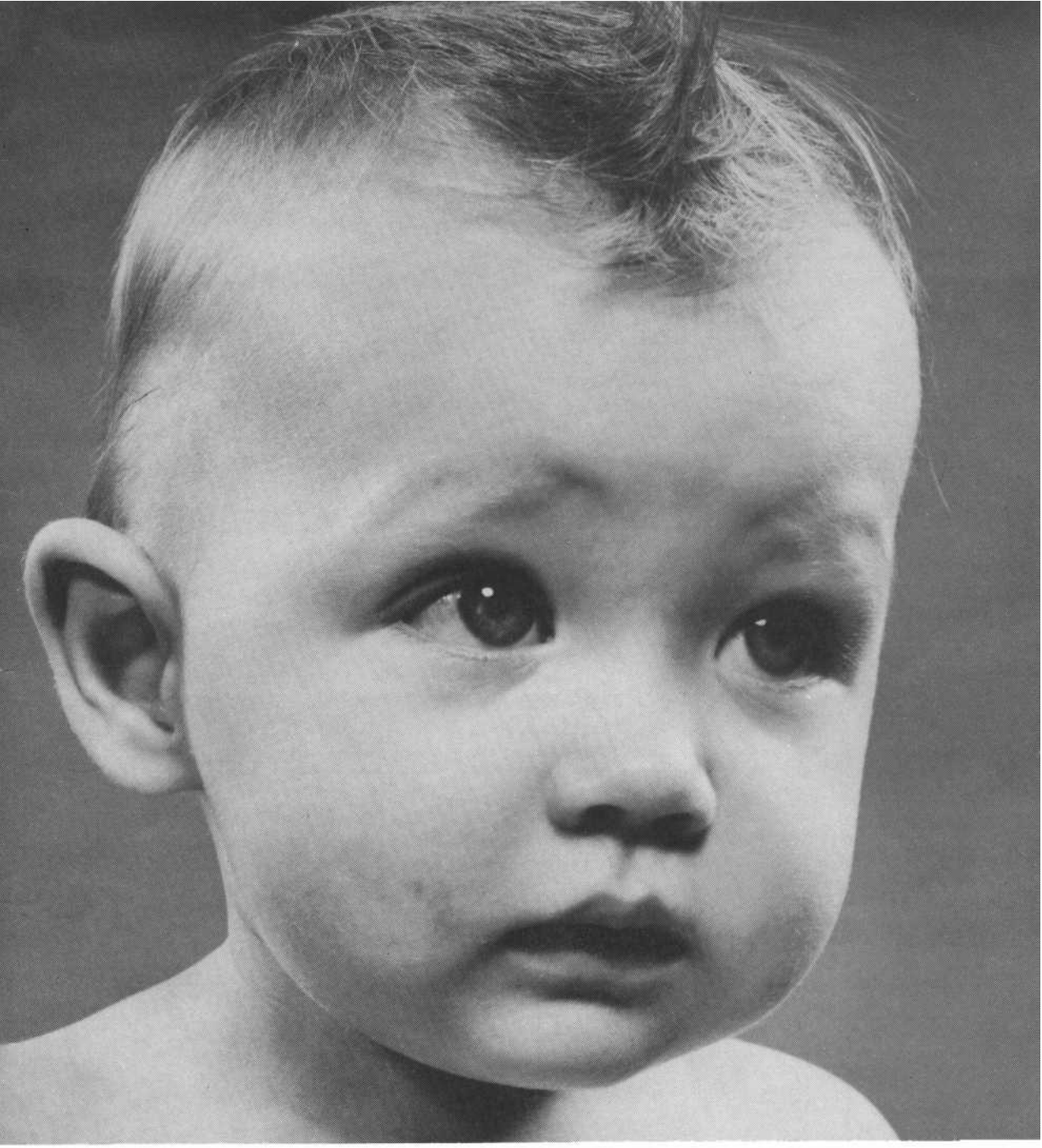

The Journal of the

CSPCC

Canadian Society for the Prevention of Cruelty to Children

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The Journal of the Canadian Society for the Prevention of Cruelty to Children

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THE NEXT REVOLUTION: PRIMARY PREVENTION OF PSYCHOPATHOLOGY

"Primary prevention, aimed at reducing emotional distress and psychopathology, borrows some of its strategies from the broad field of public health. It has long been accepted public health ideology that the massive problems afflicting human-kind are never brought under control or eliminated through one-to-one intervention. While individual treatment may be defensible from a humanitarian point of view, it is not an effective strategy for the elimination of widespread disturbances. Most of the victories and triumphs of public health, which have resulted in the conquest of many diseases have resulted from (1) eliminating the noxious agent or (2) strengthening the host. Smallpox, typhoid fever, cholera, and polio have been eliminated largely through one or the other of these public health strategies....

While the public health model is useful in approaching the prevention of mental disorders and emotional distress, there is a crucial difference that must be considered. There is not the same kind of one-to-one cause-and-effect relationship to be discovered for most of the so-called mental illnesses. While research evidence exists to establish a connection between stress and subsequent mental disturbance, the relationship is not specific as in the field of genuine disease. The fact is that any of several stresses may produce any of several disturbances in people. Acute stress resulting from the death of a spouse or child, the loss of one's job, the termination of a close friendship or personal relationship may produce depression in one person, addiction to alcohol in another, withdrawal in another, neurotic symptoms in another, and no apparent disturbance in another. The search for a specific cause for alcoholism or for suicide is doomed to failure for this reason.

Opponents of efforts at primary prevention have seized on these non-specific relationships as grounds for their favorite argument: "We do not know enough yet about the causes of each mental illness to do anything significant about prevention." This invalid argument relies heavily on the traditional illness model that holds that emotional disturbances are genuine sicknesses, and that all such conditions have a specific cause.

The health industry has long resisted efforts at prevention. Our whole health delivery system emphasizes high technology medicine that focuses on treatments that are highly profitable for hospitals, physicians, and the drug industry. Of the billions of dollars spent on cancer research, less than 1 per cent has been spent on efforts at prevention. Although it is generally acknowledged that most forms of cancer are due to environmental pollution and life styles, cigarette smoking, diet, industrial pollutants, etc. — research is still aimed at discovering a "cure" for cancer while 20 million Americans go without any health care, and another 50 million are seriously under-served. Medicine and surgery continue to prefer dramatic heart transplants, coronary bypass operations and research for curative drugs while preventive efforts are neglected. In the field of mental and emotional conditions the Mental health Establishment has continued to emphasize one to one treatment, emphasizing drugs and other physical methods of treatment...."

George W. Albee, Ph.D.
University of Vermont, Burlington, Vt.

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THE CSPCC

WHAT IT IS — HOW TO JOIN

— HOW TO GET THE JOURNAL REGULARLY

The Canadian Society for the Prevention of Cruelty to Children is an independent, non-governmental, non-profit, federally incorporated organization which is supported financially by Membership Fees and Donations from individual Canadians who share the concerns of the Society.

The purpose of the CSPCC is to mobilize public support for programs and policies which have some hope of preventing the permanent damage which can result from emotional abuse and neglect of very young children. Better preparation for parenthood, better support services for families with young children, and obstetrical practices which facilitate bonding are but a few examples of such preventive measures.

Increasing the number of members in the Society, and publication of the Journal are at present the principal means by which the CSPCC is working to unite those who share a concern for the importance of the Society's objectives.

Membership in the Society is ten dollars per year, twenty-five dollars for three years. Cheques or money orders should be made out to "CSPCC" and mailed to CSPCC, Box 700, Midland, Ontario. L4R 4P4. Membership Fees and Donations are income tax deductable.

The CSPCC Journal, published four times a year: February, May, August, and November, is mailed without charge to CSPCC members.

On receipt of your annual (or three year) Membership Fee, an Associate Membership Certificate, Official Receipt for tax purposes, and the first of four (or twelve) issues of the Journal will be sent to you.

CSPCC National Office: 298 First Street, Midland, Ontario. (705) 526-5647.

Letters

Dear Dr. Barker:

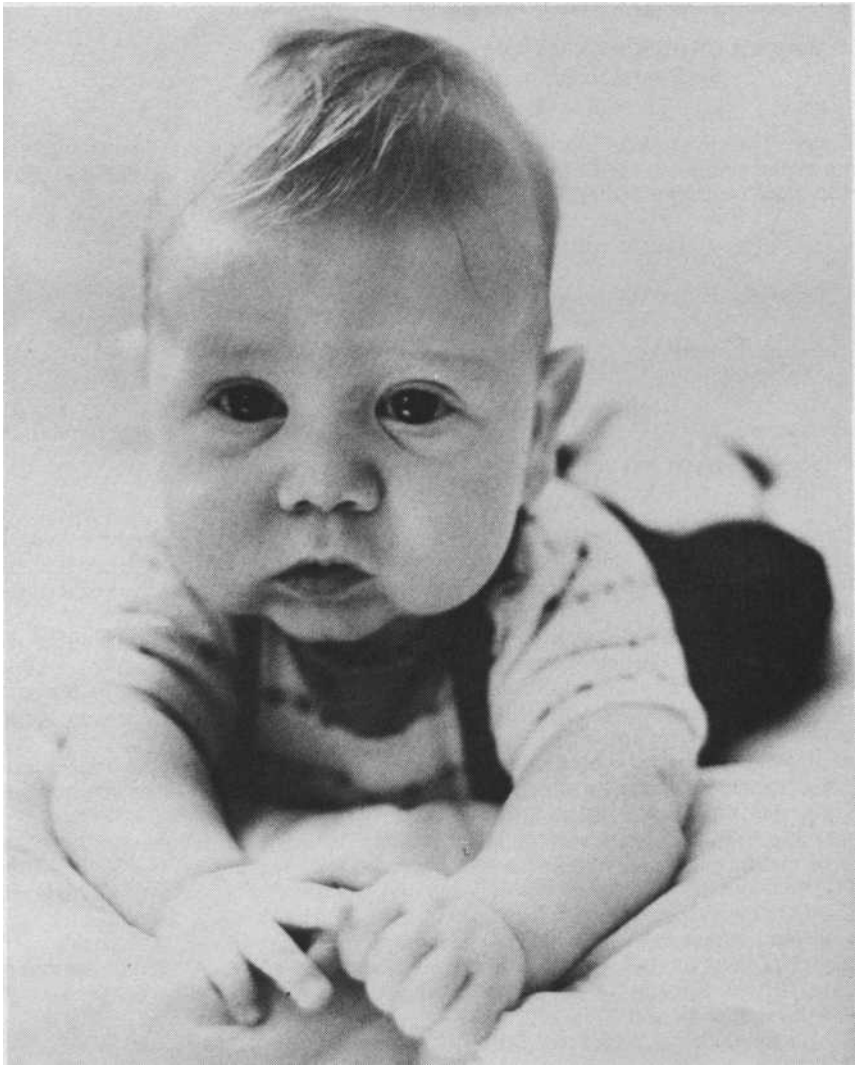
If I had given far more of my love and devotion - if I had been far more responsive to my son's special needs - if I had given my wife the support and encouragement she desperately needed (and didn't get) in dealing with the education and medical people - if I had been far more aware of all my family's needs, one of my beloved sons would not be a patient in a mental hospital this very moment....

The Professional and the family must share together in teaching the next generation how to become a better parent both from the male and female point of view.

We are going around in circles in dealing with our brand new parents. My wife and I, while only a grade eight type, if my role expectations of a father for his sons were in better perspective our whole family might have been more tolerant of each other, one to another.

I do not have all the answers for everything; I do not even have some of the answers for some of the things. Each of us should speak up as best we can, in our own way maybe down the road a bit more we will all meet together as one world, one family...

Sincerely,
Don Tickle
Collingwood, Ontario.



Letters

"If I had given far more of my love and devotion"."". one of my beloved sons would not be a patient in a mental hospital this very moment""

"Sure our parents' experience with us helps mold much of what our character will later be like, but it is our choice to be a certain way, to do a specific thing". We are the masters of our destiny"."

Letters

Dr. Barker,

I really don't feel it necessary to tell you the circumstances of my situation as I know you're aware of my situation. But, for the sake of those who don't, I'm incarcerated in a maximum security institution against my will until there are reasonable grounds to see me safe enough to re-enter society. I have committed several very serious crimes against society and man to warrant my incarceration. Throughout most of my life I've rebelled against society in one way or another, inflicting pain on myself and others for selfish reasons by my distorted perception of how things really were.

But this isn't what I really wanted to write about. What I really wish to write to you about is children and their relationships with their parents. I had an experience not too long ago that taught me a valuable lesson that I wish to share with you.

I had sent my mother a couple of copies of the Society's Journal to read as I felt they might broaden her perception to the urgency of this topic. Well, she wrote back a couple of weeks later saying how bad she felt about not bringing us children up properly and she felt like a failure as a mother. This hurt me very much as she was a very good mother. She had done her best to bring us children up on her own. With my father leaving us at a very young age she had a tough job. We lived on mother's allowance and welfare for quite a few years. My mother went without for so many years just to make sure us children ate and had clothes on our backs. We wore others hand-me-downs, on a few occasions Mom had to go to the butcher shop to get free scrap bones to make soup so us children could eat. For a while three of us had to sleep in one bed as there just was not enough room. Yes my mother had a tough time bringing us children up, we were poor.

Throughout my younger years I never felt a love or acceptance from my mother. I usually felt I was being blamed for everything. I wanted so badly for her to love me. Someone to love me anyways. Any woman that would ever be nice to me I wanted her to be my mother as I felt my real mother didn't care.

As I grew older I tried to recreate that love I never felt from my mother in my relationships with other women and when I could not achieve that dream I'd become hateful and strike back in hate. I blamed my parents for all my misfortunes in life. It was their fault as they had brought me up that way.

For many years I blamed my-mother for my misfortunes and I made her feel it whenever I could. Well, I've finally grown up and look where I am. Was she the cause of this? No. How could she, she was a hundred and forty miles away in bed sleeping.

Forgive me for getting carried away, but I just wanted to make a point here, and that is, children must take a lot of the responsibility for the way they turn out. The road I took was the road of my own chosing. That was a hard reality for me to own up to but its true.

It hurts me in some ways to hear young people say their parents don't understand them etc., etc.. Maybe they don't understand the parent. There is always two sides of a coin and that must be remembered. Myself, I distorted much of what I experienced, then blew it all out of proportion in my mind as much of my experience was one sided, my side. I never asked, so all I had was my imagination to answer me.

Sure, our parents' experience with us helps mold much of what our character will later be like but it is our choice to be a certain way, to do a specific thing. We are the masters of our destiny.

I am not in any way trying to negate the fundamental ideas of the CSPCC as I feel them all to be true. What I am saying is child abuse lays a framework for a person that could very well end in violence against others or himself ,' herself. But we the individuals make the final decision as to the direction of their lives.

Beling locked up like this in an institution for an indefinite period of time is a sad way to come to this realization. I wish others don't have to go the route I have to come to that realization.

Sincerely,
Robert Morrison.

VOLUNTARY CHILDLESSNESS IN MARRIED WOMEN

The following article consists of excerpts from a paper entitled "Psychological Correlates of Voluntary Childlessness in Married Women" presented at the Conference of the Eastern Psychological Association, Washington, D.C. by Dr. Judith Teicholz.

Dr. Teicholz received her doctorate in Counselling Psychology from Boston University, and is a clinical instructor in Psychology and Psychiatry at Harvard Medical School, Massachusetts General Hospital. She is married and has a six-month-old son. We are grateful to Dr. Teicholz for forwarding her paper to us so that we might print portions of it in the Journal.

"... women who choose to remain childless are variously assumed to be selfish, irresponsible, immature, abnormal, neurotic and even unnatural!"

This report is about women who have made a voluntary decision never to have children. Despite demographic findings (Brown, 1976) that birth rates have declined in recent years, it should be noted that these decreasing fertility rates do not reflect an increase in the numbers of couples who choose to remain permanently childless. Rather, the reduced birth rates seem to reflect later marriages, postponement of first births, and the choice for fewer children per family. Similarly, the recent popularization of the "child-free" choice in the media (Rivers, 1975; Whelan, 1975) and the work of such groups as Zero Population Growth and the Association for Non-parents, may have succeeded in making the choice against parenthood a less troubled one for those who do choose it; but again, the statistics do not yet seem to indicate that there has been any increase in the percentage of married couples who ultimately choose to remain permanently childless. At least, up until two years ago, this percentage had remained fairly constant in the United States and Canada throughout the twentieth century, at about 5 per cent. (This 5 per cent approximation is based on the work of sociologist Veevers at the University of Western Ontario, 1972, 1973a, 1973b, 1973c, 1973d, 1974; and the work of Pohlman, 1970, done at the University of the Pacific - the 5 per cent estimate required the development of an elaborate formula for interpreting census data). It must be kept in mind, then, that the focus of this study is a very small minority of married women, a minority who have chosen to deviate from the time-honored, near-universal norm of motherhood, a norm that has always had the full support of all the major religious and socio-political institutions in all societies across time and place.

So it should surprise no one that such a minority is not held in high regard by the general, lay public: and in fact, attitude surveys carried out at various points in time, from the early 1900's to the mid 1970's, have suggested that women who choose to remain childless are variously assumed to be selfish, irresponsible, immature, abnormal, neurotic, and even unnatural! (Popenoe, 1936; Rabin, 1965; Rainwater, 1965; Veevers, 1973a). One purpose of this study thus became an attempt to determine to what extent these popular attitudes represented popular wisdom, and to what extent they represented nothing more than popular prejudice.

Although, very recently, a few studies have been reported which involved empirical observation of voluntarily childless couples (Gustavus and Henley, 1971; Malmquist, 1971; Silka and Kiesler, 1976; Kaltrieder and Margolis, 1977), many of the professional judgements concerning voluntary childlessness, to date, have been based on generalizations which were made from astute observations of individuals in psychotherapy (Ovesey and Person, 1956; Nagera, 1975; Flarsheim, 1975), or on logical extrapolations from theory (Horney, 1973; Abraham, 1974; Deutsch, 1974), but not grounded in empirical observations of voluntarily childless women outside of a clinical setting.

Both the attitude surveys and the professional literature, furthermore, seem to suggest that parenthood is judged to be a more critical ingredient in the psychological health and social adjustment of women than of men. In many cases, in fact, motherhood is accepted as the very definition of womanhood, or as the absolute equivalence of femininity. On the basis of the literature on childlessness, as well as of the literature on normal female development, then, a group of

" . . . parenthood is judged to be a more critical ingredient in the psychological health and social adjustment of women than men."

hypotheses were formulated about how a group of women who chose to remain childless might be expected to differ from a group of women who expressed the normal desires and plans to have children.

The general expectation seems to be that women who voluntarily forego motherhood will be less well socialized - that is that they will be less likely to have internalized the general values of their society, since they have not internalized the specific value of motherhood; further the expectation is that they will be more anxious and more neurotic than other women; and that they will be less feminine in their identification than most other women as well. The specific hypotheses that were developed for evaluation in this study were grouped in three clusters, then, pertaining to (1) the level of socialization, (2) the degree of anxiety and neurotic adjustment, and (3) the extent of feminine sex role identity.

The study was limited to an ex post facto design, comparing two "groups" of women, self-selected for membership in one of the two comparison groups on the basis of their own previously made decisions, either to have, or not to have, children. There was, of course, no possibility of obtaining a random sample of voluntarily childless women since it was known that they made up only about 5 per cent of all married women. An attempt was made simply to find a statistically appropriate number of women who would be eligible to participate in the Non-mothers group, and then to find a comparison group of women planning to have children that would match them in age, education, marital status, and socio-economic background.

"The results of this study do not lend credence to the negative judgements of women who have chosen not to have children."

The women in both comparison groups had to be married and to feel that their marriage was a stable one. This was to assure that all subjects in both groups would have the usual social sanctions for having children if they so chose, and to minimize the possibility that any differential results between the two comparison groups that might emerge from the findings might be attributable to relationship difficulties, or problems with intimacy, or attributable to unusual attitudes toward marriage rather than attributable just to the choice for or against parenthood. The women in both comparison groups also were to be limited to the age range from approximately 25 to 35. Under the age of 25, it was felt women could not be expected to have made what would prove to be a permanent decision about childbirth; and much over 35, any differential findings between the comparison groups might begin to be attributable to the after effects of having made a deviant life choice, rather than a personality difference originally associated with the choice.

Further criteria for membership in the Non-mother's group were that they had to have made a fully voluntary decision, and a decision that they felt was permanent. There had to be no known biological factors that would have prevented the couple from becoming biological parents if they had so chosen; and there had to be no known genetic factors that would make it inadvisable for either member of the couple to become a biological parent. The comparison group, which I will call the Future-mothers, had to have clear and definite plans for having their first child. This meant that they were acceptable as members of the Future-mothers group only if they planned to have their first child within two years of participation in the study. Most women in this group had just recently discontinued the use of birth control or had plans to discontinue within about six months of the study. The purpose of this criterion was to minimize the possibility that there would be vascillators concerning motherhood in this Future-mothers group. Women who were already pregnant or who already had one child or

"We must conclude from these findings that . . . the decision to remain childless is not necessarily associated with social maladjustment or immmaturity , nor with neurotic adjustment, nor witls poor feminine identification."

more were also excluded from the study, in order to exclude the confounding effects of pregnancy or actual motherhood.

Contrary to expectation, it was discovered that there were no significant differences between the two comparison groups on any of the measures pertaining to socialization nor on the measures of neurotic adjustment; and that there were also no significant differences between the two groups on measures of either conscious or unconscious feminine identity.

The results of this study do not lend credence to the negative judgements of women who have chosen not to have children. On the contrary, the profile of the 38 voluntarily childless women who made up our target sample was of a highly educated and achievement-oriented group of women who have been very successful in their chosen fields of work; who tend to place a high value on the quality of their marital relationships and to be satisfied with their marriages; who score higher than the national norms on tests of Social Maturity, Flexibility, and Achievement through Independence; and whose anxiety level is no greater than that of a similar group of women who do plan to have children. The voluntarily childless women in this study were also no less identified with female values and interests than the women in the comparison group. And on a test of unconscious sexual identity, the scores of the Non-mothers were as "feminine" as those of the comparison group, and of the national norms.

We must conclude from these findings that, **ex post facto,** the decision to remain childless is not necessarily associated with social maladjustment or immaturity, nor with neurotic adjustment, nor with poor feminine identification, as these traits were measured in this study. In order to avoid generalizing from our highly selective samples, we can conclude more specifically that at this point in history, in the greater Boston area, and in the upper socio-economic and educational group largely represented in our sample, the choice to remain childless appears to be associated with positive social adjustment and mental health, and with appropriate sexual identity in married women between the ages of 23 and 38, and that the choice against motherhood does not appear to distinguish these women from other women of similar age and background on the traits measured.

"... the choice to remain childless appears to be associated with positive social adjustment and mental health,and with appropriate sexual identity. . . "

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A MOTHER'S WORKING DAY

A photostory **by Ellen Tolmie**

This article was originally published in the Canadian Magazine as a cover story, The Bittersweet Days of Motherhood. Written as a description of an average working day for one mother and published for Mother's Day, it excited quite a response from readers. Judging from the letters-to-the-editor column a few weeks later, general feeling ran four-to-one against. One woman described it as "I could have been reading from my own diary", but "depressing", "bitter", "self-centred, resentful lament" and complaints that the mother was never smiling in the photographs characterized the other four - all the letters came from mothers.

A chord had been touched. First of all, the woman the story portrays is happily married, always wanted to have children, loves her own two deeply and is generally thought of as a sensitive and attentive mother. But loving your children, taking care of them every day and wanting to do so, does not mean that there aren't a lot of problems and stresses to the job. There are still a lot of people around, including many mothers, who feel guilty if the removal of false sentimentality from a description of motherhood reveals love and stress, surely a more deeply human combination of feeling.

Researching this story I discovered that the most general and persistent problem in a mother's work in Canada today (not to speak of the more specific problems of poverty, unwanted pregnancies, emotionally unstable parents, or the redefinition of sexual roles between men and women) is their social isolation. This has two aspects: the physical isolation of being confined to the house most of the day away from other adults, and the emotional isolation of having a job that few recognize as such and no one wants to hear about.

If a mother speaks negatively of some part of her work it is immediately implied that she doesn't love her children though other people's complaints about their work are assumed to be reasonable. One hears again and again what a precious, important, special and skillful role mothering is, but a serious discussion of the day-to-day pressures and experiences of full-time mothering is shunned.

A woman contemplating having a child today must consider leaving the world of other adults for a time, because child-care takes place in the home. Although nearly half of all Canadian married women were working outside the home by 1976, this depended directly on the ages and number of their children. Most women are married and most married women have had at least one child so when we speak of mothers we are talking about a majority of Canadian women over fifteen years of age. Although inflation and feminist issues are pushing more and more women out the door of their homes, unemployment and inadequate social child-care are pushing a lot of them back in.

If we care so much about children and their welfare, both emotional and physical, it is ludicrous to side-step a look at the real world of their dominant and most influential caretakers, the mother. Mothers are always assumed to be there but they are rarely asked how they feel. They are people too, with needs of their own. They need adult conversation, they need to talk about their work, but they also need to participate in other worlds. They need to be re-integrated into adult society along with, but also apart from their children.

Lynn Bebenek, the mother in this story, lives with her husband Michael in Kitchener, Ontario. They have two children, Jake, two and Anna, one. This is a record of her work day when Michael is away, also at work. It starts at 7:30 a.m. when her children wake and ends some twelve hours later when they return to bed for the night.

Reprinted with permission from the **Canadian Magazine**. Ellen Tolmie is a Photographer and Journalist working in Toronto. We are grateful for her permission to include this article in the Journal.

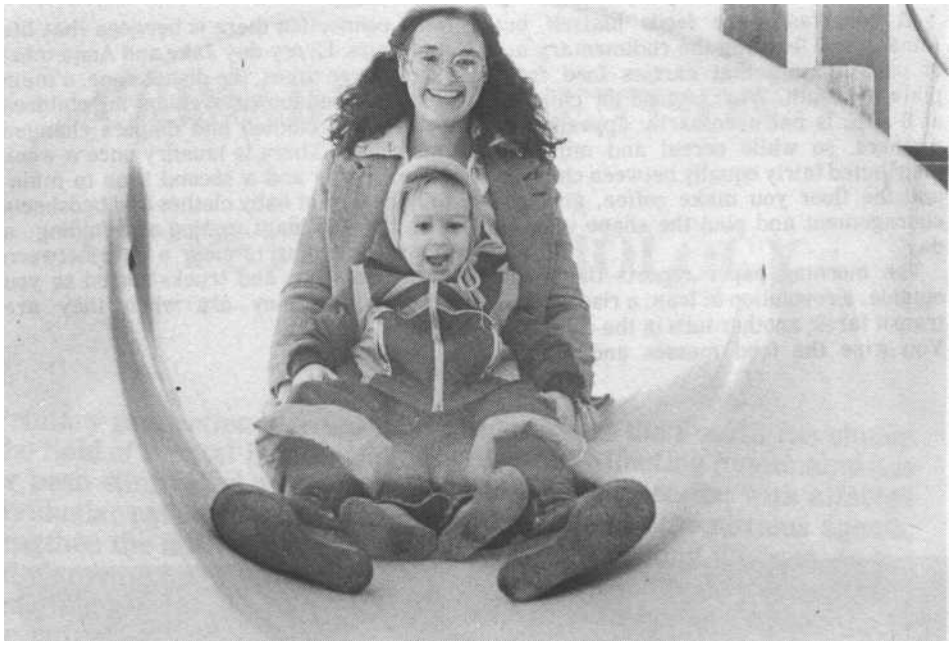
The light is barely seeping through the curtains when Michael leaves for work. Waking is a moment of quietness before the tension begins which is the immediate expression of the bond between mother and child. There is resentment attached to the tension, the frustration of knowing that in the day ahead it will be hard to get back to this silence to collect your thoughts.

Jake runs to the door to Anna's room where she is awake too. Babies wake suddenly, their liquid eyes clear and focussed and they are ready to meet their day. You listen while she climbs out of the crib, loses balance and rolls on the carpet, then they are both in the room, chattering to each other, to you, to the strong shafts of light now streaming in.

At breakfast Jake feeds himself but Anna is still learning the rudimentary act of co-ordination that carries food from plate to mouth. What is good for children at 8 a.m. is not necessarily appealing to mothers, so while cereal and milk are distributed fairly equally between children and the floor you make coffee, give encouragement and plan the shape of your day.

The morning paper reports the world outside: a revolution in Iran, a rise in local transit fares, another turn in the oil crisis. You wipe the food messes and wonder what connection there is between that life and yours. Every day Jake and Anna must be fed three times, the dishes done, a main meal planned for the evening, the children bathed and clothed and diapers changed and rinsed. There is laundry once a week for everyone and a second time to maintain the flow of baby clothes and bedsheets with the attendant ironing and folding; a general cleaning to clear a path between toys, and shoes and trucks sorted so you know where they are when they are needed.

Jake takes off with Anna's toy and her crying suggests that her world just collapsed. You comfort her with both tenderness and a sense of histrionics that she almost acknowledges. The dramas in a child's life are accompanied by your own internal monologue that feeds the intuition of response. Libraries of books on child psychology are enough for any mother to feel the need for introspection but that requires solitude and quiet so you play it by ear. If you respect a child's needs they will often return the favour by steering clear when you've had enough.



Outside in the park Jake is fearless on the slides but panics when the ducks advance squawking and nipping the breadcrumbs from his hands. They have an impudence that is an affront to his own. Anna is content inside the ignorance of babyhood where threats do not come from creatures her own size. And your frustrations fade into the late morning.

After lunch the house is vacuumed, the bathroom cleaned and the pattern of handprints wiped from walls and glass and

furniture so you can gaze in glazed satisfaction before leaving it to the realm of fantasy. Then you all dress again to go to the supermarket where you buy fourteen quarts of milk and whatever other protein you can afford while losing Jake between the aisles and leaving Anna with the cashier while you follow a voice crying "mom" somewhere near that old man's knee.

When everything is away in the kitchen and the frenzy fades you stare into space or into a little preoccupied face, half-amused, half-bored to death. At three they go to bed for a few hours and this is your favourite time of day. The mind goes dark, emptying of the automatic organization of caring for children. There is some guilt, enjoying so much the time alone, so you listen for the rhythmic breathing of their sleep. You could prepare dinner or do some sewing or water the plants but instead you settle into a book that takes you away.

A few hours later a door creaks and Jake appears softened by sleep, his entrance tentative and shy again. You realize how much you've missed him. There are two sides to the mother, child bond: the tension of responsibility where you continually watch so they don't harm themselves and then the growing interdependence, the result of more than a year being constantly together. Although sometimes longing for the independence of being childless, you also know that the world would now be less interesting without them.

In the evening the children speed up, trying to fit another day's activity into their awareness of limited time. You become an acrobat, balanced between dinner plates and their abandon to play. When Michael comes home your anticipation has infected them and they explode in his direction, so you watch father and children together. After dinner, after clearing the toys again, when they are in their nightclothes and the lights go out, you will be together. He will talk about his day, you will talk about yours, the light will fade and tomorrow you will do it all again. ■

HOW MUMMY AND DADDY AND FREDDIE AND DEBBIE STOPPED LIVING AND LOVED THE TUBE

By Bill Casselman

Once upon a time in the land of the google-box, a mother told a school psychologist the story of her children and television. The father was too busy to visit the school that day.

See we always had a TV. When we got married, Jack brought his old black and white set from home. I didn't go back to work until Freddie was six and Debbie was five. That's all alone for five years with two small kids. After Freddie gave up his nap—he was about two—I tried to get him interested in Sesame Street. Heard it was good for youngsters. I'd flick it on and Freddie would look for a while, then go right back to his toys. Sometimes I would sit down with him and try to get him caught up in it: "Look at Big Bird. And there's Cookie Monster." Still he didn't care much. But if he had his bottle while watching, then he would stay longer in front of the set. I borrowed a picture book about Sesame Street and that got him involved. It took about four months and soon he watched every day. After, Mister Rogers used to come on. Freddie learned to like that. So I had an hour or so to get supper ready.

I did try to have a quiet time after he gave up naps. You know, in his room alone. But it didn't work. TV was more effective keeping him quiet. But it really helped in toilet training. I'd put the potty in front of the set, and if he went potty he got to watch cartoons — and if he made mistakes too often, I would warn that he couldn't watch this or that. Worked for Debbie too. She seemed to like TV from the start.

When he finally began afternoon kindergarten that was a big load off. But I did notice Freddie wouldn't always go out after school and ride his bike with playmates down the block. Even if it was a sunny day. He would come home and turn on Batman or those stupid Flintstones, any show where characters clobber each other. By that time Mister Rogers was too tame. When he was five, both kids got hooked on watching in the morning before school. First they would wake up and stare at Captain Kangaroo, gel dressed watching Bugs Bunny, gobble breakfast during Fangface, see half of Godzilla, then off to school.

When Jack and I encouraged Freddie to join Cub Scouts, I was really upset. He went to about three meetings then quit. Would not go back, screaming fits, the whole production number. I didn't realize it at the time but, well, we let him quit and he didn't like Cubs because it meant he missed Superman and The Partridge Family. Bedtime was always yelling and crying 'cause they would both want to stay up and see The Waltons. One year, a local station ran Batman and those old Lone Ranger things between six and seven. That was a nightmare. Jack would come home and want the news at six. The kids screamed for Batman. And I wanted to serve supper then. At first I would pry them away from that damn boob tube, get everybody at the kitchen table, and we would eat if you could call it that — fast, gulping, grumpy meals. Jack bitching, the kids throwing a tantrum. See, just before we sat down, Jack would switch channels to the news, turn the volume up real loud. He would yell if the kids were so loud he couldn't hear the news. It went on for months. But I solved it. Brought some plastic TV trays and we all ate in front of the set. During the days I started to watch a lot of TV myself. I was kind of used to it, you know.

Now I look back on it, we never seemed to talk very much as a family. Kids never told us much about school. What little chat there was concerned television you know — "D'y'see when the Hulk creamed that guy ! " Sometimes I miss the fun my family had when I was growing up. We used to do things together. Freddie and Debbie never liked going on an outing. After about three times even the zoo bored them. Animals were better on Wild Kingdom, they said. Just not great talkers, I guess.

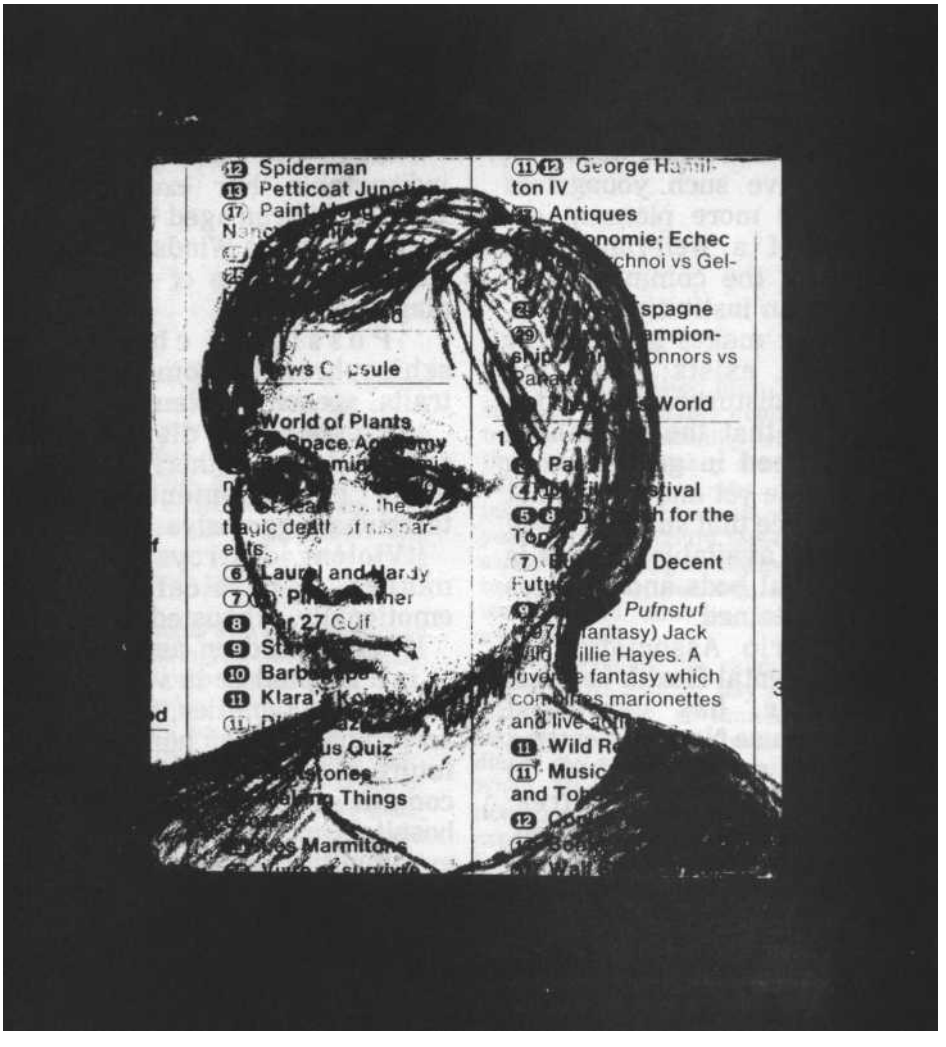
Of course, we don't have as many fights now. I fixed that by using a second TV. Jack has the color one in the living room and the kids have their own in the basement with the record player. Mind you, now they eat supper down there. But at least Jack gets to watch the news.

What I really came to talk about is they're putting Debbie into a commercial course next year when she starts Grade 9. They say she can't do advanced work because her English is so bad. We hoped Deb would get to college. And Frederick's

already in a remedial reading class in Grade 10. Is all that supposed to be my fault? I tried to get them to read when they were young. They both did their homework with the door open so they didn't miss anything on TV. I don't know when it happened to us, but there came a point — back in public school, I guess — when they would rather have watched TV than do anything else. Anything.

The school psychologist took off her glasses and looked at the mother. When the psychologist and her husband had decided on no TV in their house, friends dismissed them as weirdos. Their children were just starting day-school when they sold the set. Withdrawal symptoms caused havoc; a week of screaming, a month of pouting. But gradually her family hod free time — meals lasted longer, the family talked, read and played more. Though it was too late for the mother, the psychologist gave her a book, a frightening paperback called The Plug-In Drug *by Marie Winn. Subtitle:* Television, Children and the Family.

"Bill Casselman is a freelance writer and broadcaster who lives in Vancouver. He appears regularly on CBC radio's Morningside with Don Harron, as a panelist on CBC Radio's Conquest quiz, on CKVU TV's **Vancouver Show** where he conducts a TV column called Mediawatch. He writes and produces TV shows, and is completing a novel. His ambivalences about the electronic media are reflected in this article".



A TERRIBLE WAY TO TREAT CHILDREN

Editorial: Reprinted from the Toronto Daily Star

It is shocking to see the heartless manner in which Ontario is treating disturbed and often helpless youngsters. They are the latest social victims to be sacrificed on the altar of the balanced budget.

Keith Norton, the minister of community and social services, is cutting back on the number of beds in residential treatment centres for emotionally disturbed children. He's planning to put them in specialized group homes in the community instead.

In theory that's a good idea ; it's better to have such youngsters living in the more pleasant environment of a well-run group home out in the community instead of in an institution.

But it only makes sense if the alternative exists; for the emotionally disturbed children it would seem that the specialized care they need in group homes isn't available yet and there's not much evidence that such care will soon become available. Until it is the residential beds and services should be retained.

The Ontario Association of Children's Mental Health centres, for example, has expressed concern because Norton is cutting back on the number of beds in residential treatment centres. One five-bed centre in London, Ont., has closed already; many others are having their services reduced.

The ministry should proceed with the caution it eventually displayed in Windsor, where Western Hospital was going to close 12 of its 14 beds for severely disturbed children in July. Now the closing has been postponed until the end of March, 1980, to make sure that alternative treatment will be available.

This is the route to go. Foster homes and group homes and community services must be in place before treatment centres are closed. Extra money for prevention will not, after all, help the children who are already damaged.

That severe damage exists is indisputable. For example, last year 33 children aged 7 to 11 were cared for in the Windsor hospital. Here's how some of them were diagnosed :

"Possible childhood schizophrenia, some autistic traits, speech problem;

"Hyperactive, disruptive at school, defies authority, chaotic home environement, temper tantrums, aggressive;

"Violent, destroys property, mother physically and emotionally exhausted."

If these children aren't helped — in a hospital or in very special community facilities, rather than an ordinary foster home — their future can only be tragic. They'll commit suicide, end up in mental hospitals, or in jail. The latter two eventualities would be far more costly than treatment now.

We urge Norton to proceed with care in his search for better, less costly ways to care for disturbed children.

MORE HELP CALLED FOR TO AID `DAMAGED' CHILDREN

Reprinted from the Toronto Daily Stars: Letters to the Editor

It is indeed "shocking to see the heartless manner in which Ontario is treating disturbed and often helpless youngsters," as your recent editorial states.

Why is Social Services Minister Keith Norton cutting back on the number of beds in residential treatment centres for emotionally disturbed children? Shouldn't another $250,000 be spent to "help the children who are already damaged" and another **$250,000** and another, and another?

My answer is yes. Yes, even though it is wrong to believe that there is a finite number of damaged children who might benefit from treatment in hospitals or special community facilities. Yes, even though we know that the best residential or community based treatment in the world is too often not very successful in helping children who are already damaged. Yes, if Norton can get the money.

But he can't. He has already extracted all he can from the other ministries and he can't get any more. And he can't get more because deep down, you and I who have money prefer spending it on those things which we have been led to believe are our justified necessities or niceties, rather than paying higher taxes. Things like tobacco, alcohol, pet food, travel, entertainment and luxury cars.

And our politicans know that we as a society prefer to have our public funds spent on three-lane highways to cottage country than on our kids.

But Norton, within the limitation of that slice of our tax dollars that he controls, is doing what makes sense. At least to the extent that he is committed to his stated policy that "we need to move towards prevention and away from merely reacting and helping after damage is done".

Why, in this context, does cutting back on the number of treatment beds make sense: An overstated analogy from public health makes the point. Should a Ministry of Health with finite resources spend all its money treating individual cases of typhoid fever, and none to chlorinate the water supply?

When the harsh reality of finite resources and moves toward prevention strike home, we must direct our anger at our own inappropriate financial priorities, both personal and public, rather than at a politician who has the courage to implement a policy based on the sensible belief that an ounce of prevention is worth a pound of cure.

But moves toward prevention only make sense in the long run. They are dangerous politically in the short run, as your editorial demonstrates.

Norton will need all the support he can get from those who see the necessity of preventive measures because today's casualties, those who love them, and those of us who tend them can muster more votes than tomorrow's undamaged children.

Dr. E.T. Barker
President
Canadian Society for the
Prevention of Cruelty to Children
Midland

PRIMARY PREVENTION

OF PSYCHOPATHOLOGY

Primary prevention increasingly is regarded as the Fourth Revolution in the field of mental health. No mass disorder affecting humankind has ever been eliminated by efforts .at one-to-one intervention with affected individuals; rather it is more effective to eliminate the noxious agents, strengthen the host, or prevent the agent from reaching the host. In the field of mental health this means reducing such factors as interpersonal stress, discrimination, poverty, and sexism, increasing the ability to cope, strengthening self-esteem and support systems, and striving for justice and equality in political and social systems.

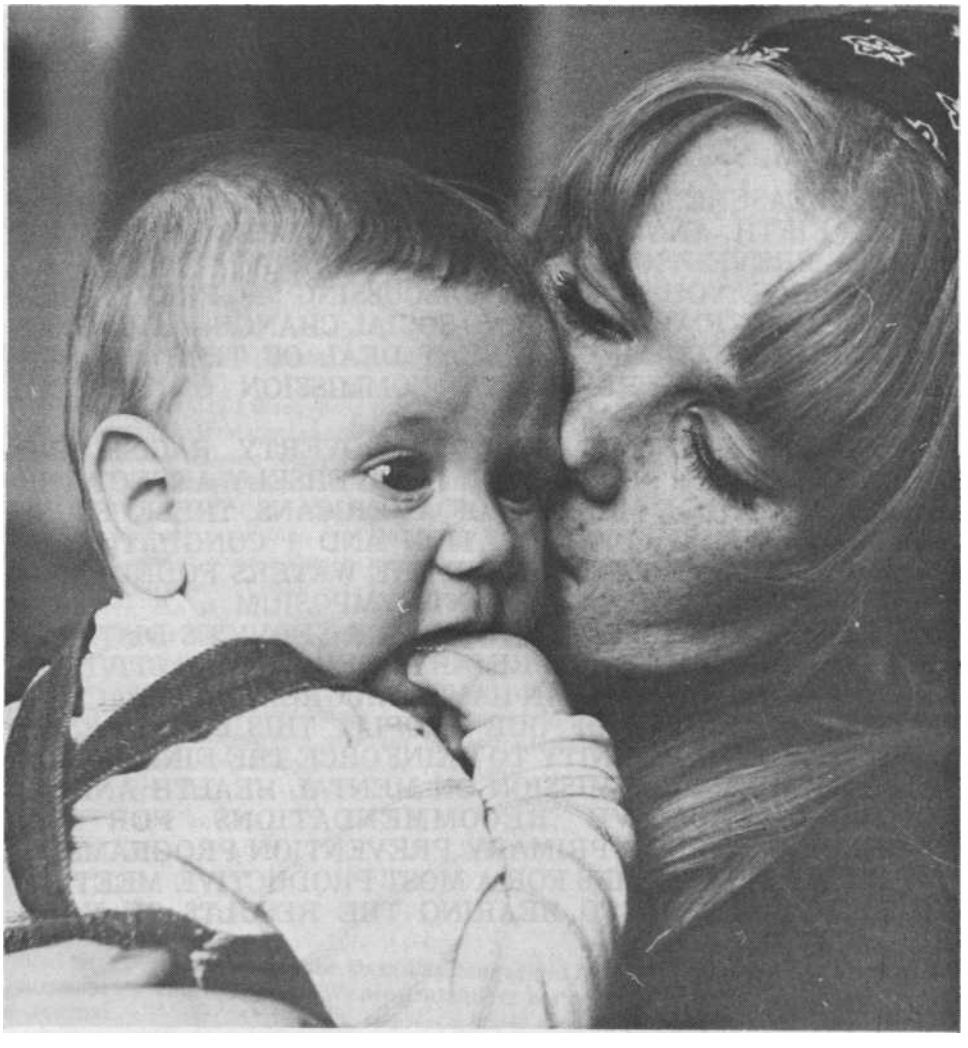
Conferences sponsored by the Waters' Foundation are held annually at the University of Vermont under the auspices of the Vermont Conference on Primary Prevention, Inc. The focus is on scientific, theoretical, and empirical approaches to the prevention of psychopathology and the fostering of competence. The results of each conference are edited and published in a series of books. The fifth volume, which will analyze needed social change and political action, will be based on the conference of June 19-23, 1979.

There .is a fair amount of evidence that supports. the argument that the incidence of emotional distress and the severity of emotional disturbance can be reduced by teaching coping skills, by identifying and establishing support groups, by raising self-esteem, and by reducing particular forms of stress. Stress involves, for example, the feeling of powerlessness that is part of our social order. Powerlessness is associated with being poor in our society, with being female, with being a member of a minority. group, with being forced into endless and dehumanizing jobs, with being unemployed. Clearly efforts. at changing these situations, involve a redistribution of power. Social efforts . and political movements aimed at the redistribution of power immediately threaten the status quo and stir up strong resistance from those who have a stake in-continuing things the way they are..

Primary . prevention, whether aimed at real illnesses or at emotional distress, has specific definable characteristics. It is

proactive; and it deals with large. groups of people not yet affected with the conditions to be prevented. While it may direct its efforts at high risk groups, these characteristics still hold. It sometimes does not deal directly with people who might be at risk; it may be concerned instead with mass media, with laws affecting children, with changing administrative policies. Persons involved in primary prevention efforts . need not be traditional mental health professionals. Primary .prevention is involved when Head Start programs teach children better adaptive skills; when slum dwellings are condemned because of the presence of lead paint; when sex education courses are taught in the schools; when sexist readers in the early grades are changed to non-sexist ones; when job skills are provided to unemployed teen-agers; . when mass media are enjoined from showing minorities and women in demeaning and stereotyped roles; when programs to reduce unemployment are introduced; or when tax rates are modified to alter massive inequalities in income.

George W. Albee



George Albee obtained his Ph.D. in Psychology from the University of Pittsburg in 1949. He was Professor of Psychology for sixteen years at Western Reserve University, and since 1971 Professor of Psychology at the University of Vermont. In 1957, he was the Director of the Task Force on Manpower of the Joint Commission of Mental Illness and Health. The book he wrote as a report on the nation's mental health manpower shortages, was a major factor in redirecting strategies of intervention, and his work with the Commission lead to the development of Community Mental health Centres in the Unites States. He has worked as consultant to the Peace Corps and to the Surgeon General of the U.S. Army. He served as President of the American Psychological Association from 1969 to 1970 and was Chairman of the Task Group on Prevention of the President's Commission on Mental Health from 1977 to 1978.

The series of books, Primary Prevention of Psychopathology, is published by the University Press of New England. Box 979 Hanover, New Hampshire 03755.

Primary Prevention of **Psychopathology**
—Volume I : The Issues, edited by George W. Albee and Justin M. Joffe. $20.00.
— Volume II: Environmental Influences, edited by Donald G. Forgays. $15.00.
— Volume III: Social Competence in Children, edited by Martha Whalen Kent and Jon E. Rolf. Spring 1979. $17.50.
— Volume IV: Competence and **Coping** During Adulthood, edited by Lynne A. Bond and James C. Rosen. Available Spring 1980.
—Volume V: Prevention through Political Action and Social Change, edited by George W. Albee and Justin M. Joffe. Available Spring 1981.

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PMS GEORGE W. ALBEE, PH.D., DLR

DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF VERMONT
BURLINGTON, VERMONT 05405

IT IS A PLEASURE TO SEND GREETINGS TO THE PARTICIPANTS IN THE FIFTH ANNUAL VERMONT CONFERENCE ON THE PRIMARY PREVENTION OF PSYCHOPATHOLOGY.

THE TOPICS YOU WILL BE DISCUSSING - PREVENTION THROUGH POLITICAL ACTION AND SOCIAL CHANGE - ARE ONES WHICH WERE ACCORDED A GREAT DEAL OF TIME AND ATTENTION BY THE PRESIDENT'S COMMISSION ON MENTAL HEALTH.

IT IS CLEAR THAT THE IMPACT OF POVERTY, RACISM AND DISCRIMINATION IN ALL ITS FORMS ADVERSELY AFFECT THE MENTAL HEALTH OF MILLIONS OF AMERICANS. THESE ISSUES DEMAND CAREFUL CONSIDERATION AND I CONGRATULATE THE VERMONT CONFERENCE AND THE WATERS FOUNDATION FOR SPONSORING THIS IMPORTANT SYMPOSIUM.

TOO OFTEN, THE PRESSING NEED FOR SERVICES DISTRACT OUR EFFORTS FROM THOSE PRIMARY PREVENTION ACTIVITIES WHICH IN THE LONG RUN CAN HAVE FAR GREATER IMPACT ON THE MENTAL HEALTH OF OUR PEOPLE. THIS CONFERENCE PROVIDES AN OPPORTUNITY TO REINFORCE THE FINDINGS OF THE PRESIDENT'S COMMISSION ON MENTAL HEALTH AND TO MAKE CONSTRUCTIVE RECOMMENDATIONS FOR IMPLEMENTING NEEDED PRIMARY PREVENTION PROGRAMS.

I SEND MY BEST WISHES FOR A MOST PRODUCTIVE MEETING AND LOOK FORWARD TO HEARING THE RESULTS OF YOUR DELIBERATIONS.

ROSALYNN CARTER

PREVENTION IN MANITOBA:

AN INTEGRATED

AND COMPREHENSIVE APPROACH

by Jean Marie Hurd

"To be preventive care must also be comprehensive".

Philippa Fordyce

". . .Society is finally realizing that the cornerstone of good total health care is prevention. . ."

"To be preventive, care must also be comprehensive". This simple yet profound statement was made to me by Ottawa social worker Philippa Fordyce in describing the difference between the health and social service systems of Great Britain and Canada. England's system, according to Fordyce (who was educated within it), is the more comprehensive of the two and thus at this point has the greater capacity for being preventive. This is evidenced, for example, by its far more extensive use of the health visitor (public health nurse) in providing young mothers with needed support during their children's infancy and early formative years.

Fordyce's salient observation has particular relevance now for Canada, which is currently in the throes of a significant struggle at the provincial level to preserve the concept of universality in relation to its citizenry's access to health care. Canadians consider health care to be a right rather than a privilege, and universal access to it is the first and most basic step in the building of an overall system that, once accessed, is comprehensive in its approach to the total mental and physical health needs of the populace.

Because society is finally realizing that the cornerstone of good total health care is prevention, any system of care that warrants the label "comprehensive" must by definition include a strong preventive component. During the past decade, the Province of Manitoba has made considerable strides toward the achievement of such comprehensiveness by instituting a decentralized and integrated health and social service delivery system with a built-in potential for preventive programming. At the local,' regional level this system operates in one of two ways: (1) through the combined efforts of a multidisciplinary human service team (public health physicians and nurses, social workers, dental and mental health workers, income security workers, etc.) under the aegis of the province's Department of Health and Community Services, or (2) as a district health system (community health centre) team under a local governing board which often employs its own physician(s) and nurse-practitioner and directs the operations of the local hospital and , or personal care home. It is important to note that in those regions where the Children's Aid Society carries total or partial responsibility for statutory child welfare services, the CAS workers are active participants in the Departmental and district health system teams. The interdisciplinary and inter-agency cooperation that has developed as a result of combining services at the local level has given rise to a number of creative experiments in prevention that have significant implications, both in and of themselves, and as products of a planned, governmental system that was designed to enhance the development of such experiments.

"From an operational standpoint, care that attempts to be comprehensive usually starts with treatment (frequently crisis-oriented) and backs up to prevention."

PREVENTIVE MODELS IN MANITOBA

From an operational standpoint, care that attempts to be comprehensive usually starts with treatment (frequently crisis-oriented) and backs up to prevention. As representatives from the various disciplines meet together to discuss individual cases and plan for better total service delivery, the discovery of the need for a preventive orientation is inevitable. Manitoba's experience is no exception. While its team members have found no easy solutions for the problems inherent in the transition from a treatment to a preventive emphasis, they have initiated some innovative and effective models, a few of which are discussed below. (Only those which have relevance for prevention oriented toward child and family services are mentioned).

1. DEPARTMENT OF HEALTH AND COMMUNITY SERVICES TEAM

An outstanding example of a Departmentally-sponsored team is one based in Neepawa, serving a population of roughly 21,000 in the northeastern sector of Manitoba's Westman Region. This team initially met monthly, but after its first two years of operation it subdivided into four "mini-teams" which meet regularly in the four geographic areas where services are delivered. Experience has shown that local concerns are best met this way. The full team meets every three months, concentrating on inservice education and on the discussion of concerns of a comprehensive nature, with special emphasis on programming oriented toward prevention and positive growth and development rather than the treatment of pathology.

Systems in themselves can be sterile when divorced from people, however, and the Neepawa system, while the product of a prodigious team effort, nevertheless reflects the unique personality of its leader, health educator Marie Salway. Recipient of Health and Welfare Canada's 1977 Lifestyle Award for Manitoba, Salway embodies prevention in action. Coordinating the efforts of the four mini-teams, she sets the tone for an ongoing comprehensive (and thus preventive) educational program, not only for team members but for the entire area community. She ensures ongoing liaison between community team members and hospital / personal care home staff, and between the human service professionals and the many lay organizations concerned with specific aspects of the human services. As a result, the Neepawa Area — a widely scattered geographic unit chiefly agricultural in character — has achieved an unusual balance of preventive and treatment services and a unique esprit de corps involving human service professionals and consumers alike.

An interesting example relating to a specific case illustrates the impact of Neepawa's community effort. A tiny infant who evidenced symptoms of severe failure to thrive came to the attention of the local team. The family physician was unwilling either to recognize the condition or to admit the child to hospital for assessment. The CAS worker, a regular member of the team, happened to be out of the country on holiday; but such was the rapport between worker and team that the team itself, acting on her behalf, exerted enough collective pressure on the physician to persuade him to admit the child to hospital for complete medical and psychosocial assessment. From there, appropriate treatment plans were made, and the CAS worker on her return assumed the management of the child, with on-going consultation from the team.

2. DISTRICT HEALTH SYSTEM TEAMS:

Two district health system teams offer unusual examples of effective preventive services. One is that of the **Seven Regions** Health Centre in Gladstone, a town of 1200 in Manitoba's Central Region. The Health Centre (a district health system that includes the area's hospital and personal care home) services the town itself plus a far-flung area including the Sandy Bay Indian Reserve.

Perhaps the most damaging facet of native health care in Manitoba (and presumably elsewhere in Canada) is the frequent removal of native children from their parents for hospitalization — most disastrous at birth and in the early formative months of life. The natural bonding between parents and child is thus interrupted, and the child — often thus conditioned to a white culture, and all too frequently placed in a white foster home for a type of "half-way house" care before being returned to his parents — is never completely accepted back into his own home. A childhood of neglect is often the price he pays for his "optimal medical care".

Dr. Waldie Loewen, a Gladstone physician associated with the Health Centre, has taken decisive steps to break this disastrous pattern. With team backing he has established an active medical outreach program, regularly visiting the Sandy Bay Reserve where he focuses mainly on preventive health care. As a result, the hospital admission rate for native children has dropped markedly. Furthermore, the Health Centre arranges for mothers of children who do require hospitalization to board-in during their children's stay, thus preserving the parent-child bond.

Another district health system, **the Leaf Rapids Health Centre**, provides a fascinating "one-of-a-kind" example of preventive health care at its most comprehensive. Leaf Rapids is a mining community of 2500, carved out of the bush of the Manitoba North and built by the provincial government in the early 1970's. The town is so designed that all services — school, health and recreational facilities, bank, stores, hotel, etc. — are housed under one roof at the heart of the community, with the houses laid out in bays around this community center in such a manner that no one is over a five-minute walk from "town".

During its formative years the Health Centre enjoyed the services of Vi Petrinka, an able and charismatic nurse practitioner who quickly gained the confidence of the community, especially of the young mothers who desperately needed support in childbearing and childrearing, isolated as they were in the bush without the support of extended families. Petrinka also provided stability for the health services during the continuous turnover of resident physicians (a phenomenon which seems to be a fact of life in the North).

A prenatal screening program was developed which resulted in the early identification of both medical and psychosocial high-risk mothers. Careful follow-up was ensured, and those mothers referred to the Centre social worker received long-term counselling rather than crisis intervention. Mothers and babies were closely monitored postnatally and throughout the child's early growth and development. If the mother failed to keep a medical appointment, the nurse-practitioner visited the house instead.

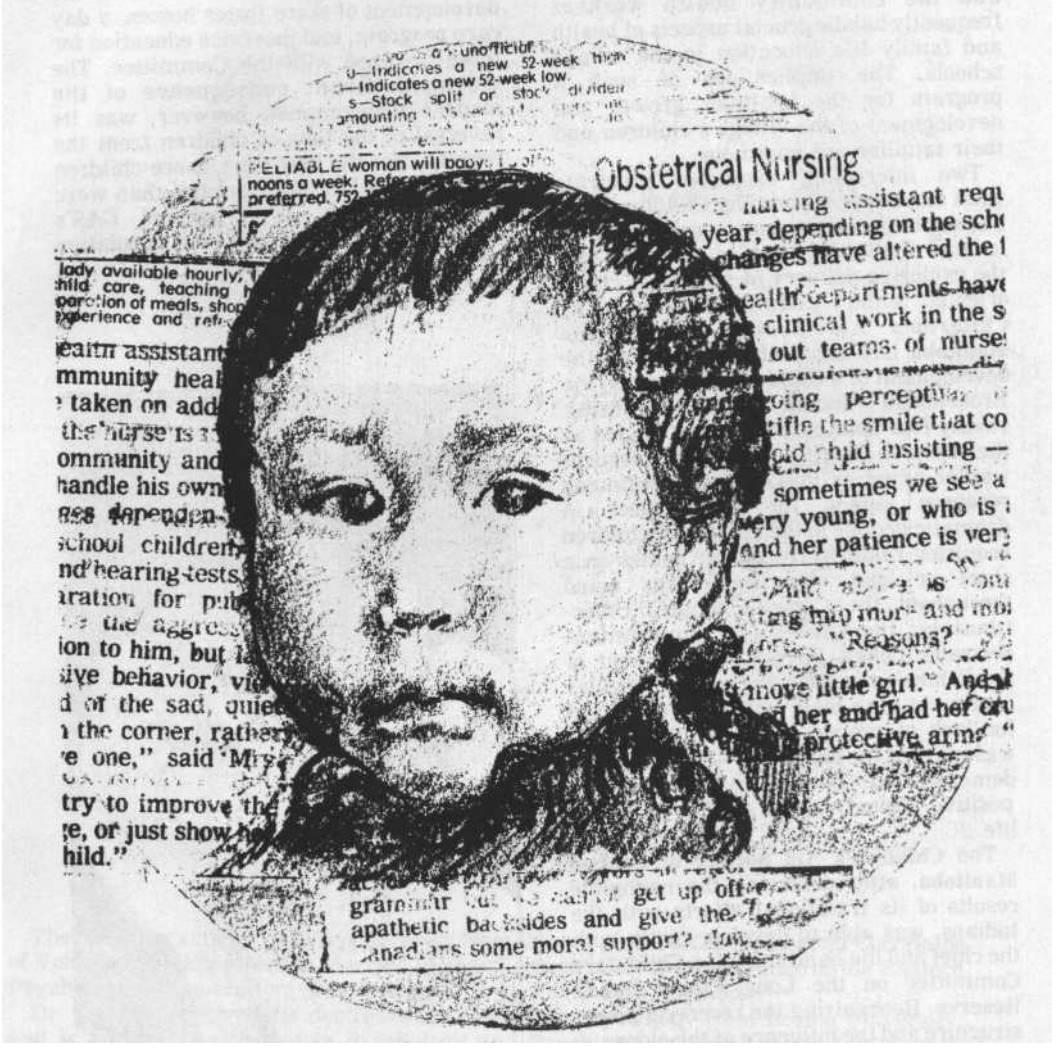
Petrinka remained with the Centre for roughly five years. Toward the end of this period, it was discovered — to the staff's apparent surprise — that, contrary to what is ordinarily expected in an isolated, transient mining community, there was a remarkable absence of abuse and severe neglect among children in the 0 - 5-year age group. (This assessment allowed for the impact of multiproblem families that quickly wore out the town's services and moved on to other communities). While such a program can hardly be duplicated in other locations with less controlled environments, the principle it illustrates is nevertheless valid. "To be preventive, care must also be comprehensive".

"Perhaps the most damaging facet of native health care. . . is the frequent removal of native children from their parents for hospitalization-most disastrous at birth and in the early formative months of life."

3. NATIVE HEALTH AND SOCIAL DEVELOPMENT MODELS:

The province's Community Health Worker Program (New Careers, Department of Manpower and Continuing Education) has offered a unique approach to native health care in Canada. Modelled after an Alaskan prototype, this program has trained native persons from remote Metis villages to give primary care to their fellow villagers, thus supplementing the very limited services available from provincial physicians and nurses, who among them are able to arrange at the most only two short visits per village per month.

The community health workers, who have a maximum of a Grade 9 education, have been trained by Norma Hopps of New Careers, a skilled nurse who is a veteran of CUSO educational and service programs in Africa. Each worker's education was extended over a two-year period during which two-week training sessions were interspersed with six weeks on the job, where she worked if possible with a senior community health worker. Once trained, the workers have been hired by the Department of Health and Community Services as resident health workers in

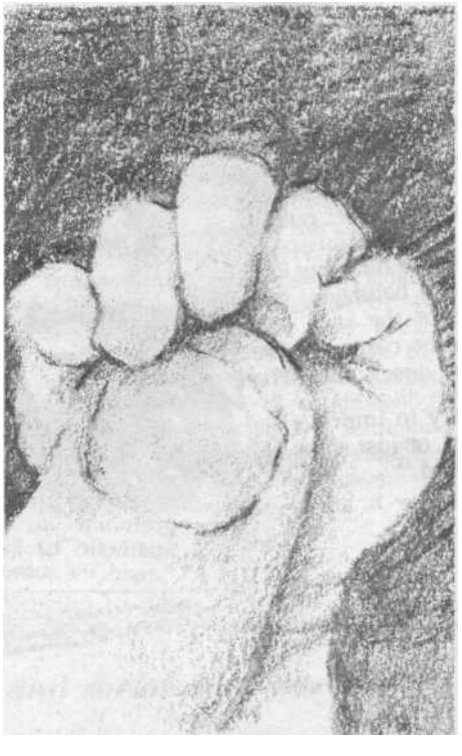


"Two interesting examples illustrate what can happen when the Children's Aid Society initiates preventive programming instead of allowing itself to be locked into the exclusive delivery of statutory, crisis-oriented child welfare services."

their own villages. Not only have these workers been able to provide primary care of a remarkably high quality, but the preventive activities they carry out are equally impressive. Home visits are made weekly to each village family for the purpose of health assessment and support, and the community health workers frequently handle crucial aspects of health and family life education in the village schools. The implications of such a program for the healthier growth and development of the village's children and their families are enormous.

Two interesting examples illustrate what can happen when the Children's Aid Society initiates preventive programming instead of allowing itself to be locked into the exclusive delivery of statutory, crisis-oriented child welfare services. **The Children's Aid Society of Eastern Manitoba** has successfully catalyzed the development of a Child Care Centre on the Brokenhead Indian Reserve, utilizing twenty-four hour native staffing funded by the reserve itself. One CAS resource worker acted as initiator and continuing resource person for the project. A dramatic decline in the number of children requiring removal from their homes on a short or long term basis was noted throughout the Centre's tenure. Unfortunately, the subsequent government restraint policy forced redeployment of the Centre's resource worker to a regular treatment case load, with the result that for lack of proper guidance, the Centre was marked for phase-out — in spite of its demonstrated cost-effectiveness and its positive impact on the quality of Indian life.

The **Children's Aid Society of Central Manitoba**, after assessing the negligible results of its traditional efforts with the Indians, was able to develop jointly with the chief and the band council a Child Care Committee on the Long Plains Indian Reserve. Recognizing the reserve's power structure and the influence of the elders on family development and child care, CAS stressed the need for a co-operative approach and phrased the Committee's purpose in positive, preventive terms, i.e. to keep the children with their families on the reserve. A native child care worker (paid by the Department of Indian Affairs) was located on the reserve, liaising with CAS. This arrangement resulted in the development of more foster homes, a day care program, and inservice education for those involved with the Committee. The most significant consequence of the model's development, however, was its reversal of the flow of children from the reserve. For the first time, more children were returned to their families than were taken into care. As a spin-off, CAS's credibility with the reserve's population has increased markedly.



4. LAW ENFORCEMENT MODELS:

While the preventive models initiated by the RCMP and the Manitoba Police Commission are oriented chiefly toward older children and youth and the general adult population, they bear mentioning because of their important indirect effect on the very young child and his parents. Also, they establish an important principle that is not commonly known: no one is more interested in or concerned about the need for preventive programming than is the police officer. His frequent contact with the results of abuse and neglect and his frustration with the inability of law enforcement to find anything other than the most temporary solution to the problems they present makes him a primary mover in the cause of prevention. In Manitoba, the RCMP's **Native Constable Program** and the Manitoba Police Commission's Summer **Student (Recreation) Program** for native communities are good examples of law enforcement's demonstrated ability to function preventively.

"... no one is more Interested in or concerned about the need for preventive programming than is the police officer."

5. MEDICAL MODEL

In January of this year an important decision was released, prepared by the College of Physicians and Surgeons of Manitoba and produced by the Department of Health and Community Services. Entitled **Child Abuse: Physician's Protocol,** it is available in brochure form to all Manitoba physicians and to the various disciplines working with them. The brochure recognizes as its progenitor the "Guidelines in Cases of Child Abuse", a protocol released jointly in 1975 by the Department and the Attorney-General calling for the co-operation of medicine, social services and law enforcement in the identification and handling of child abuse.

The new **Physician's Protocol** is notable, not only because of its complete and thorough approach to the problem of child abuse as a clinical entity, but especially because of its emphasis on prevention. In the section entitled "Prevention", for example, the brochure includes the following comments:

"It is important to recognize the degree to which healthy bonding between parents and their offspring strengthens the positive aspects of the relationship and lessens the likelihood of negative parental feelings of a degree great enough to lead to abuse. Thus, everything that strengthens and supports the attachment process can be viewed as a preventive measure as far as child abuse is concerned.

The most fertile area for professional intervention of a prophylactic nature occurs in relation to conception, pregnancy, birth and the immediate neonatal period....

Events which are not conducive to healthy mother / child bonding bear careful re-evaluation in the light of all that we are beginning to understand about human parenting behaviour.

At any point along the life cycle from conception to neonate, there are opportunities for helpful professional intervention which can reduce future abuse and help foster more positive successful and enjoyable parenting."

It goes without saying that a broad understanding by the medical profession of the concepts identified above can be of inestimable value in the promotion of all aspects of prevention in this area. The multidisciplinary effort that assisted in the production of the College of Physicians and Surgeons' **Physician's Protocol** stands as a significant example of what can be achieved when the major disciplines concerned with both the preventive and treatment aspects of a problem decide to tackle the problem co-operatively.

"The most fertile area for professional intervention of a prophylactic nature occurs in relation to conception, pregnancy, birth and the immediate neo-natal period..."

IMPLICATIONS FOR FUTURE DEVELOPMENT

As a result of a study by the Department of Health and Community Services in 1977-1978, the preventive and treatment models relating to child abuse and neglect throughout the province (excluding Winnipeg) were identified and assessed. A multidisciplinary provincial committee, consisting of representatives from the Department, district health systems, CAS, the medical profession and the RCMP was appointed to continue, with administrative advisory input, the task of public and professional education and program development.

At a final multidisciplinary planning session in Winnipeg, delegates from throughout the province laid out a suggested future course of action. Major among the innovative recommendations made was the call for a dual approach to the problem of child abuse and neglect at the community level. It was recommended that a professional **Treatment Team** be appointed to handle identified cases, to be complemented by a local **Child** Care **Council** consisting of concerned community members, lay or professional. The main purpose of the Council would be to develop a broad spectrum approach to the prevention of mental and physical abuse and to the promotion of healthy child and family development.

Augmenting its positive approach to preventive care was the planning group's call for the preparation of a declaration of children's rights for proposed addition to the Manitoba Child Welfare Act. In summary, the group recommended that all citizens, professional and lay alike, lobby for the development of preventive community services by establishing the fact that "such preventive programs represent the only cost-controlled, financially responsible system that can be defended".

Since the conclusion of the Schreyer Government's intensive development of health and social services that are integrated and comprehensive, and thus conducive to the evolution of preventive programs, Manitoba has changed political parties and is thus currently under the aegis of a different political philosophy. How much the human service delivery system will change as a result is yet to be determined. Some programs have already been phased out; others will probably plateau, and some — particularly if they enjoy strong community sanctions — will presumably survive, and perhaps develop further.

"... all citizens, professional and lay alike, (should) lobby for the development of preventive community services by establishing the fact that such preventive programs represent the only cost controlled, financially responsible system that can be defended."

"Whatever the future holds, however, one conclusion is inescapable. The Manitoba experience attests to both the efficacy and the costs benefits of preventive programming in child and family services. Another significant step has been taken in Canada toward making prevention in actual fact "the art of the possible,"

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Jeanne Marie Hurd initially received an M.A. from Columbia University in Education and Theology; then in 1956 a Masters of Nursing degree from Yale University, specializing in the care of emotionally disturbed children. From 1972 to 1975 she was an Assistant Professor in the School of Nursing at the University of Wyoming. From 1975 to 1978 she worked as a Senior Program Consultant in the Department of Social Development, Government of Manitoba. Among other things, her work there involved her on the Board of Directors for the Manitoba Institute of Social Workers, the Joint Ministerial Task Force on Nursing Education, community health nursing and child abuse programming. She is presently a lecturer at the School of Nursing at the University of Ottawa, and is President of the Ottawa Chapter of the CSPCC.

WHEN A GROWN MAN WEEPS

He stood, leaning against a grey brick wall on a quiet, tree-bordered street. His childhood was a vivid nightmare imprinted in his warped mind. He remembered the brutal beatings, the accidental killing of his twin brother, and the terrifying nights spent hidden under the basement staircase. He was robbed of his childhood pleasures, those special things which make a childhood so free and happy-go-lucky and now he was forced to live the rest of his life with the mind of a child.

His hands were deathly cold. It was winter and the day was cloudy and crisp. The orange rays of the setting sun fanned out from a crack in the solid grey canopy above the tree tops. He warmed his hands in his cloudy breath, then put them back in his pockets.

She was on her way home from piano lessons. She was innocently young and terribly fragile. He took his hands from his pockets and lit a smoke. She hummed a faint tune that was in perfect co-ordination with her shallow character and tiny body. He was six-foot-four and half as wide under a grimy trench coat. She wore a pink and red toque and a small ski jacket that was too big for her. He pushed himself from the wall and stepped on his cigarette before leaving. His head was slightly foggy and his steps were awkward and uneven. The darkening street and creeking of the dead, winterized trees stopped her humming. She whistled for a short time, then pressed her lips tight together in fear. He walked toward her now, gliding almost evenly with long, pounding strokes of his legs.

The sun was no longer orange and the crack in the clouds was neatly mended, causing a quick blanketing of darkness. Snow began to fall.

She walked slowly with her eyes planted toward the ground and the eerie setting of the blackening street allowed her imagination to make her heart pump violently. He was a giant, looking down at the split in his workboots and the cold, black steel covering his toes, exposed. Her boots were soft and they squeaked. Her tiny left hand clutched a grade two spelling book. His mighty right hand had no index finger. She looked up and stopped walking. Her boots fell silent. He pounded forward. She squatted and cried. He pounded. She screamed a quiet note and silence was her only answer as he reached for her with a huge four-fingered hand. She closed her eyes and he wiped the accumulating snow off her shoulder before moving on.

She dropped the book and ran home to her worried mother, her loving father, her twin sister, and her dog, Shaggy.

He stepped off to the side of the street and mingled with the sheltering trees, weeping like a child he had never been...

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Grade 11

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LA PROCHAINE REVOLUTION: PREVENTION PRIMAIRE DE LA PSYCHOPATHOLOGIE

"La prevention primaire, qui a pour but de réduire les problèmes émotionnels et psychopathologiques, emprunte quelques unes de ses stratégies au domaine diversifié de la santé publique. Il est depuis longtemps accepté que les problèmes massifs qui affligent la race humaine ne sont jamais controlés ou éliminés pat une intervention directe. Même si on peut défendre un traitement individuel d'un oint de vue humanitaire, ce n'est point une stratégie efficace à l'élimination des problèmes étendus. La plupart des victoires et triomphes de la santé publique, dont la conquête de plusieurs maladies, sont le résultat de (I) l'élimination de l'agent nuisible ou (2) renforcement de l'hôte. La petite vérole, la typhoïde, le choléra, et la poliomyélite furent largement éliminés par l'une ou l'autre de ces stratégies de la santé publique.

Même si le model de la santé publique est utile à une approche pour la prévention de désordres mentaux et émotionnels, il y a une différence cruciale qu'il faut considérer. Il n'y a pas la même relation directe de cause à effet pour la plupart des dites maladies mentales. Il existe plusieurs évidences qui établissent une relation entre le stress et des désordres mentaux subséquents. Néanmoins la relation n'est pas spécifique comme dans le domaine des maladies bien définies. Le fait est que différents stress peuvent induire différents problèmes chez des individus. Un stress résultant de la mort d'une épouse ou enfant, la perte d'un emploi, l'interruption d'une amitié intime ou relation personnelle peut produire une depression chez l'une, une dépendance à l'alcool chez l'autre, réclusion chez celui-ci, névrose chez celle-ci, et aucuns symtômes apparents chez celui-ci. La recherche pour une cause particulière à l'alcoolisme ou au suicide est destinée à l'échec dû à cette raison.

Ceux qui s'opposent aux efforts de la prévention primaire se servent de cet exemple pour appuyer leur argument favori: "Nous en savons encore trop peu sur les causes de chaque maladie mentale pour faire quoi que ce soit de significatif pour la prévention." Cet argument non valide se base fortement sur le model traditionnel des maladies qui soutient que des perturbations émotionnelles sont des maladies définies et que pareils cas ont des causes bien spécifiques.

L'industrie de la santé a depuis longtemps résisté aux efforts de la prévention. Tout notre système de la santé met l'accent sur une haute technologie médicale qui se concentre sur dew traitements grandement profitables pour les hopitaux, médecins, et l'industrie des médicaments. Sur les milliards de dollars dépensés pour la recherche sur le cancer, moins de 1 pourcent fut accordé à la prévention. Même s'il est généralement reconnu que la plupart des cancers sont dûs à la pollution de l'environnement et mode de vie, la cigarette; la nutrition, les substances polluantes des industries, etc. Les recherches se concentre toujours à découvrir un remède pour le cancer tandis que 20 million d'américains sont sans soins médicaux, et un autre 50 million sont sérieusement sous desservis. Médecine et chirurgie continues à donner préférence aux opérations cardiaques et à la recherche pour des remèdes tandis que les efforts pour la prévention sont négligés. Dans le domaine des afflictions mentales et émotionnelles, l'établissement de la santé mentale continue à mettre l'accent sur le traitement direct, les médicaments et autres méthodes de traitement physique..."

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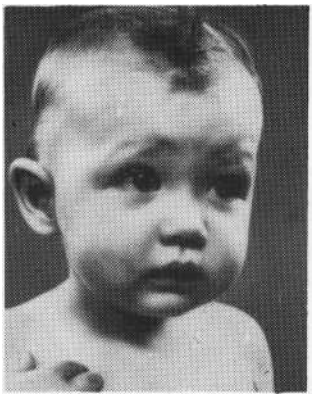

Recognizing that the capacity to give and receive trust, affection and empathy is fundamental to being human.

Knowing that all of us suffer the consequences when children are raised in a way that makes them affectionless and violent, and;

Realizing that for the first time in History we have definite knowledge that these qualities are determined by the way a child is cared for in the very early years.

CSPCC CREDO

WE BELIEVE THAT:

- The necessity that every new human being develop the capacity for trust, affection and empathy dictates that potential parents re-order their priorities with this in mind.
- Most parents are willing and able to provide their children with the necessary loving empathic care, given support from others, appropriate understanding of the task and the conviction of its absolute importance.
- It is unutterably cruel to permanently maim a human being by failing to provide this quality of care during the first three years of life.

THERE IS AN URGENCY THEREFORE TO:

- Re-evaluate all our institutions, traditions and beliefs from this perspective.
- Oppose and weaken all forces which undermine the desire or ability of parents to successfully carry out a task which ultimately affects us all.
- Support and strengthen all aspects of family and community life which assist parents to meet their obligation to each new member of the human race.