South African cities who are working "on the street". According to two different head counts made by Jill Swart (pers. comm) at known sleeping places in Hillbrow, Joubert Park and Berea in Johannesburg at the end of 1985 and the beginning of 1986, between 110 and 140 boys were sleeping on the streets in these areas. That is, this number of boys seemed certainly to be *living* on the streets in that area during that time. In the light of the estimate of 600 street children in Johannesburg and Lenasia, it would seem that at least one third of the children who are visible on the streets during the day or night are "working" children who return home with their earnings.
Whatever the actual figures, and we are obliged to ascertain these more carefully, we should recognise working children of needy families, as compared to homeless children, as one part of the group of children visible on city and town streets.
Both groups of children are drawn to the white urban areas as unconsciously as bees to honey. The children's survival is made possible by their efforts to skim off a very small share of the personal wealth to be found in these areas.
While the solution to the problem of working children is, in the long-term, one of government policy concerning development and employment, in the short-term we may have to respond to these children's condition in constructive ways. For example, by accepting their need to work, by creatively providing them with schooling which does not preclude their work, and by providing them with shelter and protection from danger while they are "working" on the streets.

Children of the street

The contention that a good deal more than half of the visible children on the streets are "of the street" is supported by the records held at Twilight in Johan-

nesburg. Of 86 boys whose records we could trace, 59 percent had been there, (admittedly, some inconsistently) for more than a year. This group of children have nowhere else to be. They are "throwaways" and "runaways", children whom families and communities have failed. Some of them, about 10-20 percent, are second-order runaways; having run away from child care institutions, or other social programmes. A sense of failure is felt acutely by *ourselves*, when they run away from *our* care. In South Africa, as elsewhere, the phenomenon of children who are abandoned, unwanted, neglected or abused, has been linked to socio-structural factors which, primarily through urbanisation and impoverishment, cause distortions in family and community life. However, the horrifying backgrounds of many of these children are well known to most of you, and there is little that can be gained from reiterating accounts of captivity, brutality, and sexual molestation which recur in their histories.

Beside the care, protection and education which most of the shelter programmes now attempt to provide, many of these children require expert psychotherapeutic measures to assist them to overcome blocks to their adjustment which have been occasioned by the trauma and cruelty they have experienced. We also have to recognise that the responsibility for the children is a permanent one. In only some cases can family life be rehabilitated. In its place we have to find ways of giving the children certainty, security and a sense of community. The shelters so far established, were not founded to provide, and do not have the facilities to provide, a long-term commitment to the children.

Dangers of street life

We also have to find ways to tempt the boys and girls who are "of the street" to leave the streets as soon as possible. Our own study showed that the longer children spent on the streets, the worse their prognosis for educational rehabilitation became. Not only did they progressively lose the basic educational skills they might have picked up in a few years of schooling, but they began to acquire handicaps. The longer the boys had spent on the street, the more likely it was that they would show indications of cognitive and perceptual dysfunction. The reasons for this trend are multiple – and include the long-term effects of glue-sniffing, injuries and accidents associated with glue intoxication, and injuries and accidents associated with the violence and exploitation intrinsic to street life.

It is a simple fact that street life is very dangerous for children. Glue-sniffing is always accompanied by the threat of death, and by the possibility of permanent organ damage, even more so because the children have limited access to medical help in an emergency. Children are also physically and socially powerless in relation to all other groups and individuals on the street. As a result, many dangers confront them on the street, and the children often pay dearly for their relatively good street "earnings" of about R20 a day (Jill Swart, pers. comm; Colin Pungula, pers. comm.).

There is the other possibility that the longer the children spend on the streets, the more likely becomes their entry into criminal activities. We found that about 23 percent of the boys we examined exhibited attitudes and/or behaviours consonant with what is commonly called delinquency. Whether the kinds of anti-social attitudes and behaviours we found had precipitated running away from home, or whether the children have gravitated towards a criminal subculture since embarking on street life, is not known. Nonetheless, probably about one fifth of street children may be involved in anti-social activities, and some may already have acquired a set of attitudes and beliefs congruent with criminality. This particular group of children poses additional problems for efforts to help street children. The high visibility of criminal or delinquent activities, even amongst a small group of street children, tends to antagonise the communities in which they occur, and they provide the authorities with a rationale for adopting a punitive attitude towards all street children.

Causes of the street children problem

Only a very small number of the street children are orphans – 8 percent in our sample and 6 percent in the group studied by Scharf *et al* (1986). Otherwise, several family background factors have emerged as salient in a number of studies: poverty, unemployment, nuclear family upheaval in the form of death, desertion, remarriage, and single parenthood, alcohol abuse amongst parents, overcrowding, school failure, and so on (Jayes 1985; Scharf *et al*, 1986). In our own study we found that more than 50 percent of the boys had come from disorganised homes, living with relatives, or only one parent.

While these kinds of factors may be necessary conditions for producing the kinds of stresses in families which predispose children to run away or be abandoned, they do have, in fact, much less explanatory value for understanding the problem of street children than is usually supposed. The reason why these factors are only very broadly implicated in explaining the phenomenon of street children is that most of them are typical, or largely typical, of the homes of many of the nearly 3,5 million children of the same age to whom we referred when making our estimates.

Whilst this is an exceedingly complex topic, I would like to provide some evidence for my assertion regarding how widespread among black families are the social background factors presumed to be typical of the histories of street children.

- Mother-child units either alone or in multiple family households have been estimated to comprise between 35 percent (Pauw, 1963) and 60 percent (Steyn, 1974) of all families in urban areas. In our studies we have found that fathers were absent, for one or other reason, from 43 percent of the urban black homes we sampled (Richter, Griesel and Etheridge, 1986). It was estimated in 1970 that more than one half of men in KwaZulu were away from home as migrant labourers (Nzimande, 1985). Therefore, for both urban and rural black families, single parenthood or disrupted family life characterises between one third and one half of all black families.
- The housing shortage means that high household densities typify most black and coloured homes. We have found in our studies that the average number of people per household in urban black homes is seven, with a range between two and twenty-two. Simkins (1986) has calculated that the average number of persons per living room in coloured households is nearly three, as compared to less than one person per room in white households. Wilson and Ramphele (1987) quote a survey in the townships of Port Elizabeth which indicated that 40 percent of households consist of shared accommodation, and that in more than 10 percent, three or four families shared the same house. This kind of crowding should not be confused with extended families. Living with many people does not necessarily imply that they constitute a support system for any particular person or group in need.
- As an indicator of pervasive poverty, it is reckoned that about one third of black children under fifteen years of age show signs of malnutrition (Ndaba, 1984; Wilson and Ramphele, 1987). D'Souza (1987) has estimated that about one fifth of rural households are in a state of severe poverty or destitution, having no visible income and few, if any, assets.

• About 50 percent of the sample of school children in Soweto studied by Gordon (1983) failed at least once during their first three years of school. Of the 600 000 black students who began school in 1968, only 5 percent completed in 1980. The rest of the children dropped out of school (Gordon, 1983). It is estimated that about 50 percent of all black pupils leave school by fourteen years of age, many of them functionally illiterate (Marcum, 1982).

I have presented this information to make two points: Firstly, to illustrate that these kinds of factors explain the existence of street children only in a very general sense, and secondly, in order to call attention to the social cohesion and integrity of black family life, in spite of enormous difficulties, and which we should attempt to support in every way possible.

About one third to one half of all black families in South Africa endure the structural and functional stresses I have described. In order to understand the forces operative in the case of any particular street child, we will have to focus on psychological and motivational characteristics to complete the picture. We already have some indications in this direction. For example, both Scharf *et al* (1986) and Swart (1988) have pointed to a characteristic runaway response to interpersonal problems among street children. In our study we found that street children had a greater sense of control over their lives than would normally be expected of children of their age. We need studies of the personal profiles of street children in order to understand them. If we don't have this type of understanding, they may defeat our efforts to help them by "running" away from us, as they have run away from others in the past.

I said that drawing attention to the difficulties of so many black families was in a sense a tribute to the resilience of social relations, and the compassion towards children, which must pervade most communities in spite of hardship. More than twice the number of places in child care institutions are available for white children as compared to black and coloured children (South African Institute for Race Relations Handbook, 1986). If the numbers of street children I have estimated are a manifestation simply of the need for more facilities, it would show that the number of black children in need of care outside of family life is less than what we would expect on the basis of the white figures.

For this reason, I believe that we should make every effort to design outreach programmes to support black families in providing children with care. We should develop social policies and mechanisms to respond with assistance to families in crisis, before parents and children lose their capacities for nurturance and affection towards each other. We should also be sensitive to the knowledge that the shelters are materially a great deal more comfortable and stimulating than are the home environments many parents can provide. While we obviously need to extend help to the street children, we should be careful not to undermine or invalidate the best efforts that many parents can make on behalf of their children.

The attitudes of South Africans on these issues will have to change if we are going to be able to adapt to, and deal with, our social problems. Perhaps too, like in the rest of the world, we may have to acknowledge the changes in family life which have almost imperceptibly crept upon us.

The self-sufficient, enduring, nuclear family, caring for its own children, is a model of child care which barely exists anymore. For example, Hernandez (1986) has estimated that 50-75 percent of the 1980 birth cohort in America may live in one-parent families during their childhoods. More and more children will become the shared responsibility between one or more parents, and the communities in which they all live.

The truth of this assertion is brought home clearly by examples such as those of a single mother of a future street child who takes her boy to the police station for a hiding because she no longer can maintain control over her child, or of a destitute and desperate mother who offers her child up for care to a shelter for street children.

Much as some people would wish, the street children in the towns and cities of South Africa can't be sent away to *someone else*. They come from, and belong to, each of those cities and towns, blinded as we are to this by the fact that they are made to live outside the towns.

The street children are our problem. The buck, as it were, stops here.

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Gangs and Street Children in Worcester

Erena van de Venter

Erena van de Venter is a social worker at the Child and Family Welfare Society in Worcester.

During 1982/1983 the Worcester Child and Family Welfare Society became acutely aware of the problems the anti-social gangs were creating in the community when one of their foster children was gang-raped and seriously injured. The Society realised that the police could not control or change the situation. Gangsters were controlling their communities and frequent gang fights turned the townships into war zones. The Child Welfare Society therefore decided to appoint a social worker who would work directly with these gangs. In September 1983 the gang community work project, "New Life" commenced.

New Life

Four years of intensive involvement with the gangs led to a greater freedom and safety for the inhabitants of Worcester. Young people from an area controlled by one gang, could now safely visit relatives in areas controlled by rival gangs. The focus then changed to more preventitive work with the youth who, because of the circumstances in which they grew up, had become involved with gang activities from a very tender age. The schools in the areas which the gangs frequented had many truancy problems. These youngsters were hanging around with older gang members and frequently became involved in petty crime. Many also scrounged for food on the rubbish dumps. School feeding schemes were thus started with a view to enticing the children back to school and feeding them properly. After school care programmes and anti-drug abuse campaigns also fulfil a very real need.

However, tackling the problems of the children living in and off the streets, is a difficult and complex project. As has been stated by Annette Cockburn, "street children do not benefit from traditional facilities, so alternative ways of addressing the problem have to be sought".Even reaching out to the street children proved that it would be a difficult but nevertheless exciting road.

Ricardo

I had heard that Ricardo was a street child and glue-sniffer. When I found him in the Riverview area, I tried my usual charm to get the little guy talking, but nothing turned him on. "Glue-sniffing? What's that?" he asked in an I-don't-know-what-you're-getting-at attitude.

Fortunately David, a rehabilitated ex-gangmember working with me on certain projects, offered to help. He asked if he could have a minute alone with Ricardo. I don't know what language they spoke, but within the next two minutes Ricardo was with us in the car, eager to take us to his friends, acknowledging that they were all street children and sniffing glue.

When we reached the park, Ricardo asked me to park two streets away, totally out of sight. He and David approached the group on foot, but when they saw the stranger with Ricardo, they started running. (How suspicious they were, or was it guilt or fear? What makes them so distrustful?).

When David realised they were running away from him, he used his gang language to stop them. I'd rather not repeat what he said. Anyway, to prove they were not "moffies", they stood still and allowed Ricardo and David to approach them.

When the signal was sent to me, I was allowed to bring our combi around. I was at first suspiciously accepted by the group, but the word must have spread, because from then on the other street children have also accepted my role.

Eigel's Home

It was in April 1987 when we made our first contact with the street children of Worcester. Now, a year later, we are grateful to say that Eigel's Home has opened. Eigel was the first rehabilitated gangmember, who was murdered. His last request was (169Please look after my children". Eigel's Home is very small and is being used temporarily until a larger place can be found. This home has however given us hope, because the six kids who have come off the street to live with Dorothy and Clifford, the house parents, have all (except for one who could not cope with the structure) gone back to school after an absentee period of two or three years. One boy, aged ten, had never been to school before. For them glue-sniffing and beggar life-style has stopped.

Our vision is to work on the same principles as The Homestead and Cape Town Child Welfare Society, namely, the three-phase programme: a shelter, a second stage unit, and an after care centre.We are very fortunate in having a group of youngsters from the local high schools who are sympathetic and eager to help the dilemma of the street child. With them and other motivated volunteers, including a clinical psychologist giving us his free time, we will find out how many kids are roaming our streets. Within the near future we would like to take in more children, especially those who come begging for help but whom we have to turn away due to lack of facilities and resources.

Nuusbrokkies Newsbriefs

NATIONAL

Large Attendance at National Workshop on Street Children

An unexpectedly large number of delegates registered for the three-day Workshop on Street Children which was held at the Salesian Institute in Cape Town from 7 to 9 July. The organisers had originally expected 35 to 40 delegates. As it happened, some 45 organisations and seven state departments sent over 130 delegates. There were only five plenary sessions, most of the time being devoted to practical workshops. The Keynote Speaker was Professor Linda Richter of the Institute of Behavioural Sciences at UNISA, and the Guest Speaker and consultant was Professor Mike Baizerman of the University of Minnesota in the USA. Wilfried Scharf of the Institute of Criminology at UCT presented the Opening Address, Chris Giles spoke on The Psychology of Street Children, and NACCW National Chairman Ashley Theron spoke on the Key Role of Child Care Workers.
A number of state departments were officially represented, including the Department of National Health and Population Development, the Departments of Health Services and Welfare of each of the Houses of Parliament, and three of the four Provincial Administrations. The workshop concluded with a frank exchange between delegates and state representatives which reflected a number of positive developments. At the workshop the NACCW was asked to develop its own role as the co-ordinating body for organisations serving street children, specifically by creating portfolios with this responsibility in each of its Regions.

National Executive Committee and NACCW Staff Meet in Cape Town

The full National Executive of the NACCW met on Tuesday 5 July. The meeting was preceeded by a workshop on the goals, current functioning and forward planning of the Association. The Executive Meeting approved the appointment of Tessa O'Grady as PRO/Fund Raiser for NACCW, and the establishment of a Fund Raising Sub-Committee to be based in Johannesburg. The need for a half-time Regional Director for the Western Cape was set as a priority, with the intention that a full-time person be shared between the Region and the national office. The meeting reviewed action taken on the Resolutions of the October 1987 Biennial Conference, and also examined the latest statement on state welfare policy.
During the same week the NACCW's professional staff met several times to consider a number of issues including training courses, the Institute of Child Care, publications and forthcoming conferences.

Visit of Prof Baizerman

A familiar face in a number of child care agencies during July

has been that of Professor Mike Baizerman of the Centre for Child and Youth Development at the University of Minnesota. Prof Baizerman attended the National Workshop on Street Children in Cape Town as a consultant before starting an energetic programme of visits to institutions, projects and state departments where his volatile mind and deep experience of child care has stimulated valuable discussion. Mike's visit has cemented the very helpful relationship which exists between his university and the NACCW.

At the Street Children Workshop: Caroline Thekiso (Twilight), Mrs M.F. van Rooyen (Health Services & Welfare), Mr Eddie Harvey and Ms M Landman (National Health) with Monica Moloantoa (Proscess)

NATAL

Regional Meetings

Heather Brownlee addressed a Regional Meeting of the Association at Lakehaven Children's Home on Friday 22 July. She spoke on Secondary Abuse of Children in Children's Homes. Lee Loynes discussed work with adolescents at a social workers' meeting at Wylie House on 7 July. Lee is engaged on a programme training volunteers and host parents for children's homes under the auspices of The Children's Foundation, and those in the Natal area interested can contact her on 031-82-3368.

Public Meeting on Street Children

About 100 people attended a public meeting in Durban on Thursday 14 July, hosted by the Durban African Child Welfare Society, to discuss the problems of street children in the city. Khayalethu's shelter was burned down recently, and there is strong public reaction to its resiting in another area. Professor Mike Baizerman from the University of Minnesota who visited Khayalethu in Durban under the auspices of the NACCW, emphasised that street children were a worldwide phenomenon which each country had to learn to work with.

EASTERN CAPE

Border Courses

Module 1 of the BQCC begins in East London at a weekend course at Malcomess House from 22-24 July. On the weekend 29-31 July a weekend course for senior and middle management staff will take place at the King Williams Town Children's Home, where the subject will be Counselling Skills. Jacqui Michael, Transvaal Chairman of the NACCW and Director of The Children's Foundation, will teach this course with Regional Director Lesley du Toit.

BKK in Port Elizabeth

Die Basiese Kwalifikasie in Kinderversorging (BKK) begin Woensdag 27 Julie by Oostelike Provinsie-Kinderhuis. Sowat 40 studente word by hierdie geleentheid verwag. Die kursus word deur die NVK in samewerking met die Departement Maatskaplike Werk by die Universiteit van Port Elizabeth aangebied.

TRANSVAAL

Shortage of Social Workers

Over the last nine months, five of the eight children's homes for white English speaking children in the Johannesburg area have experienced a turnover of their social work staff. This is clearly very disruptive for the organisations involved and invariably has serious negative implications for the children. This problem has been compounded by the fact that there is a serious shortage of social workers, and it has become increasingly difficult to find suitable applicants for vacant posts. The development of residential social work as a specialised field of service is severely hampered, as we continually lose the expertise of experienced workers. It is distressing to note that there does not appear to be any indication that this chronic problem will be resolved in the near future.

Basic Qualification in Child Care

Module 2 will commence on the 10th August. This module has two themes: (1) Understanding Child Development; (2) Observation and Evaluation of Children. The lectures will be held at the Transvaal Memorial Institute (TMI) from 09h15 to 12h00.

Institute of Child Care

A course on Techniques of Communication and Counselling is planned for members of the Institute. Details will be circulated in a Regional newsletter.

Workshop on Groupwork

A two-day workshop will be offered in conjunction with the Family and Marriage Society on groupwork with children who have experienced separation and loss. This course is designed to enhance skills in communicating with children in groups, to develop skills in designing groupwork programmes, and to identify and respond to group dynamics. The workshop is aimed at all those involved in rendering groupwork services in the organisation. It will be held on Tuesday 30th August and Wednesday 31st August from 09h00 to 16h30. Lunch will be provided. The cost is R30.00 per delegate. It is necessary to register as the numbers will have to be limited. Telephone 011-728-2044 for registration forms.