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National Association of Child Care Workers Nasionale Vereniging van Kinderversorgers

The National Association of Child Care Workers is an independent, non-racial organisation which provides the professional training and infrastructure to improve standards of care and treatment for children in residential settings.
Die Nasionale Vereniging van Kinderversorgers is 'n onafhanklike, nie-rassige organisasie wat professionele opleiding en infrastruktuur verskaf om versorging en behandeling standaarde vir kinders in residensiële omgewings te verbeter.

Rands, Sense and Child Care

In recent years a number of child care programmes have found themselves in danger of extinction on the book of financial difficulties. Some have responded positively and decisively, and are still in business. Others have been less courageous and adopted a conservative, even miserly, approach. Cuts in grocery and clothing bills, and then in staff provision, the programme offers less and less, loses its impetus and direction while senior staff spend more time worrying about money than about children. A crisis may be averted, though often in impoverished and degutted programmes which offer a stay of financial execution but doubtful professional viability. To save money, one Cape children's home dispensed with its entire middle management staff at a stroke, while a Natal home actually did away with the position of Principal!
It would be easy to say that there *should* not be financial difficulties in a service as important as child care, but the facts must be faced. Money is tight. Public policy is favouring preventitive and community services above individual remedial services. Some state departments are clearly withdrawing from the former policy of financial partnership, and any children's home relying on subsidies which increase at a rate far below that of inflation is by now being strangled. Black subsidies have not increased at all for years and would not cover even the food budget of many other homes.
Making ends meet may have more radical implications than we imagine if we carefully re-examine just what it is we are doing in child care. Some (perhaps contentious) observations may be useful in setting discussion rolling.
Working harder for money: In a recent report on American responses to state funding cuts: "Managerial policy is focused upon ways of being cost-effective *so as to still achieve results and maintain quality*". The difference emphasised here is between cost-cutting and cost-effectiveness: the former is lazy and institution-centred, utterly discouraging to staff, and frankly unworthy of child care; the latter is child-centred, understands and retains a belief in the goals of the programme, and gives hope that someone is at least still trying.
Doing better child care: The days when the private sector simply gives money "for the children" are passing. We are being called upon to justify expenditure in terms of its immediate and long-term impact on families and society, and this means honest evaluation of our programmes and of their outcome. The time is at hand when those who get the money will be those who get the results.
Getting spending priorities right: Children's homes have too serious and urgent a job to waste time and money creating indulgent environments which in any case teach children little about the real world. VCR's and swimming pools are low priorities when compared with good staff and good programmes. We should be spending our money on building trust, relationship skills and competencies in children – and leave the luxury hotel business to Sol Kerzner.
Preparing kids to live in tomorrow's world: Just how justifiable is it to be spending R60 to R80 per month per child on domestic staff? Should we not be teaching them now to manage with what they have when they go home or when they are adults? Some institutionalised children may *prefer* to stay where all their cooking, cleaning, washing and ironing is done for them, and when they do go home they place greater burdens on their families rather than being able to contribute. This could be a case of paying more for a worse product.
Preparing parents to have their children home: Often, when the child care task is completed, the parents cannot afford to have their children back home. Someone else has paid the bills for them for so long. A Durban programme leaves parents with the full responsibility for clothing, school fees, books and pocket money – and thus keeps the children a place in the family budget. A five-day care and treatment programme places children with their parents over weekends.
Developing fund-generating projects: Most children's homes have expertise with children and campuses with useful facilities often empty during school hours and underused after school. Some have started morning programmes for pre-school children or parents, or rented halls and rooms to outside groups, thereby meeting expenses of the residential work. Others have diversified professional programmes whereby resources are offered on a fee-paying basis to parents and children in the community: day care, parent groups.
None of us is exempt from pulling our weight. The state can never be allowed to renege on its responsibility to subsidise child care creatively and fairly; but it cannot be expected to foot the whole bill. Management committees cannot simply wind down programmes without first attempting to raise what is needed for their organisation; but they are only part of the team. Staff members cannot simply blame others without studying both professional and economic alternatives which could save money and keep programmes going; but they cannot make bricks without straw and need to have the tools to do their job.

COVER PICTURE: February BQCC graduates in the Border Region

School Refusal
SYMPTOMATOLOGY AND MANAGEMENT

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Definition
A child may suddenly refuse to go to school without apparent reason. He complains of aches and pains, and may cry, perspire, become pale and show signs of panic. He may want to go to school, but cannot because of acute anxiety. This condition is called school refusal or school phobia.
The terms school refusal and school phobia will be used synonymously here to refer to absence from school stemming from severe discomfort in the child when he is forced to attend. The source of the discomfort may be:
- separation from the parents or caretakers;
- separation from the home;
- being in the school;
- a combination or none of these.

It should be noted that school refusal is a disorder of social functioning and not a mental illness, although it may be a symptom of one.

School Refusal versus Truancy
The main category from which school refusal must be distinguished is truancy. The essential criteria characterising school refusers are the following:
- onset is generally sudden, with no previous history of poor attendance;
- absence from school is consistent;
- child is absent from school for long periods – several weeks, months or even a year;
- the parents/care workers know where the child is – with them or near home;
- previous school work and conduct is fair;
- the reason for refusal is incomprehensible to the parents/care workers and school authorities;
- at home the child is happy, but when forced to school becomes miserable and fearful, and at the first opportunity runs home;
- school refusers are more sensitive and introverted than truants, more socially conforming, and more dependent and socially immature.

Truants on the other hand are characterised by the following:
- academic performance is below their intellectual capacities due to lack of motivation;
- change school frequently;
- are absent from school intermittently without parental knowledge;
- are likely to have conduct disorders such as lying or stealing;
- they do not show the degree of anxiety about school that school refusers do;
- home discipline is inconsistent;
- come from families (or environments) lacking in concern about school attendance.

Manifestation/Symptomatology
What is the course and symptomatology of school refusal? The problem may begin with vague complaints about school or reluctance to attend or to remain in school in spite of persuasion, recrimination, and punishment by parents/guardians and pressure from teachers, family doctors and educational welfare officers. This behaviour may be accompanied by visible signs of anxiety or even panic in the morning when s/he has to go to school. Those who set out for school return home when halfway there, while some already at school rush home in a state of anxiety. In older children and adolescents there is a gradual withdrawal from peer group activities which were formerly enjoyed.
Manifestation may assume a somatic guise: loss of appetite, nausea, vomiting, headache, abdominal pain, diarrhea, pains in the limbs, dizziness, fever. These complaints occur in the morning before school or at school without any identifiable (overt) fear about school. At times the symptoms are only anticipated – the child avoids school in case he should vomit or faint at assembly. Many children insist that they want to go to school but cannot manage it when the time comes. Sometimes the child protests with tears or temper tantrums leading to destructive or aggressive behaviour. Usually, once the pressure to attend school has been removed, the symptoms accompanying the school avoidance dissipate.
Kennedy (Blagg 1987), distinguished between two types of school phobia, namely *Type 1* and *Type 2*, each with its own distinct set of ten symptoms. Classification can be made on the basis of any seven of the ten being present.

Type 1 Symptoms
- The present illness is the first episode
- Monday onset, following an unrelated physical illness the previous Thursday or Friday
- An acute onset
- Most prevalent in the lower standards
- Expressed concern about death
- Mother's physical health in question: actually ill or child thinks so
- Good communication between parents
- Parents well-adjusted in most areas
- Father co-operates with mother in household management
- Parents achieve understanding of dynamics without difficulty

Type 2 Symptoms
- Second, third or fourth episode
- Monday onset following minor illness not a prevalent antecedent
- Incipient onset
- Most prevalent in the upper standards
- Death theme not present
- Mother's health not an issue
- Poor communication between parents
- Mother shows a neurotic behaviour; father, a character disorder
- Father shows little interest in household or children
- Parents very difficult to work with

Aetiology (Causal Factors)
School phobics are not simply refusing to attend school, and neither are they naughty children. These children do have real difficulties which require sympathetic understanding for their resolution. This understanding comes from detailed enquiries into the circumstances surrounding their non-attendance at school. The major causal factors are listed below:
- fear of teacher, of other pupils or school work with expectation of failure – leaving or avoiding school itself becomes reinforced by the resultant reduction of fear;
- fear of separation from mother (separation anxiety). This may be exacerbated by statements such as: "Be careful not to hurt yourself on the jungle gym"; "Take care not to get lost"; "Be a good boy when mommy is not around to help you", by an overconcerned mother;
- mothers who are self-doubting and ambivalent about their children; the dependency of the child is resented and at

the same time fostered;
- children who overvalue themselves and their achievements and try to maintain an unrealistic self-image which if threatened in school leads to anxiety and consequently avoidance of school;
- one of the parents may have a history of real or imagined illness and the child has learned to take on the role of caretaker for the parent;
- irrational fear that the parents will be hurt or die if the child leaves them;
- parents or significant adults in the child's environment may view school negatively and sympathise with complaints about school or complaints about bad feelings, communicating the message that they wish the child to remain at home;
- in a large classroom the quiet, timid child may be less likely to receive the teacher's attention – this lack of attention could erode the child's desire to attend school;
- precipitating factors could include the following: minor accident; illness or operation; move to a new house; change of class or school; departure or loss of school friend; death/illness of significant relative;
- family factors; maternal anxiety; marital disharmony and parental inconsistency are significant factors;
- parents could have experienced anxiety or school refusal as children themselves.

Management and Treatment

What can the care worker do to help the child who refuses to attend school? It is obvious that management and treatment will depend on severity as well as aetiology. The care worker should be sensitive to the early signs such as odd days off school and frequent visits to the resident or school nurse complaining of minor aches and pains. A little extra help and sensitive handling at this stage can avert a full-blown school phobia. The great majority of potential or mild school refusers are successfully handled by parents or their primary caretakers using gentle but firm insistence on attendance. With regard to treatment, two points are emphasised:
- try to get the child back to school as soon as possible using any method that is less severe than physical coercion;
- treatment should be initiated immediately after the onset of symptoms as this is much more effective than treatment that is delayed for weeks or months. Early referral and successful treatment help the child from falling behind in schoolwork and from missing positive social experience in school. It is for these reasons that educational psychologists consider school phobia an emergency referral, and treatment is initiated promptly.

From the foregoing, it seems evident that the care worker should identify cases of school refusal at their earliest manifestation. Medical problems should then be eliminated before investigating other factors as soon as possible with the minimum of fuss. Unless this happens, health-related anxieties will linger on making treatment difficult. The care worker should take the child for a medical check-up, out of school hours, before referral to a school clinic. If the doctor feels there is an organic (physical) basis for the child's symptoms, clarify how long the child should be off school. If the child is physically fit but still refusing school, arrange an urgent appointment with the school clinic in your area.

The care worker should then identify any precipitating factors. In this regard it is useful to gain a picture of the child's relationships at school. If the child is unpopular and constantly teased this would provide a realistic basis for school avoidance. In this case isolate the exact form of the bullying or teasing and the possible reasons for it. Sometimes major relationship problems cannot be overcome and change of school should be considered. This decision should be taken very carefully in the light of the wide range of adjustments that are involved in such a change. The child may have to become accustomed to new rules and routines, different academic demands and expectations, unfamiliar teaching styles and approaches as well as forming new friendships. These factors in themselves can precipitate school refusal.

Where school difficulties exist, the care worker should make contact with the child's teacher and school principal. Poor communication between teachers and care workers can exacerbate the problem by leaving misconceptions and misunderstandings unchallenged. For example, the child's absence from school may result in the disappearance of previously experienced anxiety symptoms and protests. This may in turn reinforce the view of the care worker/parent that the school is at fault leading to collusion with the child about the school refusal.

It would also be important to obtain the child's perspective on the non-attendance. In this regard the following may serve as a guide:
- does the child see non-attendance as a problem?
- does the child have interests and are these being catered for either in school or at home?
- ask the child to tell you what his problems are;
- find out what the child finds rewarding at home and in school, e.g. attention, TV, privileges;
- find out what the child is punished for – what does s/he feel they should be punished for?
- what forms of punishment are used at home or school?
- what aspects of school life does the child (a) enjoy, (b) dislike, and why?
- who are the child's favourite teachers?
- how many friends does the child have? – in school/outside? What activities are they involved in?
- what does the child do when he's not attending school?

The child's answers to these questions could assist the care worker and/or teachers in maximising the incentives for being in school (friendships, games, interested teachers), and minimising incentives for remaining at home during the school day by removing positive reinforcements (not allowing child to watch TV, not giving child extra attention).

The more longstanding cases with additional problems (bed wetting, sleeping/eating problems) often require more sophisticated treatment procedures. These cases should be referred to the school clinic in your area for intensive treatment as soon as possible.

Bibliography

Blagg, N. *School Phobia and Its Treatment*. Croom Helm, London, 1987.
Gabel, S. *Behavioural Problems in Childhood*. Grune and Stratton, Inc., New York, 1981.
O'Hara, M. and Jewell, T. *Non Attendance at School: A Behaviourist Approach in Oldham*. AEP, 5 (8), 1982, 28-37.
Rutter, M. and Hersov, L. *Child and Adolescent Psychiatry*. Blackwell Scientific Publication, London, 1987.

Opsluiting: Eerste en Tweede Indrukke

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Toe ek in 1974 my loopbaan in kinderversorging begin het, is ek aan die gebruik van opsluiting blootgestel. Die plek wat hiervoor gebruik was, was 'n ou kamertjie in ons personeelkamer. Dit het 'n gesluite houtdeur gehad wat na buite toe oopgemaak het. Hierdie kamer is "normaalweg" gebruik om meisies en seuns wat onaanvaarbaar en aggressief opgetree het te hanteer. As gevolg van my eie naïwiteit, opdragte van die prinsipaal, en die voorbeeld van kollegas, het ek spoedig geleer om self hierdie metode te gebruik. Ek het dit gebruik ten spyte van die feit dat dit soms 'n verskriklike magstryd tot gevolg gehad het en dikwels vir my 'n onmenslike manier van krisis ingryping was. Daar was altyd 'n bakleiery met die woedende, skreeuende kind wat met sy rug teen die deur alles uitgehaal het om te verhoed dat die deur gesluit word. Die kamer was vensterloos en sonder enige lig. Aan die duskant was die personeel vasbeslote om die deur te sluit sodat verbale kommunikasie en onderhandeling kon begin. Hierdie kamertjie was etlike male per dag so gebruik, veral saans en gedurende naweke.

By my huidige werkplek waar ek in 1975 begin het bestaan daar geen opsluiting prosedure nie. Die afwesigheid daarvan was eers vir my vreemd en ek het 'n gevoel van onsekerheid ondervind aangesien ek begin twyfel het aan dit wat ek voorheen geleer het. Nou, wanneer ek terugkyk, besef ek dat die gebruik van opsluiting 'n valse sin van sekuriteit skep. Met tyd, opleiding en die blootstelling aan ander behandeling metodes, wat omsien na kinders se behoeftes, het my ou vrese en onsekerheid afgeneem, en het ek tot nuwe insigte gekom. Ek besef nou dat dit my verantwoordelikheid is om hierdie situasies te hanteer met 'n bereidheid om die gevolge, wat dit ookal mag wees, te dra.
As groentjie in my nuwe pos was ek natuurlik ten gunste van 'n opsluitkamer. Ek kon nie verstaan waarom my idee so streng afgekeur is nie. Die supervisors was selfs trots op die feit dat hulle so 'n tegniek kon vermy. "Hierdie plek het nooit, en sal nooit, 'n opsluitkamer gebruik nie." Ek het hulle sienswyse aanvanklik as hardkoppig beskou aangesien ek geleer het dat opsluiting doeltreffend en progressief was.

Gedurende die volgende ses jaar, deur verdere opleiding, het my mening verander. Ek het meer terapeutiese alternatiewe aangeleer, bv. positiewe beheer tegnieke, krisis ingryping, en veral vroeër reaksie teenoor aanvangs gedragsprobleme. Ek het tot die insig gekom dat ons in die eerste kinderhuis opsluiting misbruik en hopeloos te veel gebruik het, dit as 'n strafmaatreël eerder as versorging gebruik het, en dat dit slegs 'n korttermyn gevoel van sekuriteit gebied het. Ek weet nou dat mens nooit kunsies (bv. opsluiting) as 'n plaasvervanger vir persoonlike betrokkenheid kan gebruik nie. Opsluiting kan veroorsaak dat die kind die kinderversorger bv. met 'n tronkbewaarder vereenselwig. In so 'n konteks ervaar beide die kind en die kinderversorger vrees. Niemand hou daarvan om bang te voel nie. "Hoe moet ek my eie fisiese krag aanwend?" en "Tot watter mate sal my sielkundige kennis my deurhelp?" is maar twee van menige vrae wat in sulke tye by kinderversorgers opkom. Die kind vra daarenteen: "Wat gaan Jane aan my doen? Waarom word ek in hierdie kamer opgesluit? Wat gaan met my gebeur?" (Miller, 1982).

Hierdie soort innerlike verwarring kom voor wanneer die kind nie duidelikheid het oor die gesag van volwassenes en kwessies rondom outoriteit nie. Die eintlike rede vir die opsluiting verdwyn namate die een probleem vervang word deur 'n ander probleem (Redl, 1982). In so 'n patroon wat opbou en vererger, bevind kinderversorgers hulle in 'n krisis situasie wat boonop deur die kind se angs oor isolasie vererger word. Alhoewel dit waar is dat ander inwoners, personeel en eiendom veilig is terwyl 'n kind opgesluit is, bly daardie kind buite beheer en angstig, alleen in 'n geslote kamer, kwesbaar vir sy eie fisiese en emosionele toestand. Karl Latona, in sy toespraak tydens 'n Nasionale Kinderversorger Konferensie in Chicago, 1981, het beweer: "Statistiek dui veral op twee omstandighede waaronder selfmoord in kinderinstansies voorkom: (1) Die gebruik van afsondering in gedragsbeheer; (2) Waar kinders in volwasse tronke saam met volwassenes opgesluit word." Hy sê verder: "Jy moet in staat wees om die kind te beteuel, om hom by te staan, om met hom te praat, om saam met hom te huil, om alles wat nodig is te doen, maar moet hom asseblief nie alleen in 'n kamer toesluit om sy eie probleme sonder enigiemand te verwerk nie."

Lesers het al baie die "oorlogstories" van kinderversorgers gehoor "waar alles in duie stort" wanneer hulle afsondering probeer gebruik met die opvatting dat dit wondere kan verrig. Wanneer die plan misluk, veroorsaak opsluitkamers ernstige vyandigheid, wrok en wantroue — nie slegs in die kind nie. In die inrigting word opsluiting die uiterste demonstrasie van volwasse outoriteit — 'n ongemaklike denke. Namate my ervaring toegeneem het, het ek besef dat opsluiting nooit die plek van beraad kan inneem nie, en dat dit dikwels slegs as noodmaatreël deur personeel aangegryp word. Ongelukkig gebeur dit ook dat kinders sulke ervarings so negatief vertolk dat dit kan lei tot 'n breuk in die verhouding tussen hulle en die personeel. Alternatiewe strek tot voordeel ook van kinderversorgers. 'n Spanbenadering versterk verhoudings. Indien moontlik moet twee werkers een kind in 'n krisis bystaan, terwyl 'n derde werker die res van die groep ondersteun. So 'n metode dui op gesonde wedersydse ondersteuning. Kinderversorgers kan hulle aan die welsyn van kinders toewy sonder die toediening van straf. Dit dra by tot selfvertroue en professionele effektiwiteit deur die gebruikmaking van positiewe en konstruktiewe maatreëls, en skenk ook die geleentheid vir rolmodellering.

Die afwesigheid van toesluitkamers skep 'n gemaklike atmosfeer waarin kinders en kinderversorgers mekaar kan vertrou. Albei weet dat die program van opvoeding effektief is omdat dit 'n veilige plek bied waar gedragsprobleme sonder vrees, mishandeling of verwerping hanteer kan word. Op grond van dié twee uiteenlopende indrukke stel ek voor dat in die *afwesigheid* van isolasie-kamers, kinders en kinderversorgers meer geredelik vaste en terapeutiese verhoudings kan bou. Hierdie band is gebaseer op wederkerige vertroue. Ek is daarvan