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Cover Picture: *Ashley Theron entertaining in a children's home in Slovenia (Back page)*

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Two days of straight talking thaws much ice in the NACCW

On page 6 there is a full report on the NACCW's first Executive Forum which took place at the beginning of June. The *content* of those two days of meetings is there to be read, but the *spirit* of the discussions was probably of far greater significance to the Association.

Historical baggage
Over the past four or five years there has been much debate in the NACCW on what kind of organisation it is — or should be, and on what it does about children in the South African context — or should be doing.
There have been obvious conflicts between different conceptions of NACCW as being either a workers' union or a professional association, as concerned for children's rights and safety only in residential care or over a wider national horizon, as having a political or non-political orientation.
There were other creaks in the NACCW's structures which might have been more expected. For a relatively small association spread across the length and breadth of South Africa, there have been issues of effective member participation in forward planning and decision-making. A ruling from the state's Director of Fund Raising that all funds should be banked and administered centrally left some of the Regions feeling deprived and disempowered. The NACCW, in any case, serves a profession which has numerically replaced itself every three years, leaving us with a dangerously reduced sense of history and continuity in our membership.

Positive strokes
There was much to be learned from the Durban Forum. Many of those who attended remarked that, for the first time, they had really gained a full picture of what *and who* the NACCW was.
Delegates were asked to evaluate the Forum, and 100% of the evaluations were positive.
Some comments: "It was a pleasure to see that people could sit and do what we've achieved in one-and-a-half days in such an orderly manner"; "Now we really can go back and tell others what the NACCW is about"; "What stood out was how democratic our Association is — as a democrat I am very impressed by the way the conference was conducted — NACCW should be represented in the new cabinet!"; "Sharing of information was a learning experience — we welcome the openness of the NACCW to listen and guide"; "The intergroup discussions were dynamic — we are sure this will strengthen NACCW identification"; "Misconceptions about the head office of NACCW have been cleared up"; "I saw how the different regions share common problems, and now we feel empowered to go home and sort out our problems"; "The regions are now close rather than distant; I felt a sense of warmth"; "Dynamic, exciting, encouraging — very useful to get the full national perspective at all levels — very productive to have full national office input"; I think most of my expectations have been met."
There were two good suggestions for improvement. One, that such Forums should take place annually; the other, that we should try to accommodate all delegates in one centre to allow for more social interaction.

Lessons learned
Reading between the lines, there were two stronger messages.
The first, it is wrong for any of us, members, staff or elected leadership, to refer to the NACCW as if it is something separate from ourselves. When we feel like saying "The NACCW should ... " we must recognise the message as being "*We* should ... ", for ***we all are the NACCW.***
The second, the NACCW will ignore the necessity for improved communications at its peril. This means not only maintaining better consultation in decision-making, and better relaying of ideas and decisions both up and down the line between regions and national levels, but also more face-to-face contact at all levels between NACCW people. Not only because suspicion is a natural by-product of separation and non-contact. But also because, as one Cape Town delegate wrote on his evaluation, "You are a great bunch of people!"

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The Therapeutic Crisis Intervention (TCI) programme developed at Cornell University provides a model for dealing with potentially violent children and youth. The programme provides staff with the skills, knowledge and confidence to manage a child in crisis in order to bring about short term relief and long-term growth. The direct care worker is helped to attain helpful control and to maintain the dignity of both adult and child during the most difficult crisis experience.

Therapeutic Crisis Intervention

Martha Holden and Jane Levine Powers
Family Life Development Centre, Cornell University

Tony, age 14, is struggling to complete his maths assignment. He starts to complain that he cannot do the work — he does not want to do the work. He then pushes his book across the table, knocks a box of pencils on the floor, and announces that he is not going to finish the work. Carlos simultaneously starts yelling at a staff member about a punishment he received for not finishing his work. Carlos is clenching his hands and breathing faster. He begins calling the adult names; and then he approaches, waves his fist, and threatens to show just how serious he is about not taking any more "crap" from anyone.

Teresa, age 15, and Elaine, age 16, are arguing. They are becoming louder and louder. A staff member hears Elaine accusing Teresa, "You stole my blouse." Teresa responds, "What blouse, what are you talking about?" Elaine yells, "You know what I'm talking about, don't try to get out of it." As the staff member approaches to talk to them, Elaine jumps up and threatens to hit Teresa unless she returns the blouse.

Bud, 16 years old, is a very quiet and withdrawn youngster. Since he arrived a few weeks ago, staff have tried to develop a relationship with Bud by spending extra time with him and involving him in activities. They have concerns about his behaviour with the younger boys. Earlier this morning, Bud was discovered trying to take a shower with Tommy, age 12. Bud then went to his room and doesn't speak to anyone. A staff member goes to check on Bud and finds him sitting on the floor in the corner of his room, scraping his wrist with the sharp end of a paper clip.

Front-line staff in education and treatment settings face these types of incidents daily and have to make split-second decisions about how to intervene. If handled within the context of a therapeutic crisis management model, these incidents become opportunities for the child to learn constructive ways to channel feelings and behaviours. If such incidents are ignored or merely "managed," the result can be injury or a deterioration in the child's ability to cope with stressful situations. Staff must feel confident in their ability to handle crises and must have many options available for intervening.

In this article, we examine the Therapeutic Crisis Intervention programme developed by the New York Department of Social Services and Cornell University. This programme is designed to help direct-line staff deal more effectively with challenging behaviour of youth. Following is a brief description of the modules in that training programme.

Stress Model of Crisis

During a crisis, a child is more susceptible to the influence of significant others.

When a crisis erupts and a child loses control, he or she has not handled the situation well. The result is usually undesirable — destroyed property or harm to the child or to others around him. At this point, a therapeutic response by a caring adult takes on great significance.

The adult's role in the TCI model is to help the child learn more constructive ways to deal with feelings of frustration, failure, anger, and pain. Staff must help a child toresolve the inner or interpersonal conflict being experienced at the time of the crisis.

Adults also must use their therapeutic skills and knowledge to move the child to a higher level of functioning, using the crisis situation as a developmental experience for the youngster.

In order to be a catalyst for growth during a crisis, staff must acquire certain skills and attitudes. These include a knowledge of the dynamics of crisis, and competencies in communication, building relationships, and solving problems. If necessary, they must be able to intervene physically in a safe and therapeutic way. Staff must respond to the needs of the child and the environment without losing their own self-control. This is a challenging task, as a child may be emotionally and physically assaultive.

The Therapeutic Crisis Intervention model:

1. Helps adults to conceptualise the stages of crisis which a youngster goes through,
2. Explains the importance of staff's action and reaction, and
3. Provides guidance in choosing the type of intervention at each phase.

Each of these stages or phases is summarised below.

Preventing the Crisis

The *Triggering Phase* is signalled by the first abnormal behaviour or change in behaviour. An event — internal or external — upsets a youngster, which causes him or her to be agitated and anxious. Depending on the child, the resultant behaviour can be an increase or decrease in agitated behaviour or withdrawal.

For Tony, the trigger is homework. The resultant behaviour is the complaining. Elaine becomes upset when she discovers her blouse missing (the trigger) and yells accusingly at Teresa (the resultant behaviour).

Bud has been discovered in the shower with Tommy, which has resulted in his withdrawal and self-destructive behaviour. The "shower event" has triggered an emotional response which results in withdrawal and self-mutilation.

At this point, staff must recognise that the child's behaviour has meaning. The staff must help the child identify the meaning beneath the behaviour. Together, the child and staff look for alternative, non-aggressive ways for the child to express his feelings and to meet his needs.

BLOWING MY TOP
drawn by a ten-year-old boy at Rose School for emotionally disturbed children, Washington DC

Awareness is crucial when intervening in a potential crisis situation. Self-awareness helps staff to understand how their values and beliefs influence their interactions with children. By being in touch with their own feelings and reactions, adults can stay in charge of the situation and plan interventions that meet the needs of the child, instead of getting caught up in control issues. Understanding a child's history together with

the dynamics of the present behaviour helps staff to respond in the most effective, therapeutic manner. Instead of placing "band-aids" on the situation, the adult can guide the child toward lasting resolutions. However, without self-control and self-confidence, staff often become entangled in power struggles, which only escalate the situation.

Intervening Early

The second phase, or *Escalation Phase*, is characterised by increased anxiety and obvious signs of disruptive behaviour. The child is showing signs of beginning to lose control, such as talking louder or withdrawing.

Tony pushes his book across the table and refuses to continue. Carlos, also in the escalation phase, yells, clenches his fists, and breathes faster. Elaine yells and threatens to hit Teresa. Bud scrapes his wrists and stares into space, expressionless. All of these young people are experiencing increased anxiety.

They are feeling frightened and out of control, and they perceive that something important to them is being threatened. This results in increased stress.

Staff can approach these children in many ways. Some interventions may only increase the stress the child is feeling, resulting in further escalation. If the adult were to confront Tony with a list of threatened consequences for refusing to do homework, this might intensify his feelings of frustration. If Elaine were told to stop yelling and go to her room, she might turn her anger toward the staff member. If the worker enters Bud's room announcing the rules about taking showers, Bud may shut down completely.

The relationship between the staff and child is critical in helping the child calm down. Trust is the key to this phase. With trusted staff offering alternative behaviours, children can often choose other ways to "let off steam" or calm down. The objective is to interrupt the escalating behaviour and help the child to return to an emotional level where he is able to think and talk rationally. The "problem" cannot be solved until the child is calm enough to face it rationally.

There are various ways to "interfere" during the triggering and escalation phases to help the child return to normal functioning. Behaviour-management techniques, non-verbal and verbal communication skills, and problem-solving interventions can stop escalating behaviour, help the child regain control, and teach better ways to handle stressful situations. With practice, staff can learn to intervene early by prompting, redirecting, directing, and listening, helping the child to talk out his anxieties — rather than act them out.

These techniques not only teach new ways of coping with stressful situations but also enhance the relationship between the adult and the child.

The worker stands between the two young ladies, sends Teresa out of the room to look for the blouse, and invites Elaine to sit down and talk about the problem. Teresa hesitates for a moment and then leaves. Elaine follows the staff member to the sofa and continues to complain loudly about Teresa stealing her blouse. The adult responds by agreeing that Elaine has every right to be upset about a missing blouse. Elaine sits down as the adult relates how she, too, hates it when people take things and do not return them. Elaine eventually talks about how she feels betrayed by Teresa.

The staff member enters Bud's room and quietly expresses concern about Bud's well-being and his worry about the self-mutilation. The adult acknowledges that Bud is upset about the morning's incident. He invites Bud to share his version of the incident and to look at what he is doing to himself. They both remain silent for a while and then Bud speaks about how crazy he feels and how he might be better off dead.

The staff member tells Tony to take a break from his schoolwork which he can finish after dinner. He further instructs Tony to join the rest of the group outside, but to tell the second staff member on duty to come inside.

Then, turning to Carlos, the staff member asks him to have a seat and tell him what is wrong. However, Carlos

Many youth in care have come from abusive homes, where violence is a learned response to feeling threatened. The child loses control and strikes out in a way that is dangerous or potentially dangerous.

continues pacing; and his voice keeps getting louder as he yells about being picked on and getting stupid punishments.

Managing Aggression

Sometimes, regardless of staff skills, attempts to de-escalate the crisis do not work.

The *Crisis Phase* occurs when the child loses the ability to respond rationally. Many youth in care have come from abusive homes, where violence is a learned response to feeling threatened. The child loses control and strikes out in a way that is dangerous or potentially dangerous. At this point, the staff member has to take control of the situation in order to protect the child and others who may be at risk. This must be accomplished without allowing the out-of-control child to be injured or to feel abused.

Children who have been abused previously are likely to misinterpret the adult's intervention as "abusive," and some even attempt to provoke abuse from the adult.

Direct-care staff find themselves in a position of danger, having to stay composed and therapeutic while a child may be intent on hurting someone. Children need human contact, control, and support in a crisis as much as, or even more than, when they are functioning well.

By intervening physically, the staff may prevent injury but open themselves to allegations of abuse. By not intervening, staff are equally responsible for standing back and allowing a child to injure himself or someone else.

Physically restraining a child is the last, but often necessary, intervention.

Staff must be skilled and practised in safe, secure, passive holds when intervening with a violent and aggressive child. When handled in a safe and therapeutic manner, a child learns that adults can help to limit out-of-control behaviour without losing control themselves and without resorting to punishment or retaliation for the child's actions.

The immediate purpose of restraint is to provide the minimum necessary external control to ensure the safety of people. Restraint should take place in the context of an ongoing relationship with the child. Therapeutic physical restraint involves controlling the child safely and with the best interests of the child in mind, while also providing caring, support, and control.

Carlos is now verbally threatening the lone staff member, approaching in a menacing way. The back-up staff has not yet arrived when Carlos throws a chair and lunges. The staff member intervenes quickly to protect himself, initiating a single-person restraint while waiting for assistance. The second adult arrives and helps secure Carlos' legs. Neither adult speaks a word.

Learning from the Experience

In the final phase, the *Recovery Phase*, there is a reduction in tension and anxiety. This is the period when the child's defenses are lowered, and he or