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The child care worker

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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.

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GUEST EDITORIAL

Child care workers or auxilliary social workers?

The registration of child care workers is an issue the NACCW needs to address. For some years the Council for Social and Auxilliary Workers has toyed with the proposal of registering child care workers as auxilliary workers under its auspices, and although the idea was earlier dropped from that Council's agenda, it has once again come up for consideration. It would seem that some of the questions to be considered include –

- Do child care workers want to be regarded as practitioners in their own field or as auxilliary workers in another field, namely social work?
- Does child care really have its own national umbrella body in the NACCW and the Institute of Child Care?
- Is it feasible to consider registration when the majority of child care workers are untrained or only partly trained?

From its inception the NACCW envisaged a national and independent organisation which generates qualitative practice standards for the profession. The Association's mission statement: "The NACCW 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". Two of the Aims and Objects in the NACCW's Constitution are:

1. To work towards professional standards for child care workers in respect of their knowledge and skill, their status, their material circumstances and conditions of service;
5. To maintain a register of child care workers and to establish a professional Institute of Child Care as an authority on standards and practice.

As a growing profession, child care work has struggled to develop its own identity and to emerge from the shadow of the social work profession. We have made considerable progress. The child care worker sees himself as having a unique set of skills within his own practice setting as distinct from that of social work. It is known that child care workers prefer to be supervised by senior child care workers than by social workers. Yet as auxilliary workers they would have to be supervised by social workers. Moreover, a social worker may not supervise more than two auxilliary workers, so most children's homes could not comply with the present requirements of the Council.

Child care work will never develop its own identity and will never grow to maturity in this country if it must see itself as an auxiliary to social work. On the other hand, in recent years we have seen child care achieve several of the distinguishing marks of a profession: clearer task definition and professional boundaries, the development of a code of ethics, its own knowledge base and literature, certification of workers who complete child care coursework, and clearer career pathways whereby senior positions are increasingly held by child care workers. Having come this far, do child care workers really want to roll over and play dead for social workers?

When it comes to the availability of a suitable organisation for the registration of child care workers, there have been realistic questions as to whether the NACCW is truly a national body or whether it represents only limited sections of the population. The answer lies in the fact that while so many organisations in South Africa have been divided along sectional lines, the NACCW remains the only association of its kind. Those who are not members are only those who have chosen not to be members. The Association is and always has been completely non-racial. In 1990 its courses will be offered in the following languages: Afrikaans (6 centres), English (4 centres), Xhosa (2 centres) and Zulu (1 centre).

It is agreed that there are problems when it comes to registering child care workers who are neither experienced nor qualified, alas, a very large proportion of those presently in practice. On what basis does one register them? Workers who have completed a two-year course and two years in service, may join the Institute of Child Care, and this seems an appropriate body to register them at this point as child care workers. Perhaps we need to be more careful in our use of the term 'child care worker' and reserve it for those so qualified and experienced – and refer to child care interns or child care trainees for those still undergoing training. Whatever is decided, child care workers should themselves be clear as to whether they want to promote their own profession – or make it subservient to another. – *MB*

The National Executive Committee and Staff of the NACCW, together with the Editorial Board of The Child Care Worker, wish all Readers a peaceful Christmas and a happy and fulfilling New Year

Childhood Depression

A contribution by a second-year student in the National Certificate in Residential Child Care at the Cape Technikon

Everybody is at risk to depressive moods, but here I will be concentrating on depression that persists or is recurrent and interferes with the child's usual life.

Definition and Clinical Presentation
Depression is described in a medical dictionary as a lowering or decrease of functional activity with a morbid sadness, dejection or melancholy. Depression is common to all mankind. It is recognised by a feeling of sadness with worthlessness and a conviction that nothing one can do matters. Depending on the circumstances, depression may be quite natural, for example, when a loved one dies. This is known as a depressed mood, but the person is not clinically depressed. There comes a point when a response to loss and stress becomes inappropriate and this a type of mental illness.
When a child shows no sign of being comforted or of resuming his normal life within a week after feeling low, or within six months after undergoing a severe loss, he is at risk of developing a depressive disorder. If the child does not partake in usual activities, perform his work adequately or play as much as usual a week after the depressed mood began, he is at risk of experiencing more serious consequences. Other indicators are a sudden change in eating and sleeping patterns. Appetite either increases or decreases when a depressive disorder starts. The child's sleep pattern may change; he may fail to fall asleep at the usual time, or wake up during the night and have trouble falling asleep again. He may wake up in the morning very early. However, a depressed child may sleep a lot, but constantly feel tired.
Some depressed children have suicidal thoughts. As they get more depressed, they may plan or even attempt suicide. 50% of depressed children will talk about thoughts of hurting themselves, if asked. Children do not show their depression as easily as adults. Children become depressed in a quiet way and by the time they exhibit signs of depression, they are usually severely depressed.
Childhood depression has become recognised as a separate disorder for only about fifteen years, but several psychologists have described depressive states in infants and young toddlers over the past 70 years. Spitz was interested in child development when he came across 123 young children in the 1940s being raised in a South American nursery. He found that some of them tended to withdraw socially, lose weight, have trouble sleeping and become ill. Spitz called this behaviour anaclitic (leaning upon) depression. It could last up to three months, after which some assumed a rigid, frozen posture. Spitz found that all the children who developed these symptoms had been separated from their mothers between the 6th and 8th month for a period of at least three months. They had no mother or mother-substitute to lean on, hence the term 'anaclitic'. When separation ended in less than six months, Spitz found that the children suddenly became "friendly, gay and approachable, and the withdrawal, disinterest, rejection of the outside world and the sadness disappeared as if by magic." Those children whose mothers did not return became in the worst cases stuporous, agitated or retarded. Most could not be brought back to normal. Some even died as a result of their condition.
John Bowlby studied the relationship between mother and child in the 1950s. He found that the child is dependent on the mother not only for food, clothing, warmth, cleanliness, etc., but also for love, tenderness, empathy and closeness. This is called bonding. When the mother goes for a short while, the baby may cry and try to find her. When separated for a long time Bowlby found the baby's reaction could be separated into three stages: First there is *protest* which can last from a few hours to a few weeks. Then comes a stage of *despair* in which the child loses all hope and looks depressed, withdrawn and apathetic. The third stage is *detachment* in which the child seems to have accepted the help of nurses and mother substitutes. When the child has lost his mother and substitutes, he loses trust in all human beings and is indifferent to human contact. In the 1960s Margaret Mahler, one of the foremost child psychoanalysts, agreed with Bowlby that a child's depressed mood can be caused chiefly by separation.

Classification and factors associated with depression in children
One of the first people to classify childhood depression was Weinberg who drew up a set of criteria in the early 1970s. These criteria were that the child show both an unhappy mood and sense of self-depreciation and two or more of the following symptoms: aggressive behaviour, sleep disturbance, lessened desire to socialise, change in attitude towards school and change in school performance, physical complaints, loss of energy and unusual change in appetite or weight or both. The symptoms had to be different from usual behaviour and be present for at least a month. With this scheme Weinberg studied 72 children aged 6 to 12 years at a diagnostic centre who were having trouble in school. 42 of these children met the criteria for depression.
Ten years ago childhood depression was divided among three main types in school-aged children: acute, chronic and masked. The acute and chronic have similar features: impairment of child's scholastic and social adjustment, disturbance of sleeping and eating, feelings of despair, helplessness and hopelessness, retardation of movement and occasional suicidal thoughts or attempts. Children with chronic depression, in contrast with acute depression, have no immediate precipitating cause, the condition lasts longer, there is a history of previous depressive times and depressive illness in relatives, particualy the mother. In children with masked depression, the illness is associated with acting-out behaviour, for example, stealing, setting fires, drug abuse and running away.

Different manifestations of depression:
Depression manifests itself at several different levels. The first is *unconscious*, so called because the child is not aware of the real meaning of his thoughts or what motivates his behaviour. His distress may come out in a dream. Projective tests such as the Thematic Apperception Test (pictures on cards) may reveal depressive

themes. Depression also manifests itself in *verbal* expression. When asked, the child will describe his depressed feelings. Again, *mood and behaviour* can indicate depression. One can see by watching the child that something is wrong, for example, crying, slowness of movement and emotion reaction, delinquency, enuresis and physical complaints. When depression lifts, the signs of mood and behaviour disappear first, then improvement is seen verbally, and lastly preconsciously, which is at the deepest level.

Defences against depression: Depressive feelings are emotionally painful, therefore children often seek to avoid experiencing and expressing them. The most effective defence is sublimation: the child handles depressive feelings by diverting them into channels of which he and other people approve. Another defence is denial: the child refuses to acknowledge thoughts or feelings that are too painful. Again, there is projection, when the depressed child cannot accept something in himself and he attributes it to others. The child might feel he doesn't like someone, but it is easier to think the other person doesn't like him. The child may act out: he suppresses his depression by cheating, stealing, etc. Reaction formation is often used: the child talks or behaves opposite to what he feels.

Maturation: The infant is not always able to contain or get rid of depressive feelings. Since he has no words, he is unable to talk about these feelings or find solutions to those situations causing his depression. The infant is unable to develop a depression as in adulthood, as he is not psychologically equipped to do so, but he may develop a primitive depressive state characterised by a sad expression, withdrawal, failure to interact or even refusal of food. However, the infant's progress to maturation helps to counteract the depression. Depression in infants is usually short-lived, except where the child is in an institution. From the age of 5 or 6 one can diagnose specific depressive disorder. Their increased intellectual development allows them to assess the past and future. Language development allows the child to describe his feelings. With adolescence the depression is expressed more openly in word, mood and behaviour.
The DSM III lists three kinds of depression in children:
1. Major depressive disorder, single episode (acute).
2. Major depressive disorder, recurrent (chronic).
3. Dysthymic disorder (once known as neurotic).

Indications of depression as listed in DSM III include unhappiness, sadness, hopelessness, loss of appetite, disturbance of sleep, slowness of movement, loss of pleasure, low self-esteem, decreased concentration, aggressive behaviour and suicidal thoughts or actions. These may not all be present in one child. A depressed child also shows disturbance in school behaviour. Other signs are guilt, loss of interest in life, physical illness, anxiety, loneliness, restlessness, sulkiness, loss of energy, irritability and feelings of helplessness. Suicide and attempts are rare before the age of 15, but about half of depressed children have had suicidal thoughts and all suicidal talk and gestures should be taken seriously. After the age of 15 children do commit suicide frequently. There are two warnings of suicidal behaviour: one is depression and alcohol and drug abuse, and the other is suicidal talk.

With adolescence the depression is expressed more openly in words, mood and behaviour

Etiology: Causative factors
There are many sources of stress in childhood which may set off a depressive illness. There are two main groups of causes of depression: environmental and biological factors.

The family and other social causes: Family distress is frequently present in depressed children. The parents' problems and unhappiness may rub off on the child, that is, they follow their parents into their depression. Such a child's sadness may be seen as anti-social and being withdrawn. They are encouraged to mingle with other children which makes them feel worse. Some children unfortunately may be misdiagnosed as mildly retarded because of poor grades. In the same way, depressed children may be seen by some as normal and exceptionally well-adjusted (because they cause no trouble), or as anti-social or mildly retarded. Depressed families keep their members in an abnormally tight bond that creates unusual closeness and dependency. In other cases, children may be excluded from the family. There is a lack of communication between excluded members and the rest of family which causes problems. The other type is when the child is accepted only if he or she lives up to standards set by the family. Each failure is met with open expression of disappointment and disapproval. The child then feels guilty and inadequate. The lowering of self-esteem is followed by a long period of depression.

Separation from loved persons or places: Frequent separations for several months or more from important people or places may cause depression. This occurs usually during the first few years of life. This type of loss is associated with chronic or recurrent depression.

Loss of a strong attachment: This occurs when a central figure in the child's life suddenly withdraws his interest although still being present, for example, through illness, tragedy or new involvement with people as with a new baby. It is associated with chronic or recurrent depression. The child feels excluded, his self-esteem is lowered, and he experiences a feeling of loss.

Depreciation and rejection: Many depressed children have been rejected by parents or loved ones from birth onwards, or over a period of many years. They may feel unworthy or inadequate. The child may be criticised and humiliated or the parents' love of their child is never expressed. Depreciation may be shown through over-protection as well as rejection conveying the message of inadequacy and worthlessness.

Depressive disorders in parents: The most common cause in episodic or chronic depresion is depression in a parent. Some parents show clinical evidence of depression, or some may have been treated for depression. In others it is in a subtle form which didn't require treatment. Parental depression is sometimes inherited by the child or may affect the child because he identifies with the parent, or because the parent is less involved with the child he feels alone and rejected.

Sudden loss: Single episodes of depression are usually caused by sudden and permanent loss of a loved person, by death, divorce or a move away from a familiar environment.

Physical stressors: This may be a physical disability of the child or parent. These patients include mostly those enduring hospitalisation, immobilisation, pain or disfigurement. Children with disabilities such as kidney disease, severe allergies and heart diseases often show depressive