CHAPTER 3
SPECIFIC FORMS OF DISTURBANCE

3.1 INTRODUCTION

In the present chapter, a description is given of several disturbances, or deviations in children. The large variety of deviations are divided into groups. The main distinction between being restrained (rectifiable deviations) and being handicapped (permanent deviations) is already made. Andditional possible divisions are:

- o neurologically handicapped children;
- o physically (including sensory) handicapped children;
- o mentally retarded children;
- o children with learning difficulties;
- o children with behavior difficulties.

However, some specific deviations are independent of any possible division here and are treated separately. Two facts are stressed in connection with these specific forms of disturbance:

3.1.1 Some deviations overlap, e.g., a disturbed intellectual ability can be correlated with brain damage. Also, some behavior deviations have a physical basis. Brain damage can be the origin of psycho-neurological dysfunctions, of autism, and of epilepsy.

3.1.2 It is possible for a child to be multiply handicapped. Such a child, then, has more than one physical and/or psychic-spiritual negative deviation; he/she is handicapped or retarded in more than one respect, e.g., he/she is blind and mentally retarded. A spastic child is usually multiply handicapped, i.e., in sensory-motor, and in intellectual ways, as well as in his/her speech.

A limited, or altered educative aim, and a special educative task hold with respect to each form of disturbance. Each deviant child requires an individual plan of action which must be designed and implemented in consideration of his/her individual difficulties, and potentialities. Examples of such special tasks of educating and teaching are a deaf child learning to talk, a blind child learning to

read, behavior control by a spastic child, school teaching for a mentally retarded child, and pedotherapy for an emotionally disturbed child, or for a child with behavior difficulties.

In addition, a teacher of non-restrained and non-handicapped children should be acquainted with the different deviations for the sake of identifying and referring (for special help) deviant children which he/she might find in his/her groups of pupils.

In the ordinary school, often border cases and slight deviations appear. These children, in their otherness, problems, and deviations must be noticed, understood, and supported. A teacher must contribute to the balanced development of such a child. He/she must know the unique world of a deviant child. He/she must know how he/she experiences his/her being handicapped, or retarded, how his/her different world looks, and how he/she feels about his/her being different among the non-handicapped, and non-retarded.

A teacher also must consider the possibility that there are children with minimal brain dysfunction, illnesses, slight sensory defects, epilepsy, domestic problems, etc. A child who doesn't hear or see well can appear to a teacher as if he/she has difficulty understanding the learning material. Often, the child, the parent, and the teacher are unaware of the child's sensory or neurological defect. With a child, hyperactivity and motor disturbances can be paired with minimal brain dysfunction, but a teacher may interpret these as a lack of being disciplined. A child who appears stupid, lazy, or unrestrained might be suffering a chronic illness, or is from a family where extremely disturbing, and blocking circumstances prevail. A teacher can view the subtle disturbances of consciousness resulting from specific forms of epilepsy, as inattentiveness.

A teacher who is acquainted with the different forms of disturbance will recognize, approach, support, and refer these children for possible expert assistance in a pedagogically responsible way.

3.2 THE BRAIN DAMAGED CHILD

Nowadays, a great deal of attention is given to the phenomenon of brain damage in children and, especially to so-called minimal brain

dysfunction (m. b. d.)*. Other names for this phenomenon are hyperkinetic behavior syndrome, and "developmental hyperactivity". Myklebust and Dumont, however, choose the concept **psycho-neurological dysfunction,** which indicates a psychic disturbance from neurological dysfunction (inadequate functioning of the central nervous system).

The origin of this phenomenon is usually brain injury. This can occur before, during, or after birth. A brain can be injured by birth tongs, by insufficient oxygen at birth, by an inflammation of the brain tissue. or cerebral membrane after birth. Various illnesses can give rise to an abnormal pregnancy, or premature birth, by which the brain is not fully developed at birth, or an injury to the brain occurs.

3.2.1 A brain damaged child can have the following ten characteristics:

(a) hyperactivity: This is a noticeable characteristic of a brain damaged child. There is a distinction between sensory and motor hyperactivity. The former implies that, in his/her sensory perception, he/she constantly fluctuates from one thing to another. He/she cannot direct his/her sensory perceiving to one thing for long. Motor hyperactivity refers to a physical restlessness: the child is physically too active and is always in motion and, thereby, he/she is physically tireless. Thus, he/she cannot sit still when he/she must, e.g., in the classroom he/she is fidgety, he/she is overactive at the dinner table, etc.
(b) fluctuating attention: The brain damaged child cannot control his/her attention; he/she has a short attention span; he/she is distracted excessively. His/her weak ability to concentrate influences his/her learning activities. His/her behavior is impulsive--in a situation he/she acts first and thinks later. A disposition to perseverate is related to this--the extended and continued repetition of simple activities.
(c) disturbed motor and visual-motor abilities: These children show a defective coordination regarding fine and gross motor activities such as activities which require fine coordination of the muscles (e.g., handwriting, speech) and with the execution of

* "Minimal" is difficult to described precisely: a minimal brain dysfunction can have a maximally disturbing effect, and conversely, serious brain damage can have a minimal effect.

rhythmic activities. A disturbed visual-motor ability is evident in activities where movement is "led" by visual perception, e.g., copying figures, reaching for objects, etc.

(d) Tireless: While these children appear to be physically tireless, they quickly become psychically tired. This is noticeable in their unwillingness to direct themselves to a cognitive task for a long time, or to pay attention for long in the classroom.

(e) Emotional instability: Extreme fluctuations in the emotional life are characteristic of a child with brain damage. Their irrational anxiety quickly leads to panic. They are affectively impulsive. They quickly become excited, irritated, short-tempered, and are extremely touchy, and then burst into fits of rage and uncontrolled behavior. This being out of emotional control often results in anti-social behavior (lying, stealing, cruelty, sexual offense). A brain damaged child's disinhibition also is characteristic—he/she must always push, pull, linger, fold or bend things which attract his/her attention. Thus, the brain damaged child is somewhat restrained in his/her emotional development.

(f) Little tolerance for frustration: This child has difficulty assimilating failures and disappointments. He/she bursts into violent fits of passion if he/she doesn't get his/her way and becomes aggressive if his/her attempts are not crowned with immediate success.

(g) Inadequate social behavior: An idea of distance from the educators is missing: these children are too private and audacious. They show a candor which goes too far. Because of this, they are "elusive" for the educator, and difficult to be influenced pedagogically. The age mates of a brain damaged child find his/her behavior trying, aggressive, and unrestrained.

(h) Intellectual deficiencies: This can be general or specific. A brain damaged child is restrained, in general, with respect to his/her cognitive development. Because of the psychic disturbance paired with the neurological dysfunction, he/she is not able to actualize his/her intellectual potentialities adequately. His/her intelligence often is average or above average, but he/she is restrained in actualizing it. Thus, there is general intellectual under achievement.

The following specific cognitive dysfunctions sometimes appear in a brain damaged child: disturbances in language and concept formation and, related to this, disturbances in thinking. His/her thinking is concrete-bound and stereotypic, and abstract thinking is defective. For example, he/she is unable to sort into the same

groups or classes things which belong together (knives and forks as eating utensils). Also, there are memory disturbances. A brain damaged child shows additional learning disturbances, e.g., in reading, arithmetic, spelling, and writing. Hearing and speech defects often function as additional restraining factors.
(i) Disturbed perception: The visual perception of a brain damaged child is affected irrespective of how intact the optical nerve might be. He/she shows figure-ground problems and, in his/her visual perception is unable to synthesize a whole from several parts. Therefore, he/she directs him/herself primarily to the details instead of to the whole. Because the sensory perceptions of hearing and touch are defective, a brain damaged child also experiences spatial disorientation. Speech disturbances also are present in these children.
(j) Poor self-concept: On the one hand, these children flee from challenges presented to them. On the other hand, they are inclined to over-compensate for their feelings of guilt and inferiority. They continually try to control and manipulate others. They often respond negatively or aggressively to a situation to dominate it. For example, they will ignore an assignment or pick a fight with an educator or age mate.

An early diagnosis and handling of the brain damaged child is necessary. A vicious cycle among his/her failures (especially regarding learning achievements), and his/her discouragement, defiant attitude, poor self-concept, etc. is a strong possibility, and his/her entire personal becoming can become restrained.

The handling of a brain damaged child, indeed, is a multi-disciplinary task. Besides the necessary medical therapy, he/she is dependent on special instruction where the school curriculum, in form and content, makes provision for his/her problems. In addition, he/she is dependent on pedotherapy with respect to his/her disturbed emotional life, and on orthodidactic assistance for the sake of acquiring the basic skills (reading, spelling, writing, arithmetic). In educating, teaching, and in pedotherapy, he/she must be given an opportunity to express him/herself in words, gestures, movements, music, dexterity, techniques, child drawings, and in individual and group play.

His/her daily educating requires understanding and patience and includes a special task for his/her parents. In his/her daily activities, a brain damaged child needs routine and to be regulated.

The following functional exercises are needed because of the multiplicity of dysfunctions with which these children must struggle: gross motor, writing motor, visual. and auditory perception, language, and concept formation, thinking (e.g., reasoning, sorting, rank ordering), spatial orientation, body schema, eye-hand coordination, memory exercises, laterality (sidedness) exercises, etc.

3.3 THE EPILEPTIC CHILD

The origin of epilepsy is brain damage and/or brain dysfunction. Here the central phenomenon is a disturbance of consciousness (loss of consciousness) which a child experiences for a shorter or longer time. An epileptic attack, in its worst form, can be paired with a stiff tensing of the body, where the arms and legs rhythmically contract together (the so-called spasm attack). An epileptic suffers from a "disposition to spasm". With medical treatment, a great many epileptic phenomena can be successfully held in check.

3.3.1 The following forms of epilepsy are distinguished:

(a) Grand mal (large or severe seizure): Usually, the epileptic is warned by an **aura** (a strange bodily or sensory sensation, or vague feeling of anxiety) that an attack is approaching. With this, he/she can prepare him/herself to prevent hurting him/herself or break something during the seizure. In the **tonic phase** of the attack, he/she loses consciousness, his/her muscles become stiff, and tense, and he/she falls. After several seconds, the seizure moves into the **clonus phase** where bodily stiffness changes into jerky contractions of the entire body for one or two minutes, followed by a phase of sleep, or drowsiness paired with confusion and a headache. Often, a severe seizure is paired with screaming, frothing at the mouth, vomiting, tongue biting, becoming blue in the face, urinating, and relieving oneself. The deep seizure, or coma after the attack can last for an hour or longer. An upsetting experience often sets the seizure in motion.

(b) Petit mal (small seizure): This form of epilepsy shows itself in a brief loss, or disturbance of consciousness, which lasts a few seconds, paired with small contractions of the facial muscles, or the head. It has a sudden beginning and end. The child becomes pale and stares fixedly in front of him/her. Usually, he/she doesn't fall. He/she only interrupts the task with which he/she is briefly

involved. Small attacks can occur daily, even as much as a hundred times a day (pyknolepsy). This disposes the child to have physical and psychic stress. With the akinetic form of petit mal, a short-lived, complete muscle relaxation sets in. The child falls and immediately stands up again. Consequently, he/she can easily have an accident. With the myoclonic form, the limbs, or head show convulsions, but there is no loss of consciousness. Petit mal often is paired with sensations: pain, feeling bloated, anxiety, etc. Usually, the child outgrows **petit mal** epilepsy during puberty.
(c) Psychomotor epilepsy: With this rarer form of epilepsy, the child experiences a slight psychomotor disturbance. The loss of consciousness, and the paired motor disturbance might be so slight that it is not noticed. Then, he/she appears confused and awkward, and carries out automatic activities such as chewing, mumbling, rubbing, swallowing, smacking the lips, spinning around, bending over. He/she is involved in a slight twilight state within which peculiar psychic lived experiences are characteristic--illusions, hallucinations, unrealistic experience, and anxiety. Then, he/she is extremely sensitive and violently opposes any interference.
(d) Narcolepsy: From time to time, the child feels like he/she wants to sleep. He/she then goes into an abnormally deep sleep which is different from a loss of consciousness because the child cannot be awakened from the latter. Usually, he/she sleeps from a quarter to half an hour. The dream, or twilight states are related to narcolepsy where the child is confused and half-awake and contact with the environment is lost. With such a collapse of awareness, the child's handwriting, e.g., is sloppy, and irregular, and he/she behaves strangely in class. It seems that he/she schemes, but he/she is not aware of what he/she does.
(e) Another less familiar form of epilepsy is **Jacksonian** (J. H. Jackson) **epilepsy**--convulsions begin with a limb and spreads outward, some proceeding to a large seizure; localized convulsions of groups of muscles; infantile convulsions--convulsions because of child illnesses, which are paired with brain disorders; status epilepticus--contractions quickly follow each other, sometimes without regaining consciousness; masked epilepsy--epilepsy without aura, convulsion, or loss of consciousness, but with manifestations such as physical pain, vomiting, nightmares, daily anxiety, sleepwalking, fits of anger, etc.

Epilepsy has such a disturbing influence on the child's intelligence, and character that there is even talk of an "epileptic personality". These children show all sorts of peculiarities of behavior and

character. Because of the epilepsy, their intellectual achievement can deteriorate, or their intellectual potentialities remain unactualized. Although they are disposed to hyperactivity and restlessness, their psychomotor actions are slow and disturbed, and they are not flexible on a psychic-spiritual level. They are extremely unstable emotionally, and their emotional expressions can suddenly change between extremes, such as tenderness, friendliness, feelings of well-being, and contentment, on the one hand, and, on the other, resentment, audacity, cruelty, etc. They also are disposed to dejection, discouragement, a morbid religiosity, and hostility. Often, the epileptic state does not discharge into a physical seizure, but in psychic expressions. This makes these children impulsive-impatient, explosive (fits of rage), aggressive, and unpredictable. In contrast with others, their behavior then is distrustful, suspicious, irritated, touchy, mischievous, violent, moody, uncontrolled--they always want to show themselves as superior. In addition, they are exacting, and always dissatisfied, and often become destructive. Clark states the following as the main characteristics of the epileptic: egocentric (selfishness, with an excessive self-interest), hypersensitivity, a poor emotional life, and inflexibility.

Conscious and unconscious **anxiety** characterize the experiential world of the epileptic child; also, an uncertainty in his/her everyday dealings, paired with feelings of insecurity, and being menaced. He/she has trouble with problems of assimilation regarding his/her handicap. He/she fears contact with the world because, at any moment, he/she can lose that contact. His/her world has changed drastically because he/she is constantly expecting that he/she will suddenly experience the convulsion, and/or a loss of consciousness from a seizure in the presence of others. Later, when he/she regains consciousness, he/she lived experiences his/her condition in the eyes of the other—he/she is embarrassed about the abhorrence, horror, and trembling which his/her seizure awakens in others. For example, the epileptic expresses him/herself as follows about his/her defect: "I don't like falling and rolling like an animal in front of others".

The child's epileptic attunement prevents him/her from communicating with his/her world without impediment; this restrains his/her exploration of the world and, thus, also his/her personal becoming; it disrupts his/her total existence: he/she may not swim or bathe alone, ride a bike, use a stove, or a dangerous machine, etc. His/her life revolves around his/her epileptic

seizures, and around the many prohibitions, the medical treatment, and the attitude of others in this regard. He/she, indeed, lived experiences a feeling of being different, and inferior; he/she feels not free, and abandoned to his/her epilepsy. Every moment he/she knows he/she is an epileptic and can have a seizure. The fact that he/she must take medicine regularly constantly reminds him/her of his/her ailment. The future perspective of these children is dark, also regarding the choice of a later occupation. Thus, it is difficult for them to attribute positive sense and meaning to their schoolwork, and this leads to under achievement.

Assisting the epileptic child implies an intertwining of medical and orthopedagogic care. Besides medical therapy, motor therapy is needed for the sake of the epileptic child controlling his/her movements. These children usually are placed in a special class or school. With educating the epileptic child, educative mistakes, such as spoiling, over-concern, and rejection are a danger. In school, his/her weak directedness, attention-weariness, loss of consciousness, poor memory, and slow psychic tempo must be considered--with this child, insight comes slower. His/her rigidity and irritability present the educator (teacher) with special requirements. Because of the problems of these children, decidedly lower demands must be made of them in school.

3.4 THE AUTISTIC CHILD

Autism is one of the most peculiar deviations appearing in children. Where a need for contact (the need for associating and encountering fellow persons) is central with persons, with the autistic child, there is an inability to establish interpersonal communication in adequate ways. The autistic child shows a loss of contact with reality, and a withdrawal from it. Because of this, autism in a child is comparable to (but decidedly differentiated from) adult schizophrenia.

There are a few theories about the origin of autism in children. One is that the child inherits an autistic disposition. Another theory teaches that the child is extremely neglected affectively because of a disturbed mother-child relationship, or by deficient warmth, love, and contact with the parents. Then, his/her emotionality, and potentialities for human contact are not actualized. However, this theory is less acceptable. As a deviation, autism is so serious that it is difficult to accept the idea that merely affective and contact

neglect can give rise to it. Autism is not the consequence but rather the origin of a child's emotional disturbance, and impoverishment. The most valid position is that autism is the result of an organic deviation, i.e., brain damage, or an under-development of the brain.

3.4.1 The following are characteristic deviations of an autistic child:

(a) Inability to communicate: In the autistic child, there is **a serious, deep disturbance** regarding **interpersonal contact,** as well as a disturbance in the need for contact. He/she is not able to establish a genuine, personal relationship. Also, there is little or no eye contact with others, or it is evasive. It seems like he/she fails to see or looks past the other, as if he/she were in deep thought. Also, he/she is not able to communicate via a gesture (mimicry), a look or a smile. He/she is constantly directed only to the concrete objects around him/her, and dislikes being touched.

(b) Withdrawal into a personal world: Based on a disturbed awareness of reality, the autistic child creates a world and life of his/her own and exists in isolation. He/she cannot enter the world of another. He/she avoids any external intervention. He/she is unwilling and suspicious of broadening this narrow world, and he/she responds to attempts to do this with anxiety, panic, and aggression. He/she shows an urge to repetitiously be busy in his/her little world and limits his/her focus to a few things in the little world to which he/she desperately clings. He/she cannot link him/herself up with or orient him/herself outside this impoverished world. Correlated with this, the autistic child shows an avoidance of empty spaces because he/she can't handle them. He/she flees to concrete things and is attached to particular objects. He/she is "glued to that which is available" (Vedder). For example, when he/she must move from one corner of a room to another, he/she doesn't move straight across the room, but moves along the walls, or around the furniture. In addition, these children usually have one-sided interests, e.g., reading and nature.

(c) Deviant emotional life: Because of the faulty contact and emotional relationships with others, the autistic child's emotional life is poor, minimally nuanced, and flat. He/she has difficulty genuinely expressing his/her emotions, except when he/she is angry. His/her face seems limp and expressionless.

(d) Bizarre behavior: The autistic child appears to be apathetic and without initiative. His/her behavior is bizarre (excessive, unusual, strange), and unpredictable. He/she usually is headstrong,

obstinate, fickle, and changeable. Also, his/her emotional expressions are bizarre: he/she can stare or laugh without empathy or show excessive irrational "happiness". He/she shows no inner joy or sorrow. He/she shows no reasonable, spontaneous laughter.

(e) Disturbed speech: Some autistic children are mute, and some have defective speech, which mostly consists of repeating words, or short sentences. Echolalia is also characteristic of these children--the automatic repeating of the words and short sentences said by another (like an echo). In addition, their talk is monotonic, colorless, and sometimes shrill or melodious. Their speech is more spontaneous if it is a response to something communicated by another; they are at ease with a speaking partner. Thus, they can use language (speech) to a limited degree for that purpose. They scarcely answer another's questions. They have a limited vocabulary, with many clichés.

(f) Stereotypic actions: The autistic child will repeat endlessly stereotypic actions, e.g., rhythmic beats with a stick, making rhythmic movements with his/her trunk for hours, putting a tress of hair between two fingers and constantly twisting it. His/her behavior shows a compulsivity. For example, he/she will repeatedly fill and empty a little box with things or keep him/herself meaninglessly busy with strips of paper or is continually fascinated by rays of light which he/she perceives.

(g) Social disorientation: The child has difficulty joining social, pupil, and play groups. He/she can't tolerate new contacts with people, or a change of environment. For example, his/her room must be organized just so. His/her social behavior is malicious; he/she is disposed to sadism and provokes others. He/she shows no respect for adults and is disobedient and stubborn. When he/she is thwarted, he/she protests violently, paired with aggression, crying, yelling and expressions of-dismay. In his/her dealings with others, he/she is never bashful, always unashamed, frank in a negative manner, too "familiar" things with others with a deficient respect and distance. His/her presence and behavior often are extremely awkward, as noted by other persons. Because of his/her faulty contact with reality, the autistic child shows no self-criticism, or attempts at self-improvement. He/she takes pride in what he/she neglects or does wrong.

(h) Motor disturbance: The child's motor abilities are awkward and clumsy; for example, he/she finds it difficult to dress him/herself. He/she is either inordinately sloppy or neat. Owing to this clumsiness, he/she is inclined to withdraw from all sports and games.

The autistic child shows a narrow interest in school. His/her defective potentiality for contact results in a serious under actualization of intelligence. He/she will direct him/herself narrow-mindedly to a school subject which he/she is interested in, but he/she shows fluctuations in attention in subjects where there is no interest. In the classroom, he/she is obstinate, and hard to handle.

With respect to the educating or therapy of an autistic child, the following is emphasized: Because adequate communication is a precondition for educating, because of his/her defective communication, this child is **extremely difficult to educate.** He/she will reject the adults' attempts at intervening and responds strong-headedly and negatively. When contact is forced, the autistic child shows anxiety and panic. He/she is dependent on special care and educating in an institution. Therapy for the autistic child is a long, difficult task which only the expert him/herself should risk. Improvement usually comes "from within" rather than from therapy. That is, there often is a regeneration of the disturbed organic area. However, there is no total recovery.

The autistic child's world must be kept small and narrow and be characterized by a fixed routine. With the autistic child, assignments should be given in general rather than to him/her personally. He/she takes easy orders automatically--the so-called automatic command.

3.5 THE “PSYCHOPATHICIZED” CHILD

Before dealing with this form of deviation, the concept of **psychopathy is discussed.** Carp offers the following description: By a psychopathic personality is understood a personality which—mainly, from deviations in its structure--shows a considerable defect in adjustment to society, and even experiences lasting pain because of his/her disharmonious development.

It is stressed that the environment, as well as the psychopath him/herself, suffer because of his/her difficult behavior.

A psychopathic disposition is congenital and becomes manifest with the person's development. The main characteristic of psychopathy is a **disturbance in the regulation and integration** of human ways of being. Thus, his/her personality is mis-formed and

disharmonious regarding his/her **life of passions, temperament, and character.** The psychopath seeks satisfaction of his/her desires in violent ways in his/her behavior and, therefore, his/her behavior is unrestrained, strange, antisocial, unreliable, and **sometimes** criminal. Thus, owing to his/her deviant behavior, a psychopath **can** become a criminal.

3.5.1 A few characteristics of a psychopathic personality

(a) Excitable state: They are irritable, angry persons who respond to situations in extremely violent ways and burst into violent fits of anger at the slightest cause. They will surrender themselves to wanderlust, alcohol, or sexual excessiveness (deviations) to try to escape from their feelings of unrest and displeasure. They can be inconsistent, fanatic, negativistic, or antisocial in their interpersonal relationships, behavior, interests, occupational pursuits, political views, etc.
(b) Deviant attitudes toward life values: Some life values are exaggerated (e.g., religious fanaticism); others have no meaning for the psychopath. For example, he/she easily leaves his/her family in the lurch or engages in socially unacceptable acts.
(c) Deviant impulsive life: The psychopath, e.g., will shamelessly commit sexual misbehaviors, or show abnormal pleasure after a "high" (e.g., alcohol, morphine), and in this way harm his/her own physical and psychic-spiritual attunement. Other expressions of the psychopath's sick impulsive life are kleptomania (urge to steal), pyromania (urge to set fires), and an excessive drive for power (urge to control others).
(d) Deviant temperament: A psychopath can be either irrationally lively, excited, "happy", and active or depressed and pessimistic. A general characteristic is extreme irritability and an unstable emotional life.
(e) Character deviations: With psychopathy, excessive egocentrism, hysteria, a deviant fantasy life, abnormal suspicion, etc. arise. Usually, there is a lack of moral feelings; the conscience doesn't function and, thus, there are no feelings of guilt or regret over an offense committed. Other possible characteristics of psychopathy are a weak will, quarrelsomeness, and infantilism.

At this point, a distinction must be made between **constitutional psychopathy** (also called genuine or congenital psychopathy) and **acquired psychopathy.** The first is a psychiatric form, as described above. Because of his/her mis-formed personal structure, the

psychopathic child is a task for the psychiatrist and, as such, falls outside the domain of orthopedagogics.

The concept "**psychopathicized" child** refers rather to the child reaching his/her psychopathicized state during his/her development, and it is not a congenital attunement. This phenomenon also is called acquired psychopathy, pseudo-psychopathy, or "developmental" psychopathy. These mean that during growing up, the chid acquires a seeming psychopathy: he/she is so seriously affectively and pedagogically neglected in his/her first years of life that he/she shows a psychopathic image—he/she is "psychopathicized".

In the contemporary literature (compare Bowlby, Hetzer, Spitz, Wolf, J. H. van den Berg) the importance of an adequate mother-child relationship is emphasized strongly, especially regarding the early years of childhood. There is clear evidence of how disturbances in this relationship function as a psychopathy inducing factor.

Serious **affective neglect** can occur because of a deficit in motherly love (e.g., a mentally retarded mother, or a cold, emotionally impoverished mother), a disturbed mother-child relationship, or separation of mother and child by war, institutional placement, etc. Then, the child lacks the emotional warmth, love, and care of which he/she has a need. This lack of or defect in the emotional bond with the primary educator results in inadequate emotional development. His/her emotional life is not stimulated. His/her emotionally impoverished communication with his/her mother means that his/her communication on an interpersonal level remains emotionally impoverished.

Pedagogical neglect means that through mistakes in educating, too little demand for self-restraint and control are made of the child. He/she is not taught norms; he/she also doesn't learn obedience to demands, and the forming of his/her conscience is inadequate.

The above forms of neglect lead the child to show serious deficiencies in his/her psychic development: he/she is **heartless** (because of affective neglect) and **without norms** (because of pedagogical neglect). He/she is so **damaged** in the development of his/her person that he/she cannot adequately link up with his/her environment; he/she has never learned to do this through loving bonding and educating. His/her needs as a child are so badly

frustrated and disappointed that he/she responds with unrestrained, antisocial, and unprincipled behavior, which show great correspondence with genuine psychopathic behavior. Thus, he/she displays the behavior of a psychopath.

To differentiate between the child with constitutional psychopathy, and the psychopathicized child, many orthopedagogues choose the concept of **the child who is extremely difficult to educate** as referring to the child who became psychopathic through serious educative neglect. This is an apparent psychopathy which, in contrast to genuine psychopathy, can be partly or eliminated under favorable circumstances.

The psychopathicized child links up with his/her environment with difficulty; his/her behavior is unrestrained, antisocial, and violently unrestrained. There is no emotional bonding awakened, no conscience formed, or no norms and values acquired to regulate his/her behavior. Fickleness, deformity, and disharmony characterize his/her person. Examples of his/her undesirable behaviors are negativism, sexual misdeeds, theft, lying, unscrupulousness, infantility, etc.

The psychopathicized child collides with the demands of the educator regarding the expression of his/her emotional life. He/she is understandable and influencable by educating only to a minimal degree (the educator cannot get a grasp of him/her). It is very difficult, or almost impossible to bring about an improvement in him/her by ordinary means of educating, such as rewards and punishment. With difficulty, there can be an appeal to his/her conscience, or to the loving bond which ought to exist between educator and child. Because of his/her deviant behaviors and distorted personhood, he/she has difficulty joining in family life, in the classroom, peer group or society. Often, a vicious cycle arises between the child's deviant behavior and the educator's disinclination, and unwillingness to provide loving attention. The psychopathicized child often is involved with the police or child judge. He/she is dependent on entry into a special school or institution (residential orthopedagogy), also called clinical schools, or schools for children who are extremely difficult to educate.

3.6 THE BLIND AND WEAK-SIGHTED CHILD

A child is considered blind if his/her visual acuity* is 6/60 or has a field of vision of **15 degrees or less.**

Viral illnesses, brain inflammation, inflammation of facial organs, deviations in the structure of the eyes, deviations in the optic nerve, etc. can be the origin of blindness.

Because vision is the sense which best informs us about space and objects, the problem of the blind child primarily is that his/her orientation in space and with respect to simple, concrete things miscarries. He/she must listen and touch, and, in doing so, learn to move in space and learn to handle things. He/she has difficulty building up whole impression of things and places which he/she only can experience by hearing and touching. His/her thinking is not supported by visual images. Thus, the blind child must learn to know reality in other ways than the seeing child. He/she must learn to master a hostile, unseen space, and he/she must represent to him/herself unseen images in space. Further, he/she must learn what the name of a thing means without being able to see it.

In addition, the blind child finds him/herself amidst sighted people, and he/she must link up with a world which is attuned to the sighted. For example, he/she cannot play together with other children and, therefore, often feels lonely and excluded.

For the blind child, things in the world are barely knowable (some even unknowable), less usable, refractory, and even hostile. He/she is uncertain in his/her dealing with things and handles them inadequately. Qualitatively and quantitatively, he/she has less of a part in his/her reality. He/she has a limited range of action. He/she has a lack of experiences, especially visual and motor (movement). This includes things which he/she cannot perceive by the sense of touch, e.g., the sun, clouds, stars, smoke, a bird flying; things in motion or which are too large or too small to touch; dangerous things such as fire, etc. He/she cannot participate esthetic experiences.

The blind child has a faulty perception and experience of his/her own body. He/she cannot care for him/herself (e.g., hair, nails).

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* A visual acuity ratio of 6/60 means that the child can see at 6 meters what a normal child can see at 60 meters. With a completely blind child the vision is 0. Normal vision is 1 (60/60).

He/she does not know how he/she looks. Physically he/she is very dependent and must be helped a lot. Therefore, the danger is great of spoiling and over-protecting him. He/she is very aware of his/her own bodiliness. For him/her, the urgent, often unanswerable question is How do I look to another? He/she is preoccupied with his/her own blindness; he/she is thrown back on his/her own handicapped bodiliness; his/her thoughts and deeds are permeated with his/her blindness, outside of which he/she cannot live. The blind child must mostly battle with difficult problems of actualization. He/she must accept his/her own blindness and live from day to day in peace with that which he/she cannot change.

Because of his/her deviant visual ability, the blind child cultivates so-called **blindisms.** These are deviant and peculiar bodily attitudes and patterns of movement, e.g., regarding his/her walking, he/she is hesitant, cautious, restrained, inflexible, tense. He/she is less mobile and does not move fluidly. He/she plays less than a sighted child. For him/her, the space in which he/she moves is threatening. His/her trunk, neck and head show a stiffness. His/her head is fixedly directed straight ahead and hangs when he/she sits. It is directed away from a conversational partner during a discussion. His/her eyes arbitrarily stare into space without expression. The blind child is impoverished regarding facial and bodily expression and spontaneous movement. Where his/her gross motor activities are restrained, his/her fine motor ability is better controlled than that of the sighted.

Blindness interferes with the child's educating, and decidedly is a serious factor impeding his/her being educated. The mutual educator-child communication is impaired, and this often leads to misunderstanding. The child must be led to insight about him/herself and his/her life situation as a blind person. He/she must be supported by the educator to accept, assimilate, and acknowledge his/her own blindness and resulting limitations.

Blindness also impedes the child's personal becoming. Because of his/her blindness, he/she is blocked by feelings of insecurity in his/her exploration of and communication about the world. He/she lacks visual involvement with reality and doesn't know a visual relationship of understanding with persons and things. He/she is addressed and enticed less by visual things. Also, his/her acquisition of language is retarded because things and movements

which he/she cannot see are difficult to name. His/her psychic development (especially the actualization of his/her cognitive potentialities) necessarily is under actualized. He/she has to interpret concrete reality via experiences of touch and knows no optical impressions or colors. His/her world of imagining is impoverished, and schematically constructed. In general, his/her experiential world is impoverished and limited. Also, he/she **lived experiences** (sometimes intensely) his/her dependency, helplessness, inadequacy, and loneliness. He/she lacks mimicking, gesturing, and expressing feelings in associating with others. He/she lacks the other's look--the point of encounter between persons. Therefore, his/her interpersonal contact is faulty. He/she must compensate by the special use of hearing. Consequently, his/her emotional life can become nuanced in contrast to that of a deaf child. His/her thinking can be abstract if he/she has at his/her disposal the language to do this. Blindness is viewed as a lesser impediment to psychic development than is deafness.

The blind child is dependent on special educating and teaching. Learning Braille writing is a difficult task for a young blind child. In addition, these children should be given many opportunities for expression and creativity. In the physical education of a blind child, the emphasis falls on exercises for motor skills, bodily attitudes, movements, bodily and spatial orientations. Sports and games should be encouraged for the sake of these children encountering others, and the cooperation and competition which these include.

The weak-sighted child has a vision of between 20/70 and 20/200 in his/her best eye after all possible medical and ophthalmologic help, or he/she has a serious, progressive eye defect, or he/she suffers an illness which seriously impairs his/her eyesight (Hathaway). These children do not have useful remaining vision, but are far-sighted, near-sighted or can see well but only in a limited field of vision, etc. Thus, because of their limited eyesight, they cannot follow ordinary teaching, but, nevertheless, are viewed as sighted.

The weak-sighted child finds him/herself in two worlds--that of the sighted (the visual world) and that of the blind (the world of the sense of touch). In addition, he/she has a qualitatively and quantitatively lesser world and lacks certain visual-sensory experiences. Also, he/she finds him/herself in a world attuned to the sighted. Because of his/her faulty power of visual

discrimination, he/she lives, as it were, in a haze, and **things** and **space** are less manageable for him/her and, therefore, are dangerous. He/she experiences space as offering limited possibilities of movement—he/she is uncertain about the presence of things because he/she can't perceive them sharply and clearly. Because he/she is assailed by the sensory organ most essential for communication, his/her contact with fellow persons is incomplete in certain respects. More than the sighted child, he/she depends on help and protection. A feeling that he/she is not welcomed by the sighted can lead to feelings of rejection and loneliness.

The weak-sighted child occupies an uncertain status: where the blind child's limitation is accepted, and he/she usually gets much attention, sympathy, and help, the weak-sighted child is viewed as "normal" and is measured by the yardstick of the sighted, and often the same demands are made of him/her as of the sighted. It is reasoned that he/she can see and, thus, can help him/herself. Also, the weak-sighted child sometimes looks unattractive (his/her thick glasses, e.g., give his/her face a strange appearance), and he/she doesn't always easily join in with sighted children.

The weak sightedness restrains his/her psychic development and limits his/her physical movements. A retarded motor development and defects in bodily attitude often are characteristic of these children.

In addition, the weak-sighted child is more problematic than the blind child (Hijmans van den Bergh). He/she is more moody, restless, and difficult to handle. He/she finds him/herself in a difficult situation: he/she can see, but he/she also cannot see; he/she is superior among the blind, and inferior among the sighted. His/her uncertainty about his/her role in society and his/her abiding fear that, his/her defect can worsen and lead to feelings of insecurity. He/she fears his/her body and future because he/she is uncertain what role his/her body (as a weak-sighted body) is going to play in the future. The following inadequate attitudes toward one's own weak sightedness are found in these children: a disposition to give up, aggression, restlessness, and weak directedness (motivation), according to Hijmans van den Bergh.

At school, the weak-sighted child is influenced by his/her perception of teaching material, especially with reading and writing, and in his/her whole perception of the chalkboard, maps,

illustrations, etc. In his/her attempt to perceive wholes, his/her visual perception is diffuse.

As far as his/her being taught is concerned, the weak-sighted child ought to be in a special school where special buildings, lighting, and technical aids are provided. The aim of teaching him/her is to exercise and apply, as well as possible, his/her remaining eyesight, and the emphasis is on perceiving details. The weak-sighted child is sighted, and he/she needs to be helped to improve his/her visual achievement. For these children, **reading** is not only a learning subject--it is an exercise in perceiving, in seeing. With reading, at first, a large font is used. In addition, in teaching these children, stress is laid on handicraft, music, and gymnastics (teaching movements).

3.7 THE DEAF AND HARD OF HEARING CHILD

There are a variety of origins and forms of hearing disturbances. Deafness can be a **congenital** defect, e.g., if the inner ear does not develop adequately because of a (pregnant mother's) viral infection. Deafness can be **acquired** with inflammation of the cerebral membrane, which can give rise to severe deafness. The sense of hearing can be damaged before or after birth. The concept of **pre-lingual deafness** points to a hearing loss arising or existing before the child possesses any language and, thus, cannot learn language via hearing. The related concept of **deaf and dumb** is incorrectly used, since the child is not actually dumb, but simply because of deafness, has not learned to speak.

The diagnosis of a hearing defect is a specialized task--the audiologist, and ear-specialist must determine the degree of hearing loss and eliminate it (partly) with the help of modern equipment (e.g., hearing aids).

With the deaf child, the fact that he/she is backward in his/her language acquisition is salient. Because he/she masters abstract concepts with difficulty, his/her psychic-spiritual life is defective on an abstract level. Because of his/her laborious, and faulty use of language, his/her association with hearing persons is difficult. Because hearing is of special importance for the child's psychic-spiritual development, it can be expected that this development will progress inadequately. Because he/she is cut off from the world of sound, the development of his/her emotional life is faulty--it

remains impoverished and without subtleties. He/she lacks the familiarity and orientation which sound provides. For example, he/she is unable to gauge the inner emotional voice of another (anger, sorrow, joy, warmth, etc.). He/she doesn't experience the rhythm, excitement, or softness of music.

Where the hearing child's world lies around him/her and familiar sounds allow him/her to feel secure, the world of the deaf child lies only in front of him/her in what he/she can see, and, because of his/her disturbed hearing, he/she does not know what happens behind him/her. This gives him/her feelings of uncertainty and insecurity, paired with anxiety, and tension. He/she is continually surprised by the unexpected because no sound warns him/her. Because a person also communicates with reality via language and sound, the deaf child lacks many life experiences, and he/she has a limited horizon of experiences. Thus, he/she lives in a different, silent world which is narrower and more impoverished than that of the hearing child.

Of importance is the fact that, because of his/her deafness, his/her acquisition of language and speech are slow, and faulty, and have a restraining influence on his/her thinking. In his/her language, thinking, and in his/her directedness to the world, the deaf child is bound to the concrete perceptual. He/she does not have at his/her disposal the language (concepts) to think abstractly or to optimally actualize his/her cognitive potentialities. Also, in his/her fantasy world, he/she remains limited, and on a perceptual level (bound to what he/she has seen). Thus, his/her psychic under actualization is characterized by a defective vocabulary, by being bound to perceptible situations, and by being unable to think abstractly.

Because the deaf child's communication via language is handicapped, he/she communicates with his/her eyes, gestural expression, and sign language. Sign language and lip-reading are natural means of communication for him/her.

The following are characteristic differences of the deaf child: he/she expresses him/herself more frankly regarding his/her sexuality, because of his/her isolation, he/she does not learn to know the taboos and prohibitions of society, and because his/her sexuality speaks to him/her primarily on a vital level. The deaf child is strongly disposed to feelings of inferiority, and he/she tries hard to compensate for this, sometimes with great courage and a tendency

to rate him/herself and his/her achievements too high—thus, he/she overestimates him/herself, and shows conceitedness. He/she has a special fear of the strange, new, or unknown. Also, he/she is more **egocentrically** attuned than the hearing child. Expressions of this are greed, distrust, gullibility, envy, jealousy, impatience, etc. Thus, in general, he/she shows negative feelings toward fellow persons, and an inability to feel the situation of another. Also, because of his/her restrained becoming, the deaf child is somewhat infantile. He/she has a lack of self-control, self-understanding, self-insight, and a feeling of responsibility. Often, his/her behavior is trying, pig-headed, aggressive, or he/she tends to withdraw him/herself.

The acquisition of language, as a means of communication, is a **formal task** for the deaf child. In the group of children with hearing disturbances, there is a range from slightly hard of hearing to severe deafness. According to modern audiology, in almost all cases of hearing disturbances (even with extreme deafness), there is some hearing remaining which, with the help of hearing aids, can be amplified so that the child, through support, to a degree can be involved with acquiring language. Thus, for many of these children, a world of sound can be created. This remaining hearing, and its optimal use, as well as the question of whether the child is prelingually deaf, determine the ways in which the child will acquire language.

The child who is severely deaf, or "stone deaf" must acquire language in visual ways, e.g., by lip-reading, written images, objects, pictures, gestures, visual imitation, etc. Earlier, the emphasis was on sign language and lip-reading as a means of communication. Nowadays, it is on articulation-teaching. Thus, the deaf child especially learns to know his/her world through seeing and touching, and, in doing so, cultivates a concrete-perceptual attunement to it. His/her language acquires the stamp of words visually acquired and built up from sounds by which natural assimilation is lacking, and which gives it an artificial sound. In addition, the deaf child more easily learns words which name concrete things, than words which have abstract meaning. He/she uses language for representing rather than thinking. Consequently, his/her language is more limited in scope, more impoverished, more superficial, and more infantile than that of the hearing child. For him/her, language serves in defective ways to make use of his/her intelligence (e.g., think) and to express his/her own inner life.

Nevertheless, sometimes these children burst out in eruptive language expressions because of their aggression, inability to meaningfully assimilate their deafness, as well as anxiety, uncertainty, insecurity, guilt, search for acceptance, infantile attunement, strong preference, rejections, etc.

In teaching the deaf child, the emphasis is on language acquisition. For his/her adequate psychic development, language as a symbol system, and means of communicating, must be inculcated. These children are referred to individual speech classes where use is made of mirrors, hearing aids, etc. On a concrete level, simple linguistic concepts need to be inculcated. For the deaf child, free expression is important--in music, images, movement, gymnastics, sports, games, etc. In his/her educating, the vocational implications of his/her deafness must be attended to.

Where, with deafness, the hearing loss is 90 decibels and more, a child is viewed as hard of hearing with a hearing loss of approximately 30-70 decibels. Thus, the hard of hearing child has more remaining hearing at his/her disposal: he/she can hear, if spoken to loudly, or if he/she has a hearing aid. Thus, he/she can acquire language by means of acoustic methods, and, in teaching the hard of hearing child, the emphasis is on the command of language and being on guard against verbalisms (the use of words without knowing their correct meaning).

The following appear in the disturbed psychic and expressive life of the hard of hearing child: diminished interpersonal contact, and a disposition to withdraw, egocentrism, distrust of fellow persons, violent expressions of feelings, and anger, feelings of loneliness. The hard of hearing child can appear to be less intelligent--since he/she cannot hear what is said, it seems as if he/she doesn't understand what is said. Also, he/she is restrained in his/her acquisition of speech and language; usually his/her speech is unclear and his/her language limited.

3.8 THE MENTALLY RETARDED CHILD

This involves children who have defective intellectual potentialities at their disposal. Intelligence can be described as the power of a person to break through new situations (to insights, meanings, possibilities--G.Y.) which he/she continually confronts. It is emphasized that intelligence is only a **potentiality** which the child

must actualize with the support and guidance of his/her educators, and by his/her own efforts. In many cases, there is a child under actualizing his/her intellectual potentialities to a greater or lesser degree. A child has at his/her disposal an intellectual potentiality, but because of different obstructing and blocking factors, he/she does not actualize it. Then, the phenomenon of apparent mental retardation arises.

The orthopedagogue, in evaluating a child's intelligence, should not focus only on his/her intelligence quotient (IQ), especially in borderline cases, or where this involves placing the child. Different, diverse factors influence the child's implementation of intelligence, and its functioning; e.g., educative neglect, the child's attunement, his/her inability to concentrate, his/her language potentiality, his/her emotional attunement, and his/her physical attunement.

Mental retardation is a many-sided problem. As well as their intellectual deficiency, usually these children show one or more of the following disturbances: motor, sensory, speech, emotional, personality, behavior, defective language, problems concentrating, etc. Thus, they find it extremely difficult to learn, and they also are difficult to educate. Further, one can differential among slight, moderate, and severe mental retardation (see below).

The factors giving rise to mental retardation can be one or more of the following: hereditary, illness during pregnancy, brain infection, brain damage, metabolism, biochemical illness, thyroid defect, incompatible blood types (of parents), deviation in the chromosome pattern (the Down's syndrome child), etc.

The two main forms of mental retardation are:

3.8.1 Low ability

Children with IQ's from 80 to 90 belong to this group. This comprises approximately 15 percent of the school population. These children also are called dull-normal, and at school often progress approximately to grades 7 or 8. They are the group between the feebleminded, and children with normal intelligence (IQ=90-110). Thus, this group is somewhat less endowed than those of average intelligence. As can be expected, the psychic-spiritual development of the low ability child is slow, and he/she also reaches a ceiling as far as his/her psychic achievements are concerned.

Regarding his/her ability for abstract thought, he/she remains a "beginner". In this connection, Vedder makes the following comparison: if we view the different steps of intelligence as rooms of a house, then the normally gifted can move around well in the room of abstract thoughts, the poorly gifted steps over the threshold, but remains perplexed, and the moron remains standing in front of the door.

The poorly gifted or low ability child finds it difficult to acquire the basic skills (reading, writing, arithmetic) at school and, in general, experiences learning difficulties. At school, a slow tempo must be maintained with these children, and they have a need for more practice than those of average ability with respect to the learning material. The learning material offered to these children must be limited. They experience problems with arithmetic concepts, and abstract computational work. The same holds for difficult fractions and the so-called "language-sums". Because of their limited abilities, school tasks must remain limited to a concrete perceptual level.

3.8.2 Mental deficiency

The collective concept **oligophrenia** (mental deficiency) holds for the child who falls in this group. With the mentally deficient child, the deficiency is usually paired with disturbances in his/her emotional life (which remains impoverished and without nuances), his/her volitional life, conscience forming, and impulsivity. These children do not have at their disposal the ability to independently see-through situations critically and, hence, they are open to improper influences. Later, in their adult lives they are dependent on low wages and simple, routine work.

3.8.2.1 The following four forms of the appearance of mental deficiency are distinguished:

(a) Moron: The moron child has an IQ from approximately 50 to 70. At 10 years of age, he/she has a mental age of 5- to 7-years; at 15, a mental age of 7.5- to 10-years. These children do not progress at school any further than grades 5 or 6. They can learn to read, write, and calculate on a **simple** level. In their thinking, they are limited to the concrete level. Their behavior often is unstable, and problematic because they cannot always foresee the consequences of it. Also, temperamental disorders often appear with moron

children. The name **disharmonious moron** refers to that group exhibiting conspicuously asocial and antisocial behavior.

Teaching the moron child must take place with a slow tempo; the learning material offered must be limited and concrete. Teaching and educating are directed to handicrafts, which many of these children ultimately will perform.

(b) Imbecile: This is the IQ group of approximately 30-50. At 10-years of age, the imbecile child has a mental age of 3- to 5-years; at 15-years, a mental age of 5- to 7.5-years. These children are not open to ordinary teaching, and not many will receive teaching in the usual school subjects. They acquire a faulty language, on a simple level. They are not able to learn to communicate via written language. In teaching the imbecile child, the emphasis is on handicrafts, and limited knowledge. The imbecile child cannot maintain him/herself in society, and later as an adult is dependent on sheltered work. He/she can learn a limited degree of routine and discipline. Also, he/she can concentrate only for a short time. He/she has no logical thoughts, not even on a concrete level. He/she is disoriented regarding time, place, and his/her own person. The imbecile child is disposed to respond to situations with excessive anger. Normative educating with these children is almost impossible.

(c) Idiots: These are children with an IQ of less than 30. At 10-years of age, the mental age is 3-years or less; at 15-years of age, it is 4.5-years or less. This group is so-called "uneducable" and are in institutional care. They have little psychic life, and almost no language--they possibly can learn a few words, while some never learn to speak. They lead a vegetative existence, cannot feed, wash, or dress themselves, and remain unclean. They cannot perform any work. and understand only the simplest of assignments. For that reason, they are unable to avoid risks. Most idiot children die young or spend most of their lives as patients in bed. They can sit for hours and engage in rhythmic movements. Many of them have a disturbed sense of pain. Bending over and screaming often characterizes the life of these children.

(d) Down's syndrome (Mongolism): With this exceptional form of mental deficiency, the child has a conspicuously different physical appearance, which is the result of a deviation in the pattern of the chromosomes. The form and position of the eyes are characteristic--

they are almond shaped, and permanently slanted (like that of the Mongolian race, which makes this name for this mentally deficient group objectionable--hence, the name Down's syndrome). The child with Down's syndrome also has a flattened skull, thick tongue, is stout, and has an erect bodily posture; his/her neck is short and thick; his/her nose is small and broad; his/her handline is conspicuously different. These children are affectionate, sweet, and passive as babies. They learn to stand and walk at a late stage, and to be tidy. They respond quickly to their own impulses without any control or reserve. They tire quickly. These children are sensitive to the attitudes of others toward them. They respond to possible rejection by the parent with irritability, and obstinacy.

Educating and teaching the mentally retarded child require endless patience, love, and understanding. These children are placed in special schools, and classes, and in teaching them the emphasis is on individualization. Socially, they are extremely vulnerable persons. They need consistent, and tranquil guidance, and must be prepared for a later existence on a simple level of life.

3.9 THE PHYSICALLY HANDICAPPED CHILD

This has to do with the child who, with one or more of a wide variety of possible physical handicaps, does not have normal use of his/her trunk and limbs.

Injuries, illnesses, inflammation, under development, brain defects, etc., which the child experiences before, during, and after birth can give rise to all sorts of physical handicaps. Examples of these are crippling from polio, spastic crippling, orthopedic deviations of the hips, arms, and legs. These deviations usually are paired with other disturbances, so the physically handicapped child often is multi-handicapped, e.g., minor handicaps of hearing, and seeing. The spastic child, e.g., usually shows disturbances in his/her intellectual, and motor abilities, sense organs, and speech. Here the aim is to describe what being physical handicapped **means** for a child and his/her personal becoming:

Being physically handicapped strikes the child in his/her complete existence. Because of his/her physical handicap, there is a loss of the obviousness of living. Where a non-handicapped child can move, play, run around, explore his/her world, etc., this is not possible for these children. The physically handicapped child

struggles with his/her being handicapped. He/she is caught up in his/her own body. For him/her, this is a stumbling block in his/her exploration of his/her world and, therefore, also for his/her personal becoming. Also, there is a **disturbed bodily lived experience.** This means that he/she shows a negative attitude toward his/her own handicapped body. His/her body means conflict for him/her. On the one hand, his/her body fails him/her and, on the other, it is a precondition for his/her existence. He/she rejects his/her own body because it is unfaithful, and a hostile enemy. It is difficult for him/her to distance him/herself from his/her handicapped body, and he/she experiences his/her being handicapped intensely on an emotional level, among others, as a personal injustice.

The central fact remains that the physically handicapped child's psychic (cognitive **and** emotional), and physical development are restrained. His/her limited physical activity, and mobility prevent him/her from being able to play, and physically explore his/her world adequately. For him/her, this means diminished life experiences, defective possibilities for contact, and restrained intellectual development. His/her experiential world remains small, also with respect to social contact. To a great degree, he/she is dependent on others for his/her care.

Mistakes which the educator often makes with the physically handicapped child are unease in dealing with him/her, overprotecting, spoiling, overindulging, rejecting, etc. In this way, a physically invalid child can easily be educated into a mentally invalid person.

Because he/she experiences him/herself in the eyes of fellow persons as different, inferior, and unaccepted, the physically handicapped child is prone to withdrawal, social isolation, and loneliness. He/she feels that fellow persons view him/her, in the first place, as handicapped, and, in the last place, as a person. Thus, his/her experience of being different disturbs his/her interpersonal communication. In addition, he/she displays a search for acceptance amid shortcomings, and failures. Further, his/her physical limitations lead to feelings of frustration, helplessness, rage, anxiety, uncertainty, insecurity, impotence, and despondency. He/she is self-conscious, ashamed, and self-depreciating of his/her body. He/she is unable to express his/her disturbed feelings via his/her body. He/she responds to his/her conflict, and frustration,

in addition to the mentioned possibility of isolation, with aggressiveness, by which he/she then tyrannizes his/her entire environment, or he/she responds with egocentrism.

The physically handicapped child searches for the sense of his/her life, and distress as handicapped, he/she lived experiences his/her existence as less meaningful, or even as meaningless, along with experiences of self-pity, rebelliousness, desperation, bitterness, etc. "Now why must only I be handicapped?"

The major educative task is to teach the physically handicapped child to assimilate his/her handicap to arrive at self-acceptance. Besides different, adapted teaching, and intensive medical and paramedical treatment (by the neurologist, orthopedic surgeon, physiotherapist, etc.), these children are dependent on pedotherapy to give them an opportunity to express their disturbed feelings, and to support them in assimilating their handicap, other problems, and unassimilated experiences.

3.10 THE ILL CHILD

The fact that a child can have a long-term illness gives rise to questions such as the following: What does the world of the ill child look like? How is he/she impaired psychically-spiritually by the illness? What tasks does his/her being-ill hold for the child? How is the ill child's becoming adult actualized, since he/she is disturbed in his/her biological moment, and his/her body, by which he/she explores his/her world is impaired by an illness?

A few examples of chronic and long-term conditions of physical illnesses which can "paralyze" the child are the following: serious burns, heart disease, diabetes, nephrosis, kidney disease, leukemia, asthma, hemophilia, tuberculosis, skin disorders, rheumatic fever.

Also, the ill child experiences that his/her body has left him/her in the lurch. In addition, there is mention of obviousness because of what he/she previously, but no longer could do, and what his/her peers still can do. There are certain things he/she cannot or may not do. His/her sickness gives rise to an impotence, and feeling limited, and leaves him/her more dependent than previously.

The illness prevents the child from associating with peers as before and, thus, entails for him/her the possibility of seclusion, loneliness,

and boredom. Illness also means for the child pain, discomfort, and disruption; and, less than the adult, he/she is not able to understand the sense of his/her illness, suffering, and hardship.

The physical illness and related treatment often stimulate fear in the child. He/she is removed from the trusted, secure atmosphere of his/her home, and is placed in the unfamiliar, and often anxiety stimulating atmosphere of the hospital. There, he/she fears the unknown, the threatening, the pain, and discomfort, and the many examinations by unfamiliar doctors, with strange equipment. He/she fears the seclusion; he/she is afraid that he/she will not be healthy again, or that he/she might die.

Also, he/she asks about the meaning of his/her being ill, about its origin, about the sense of his/her distress and misery, and about the sense and destiny of his/her life as an ill life. He/she can respond to these questions with rebellion and aggression, or isolation, or regression, as well as to his/her situation of distress.

The child's being ill limits his/her going out to the world and, thus, his/her exploration of and learning to know it. This also limits his/her dealing with things. His/her restricted possibilities of movement limit his/her playing, which is the most essential way a secure child is involved with reality (Langeveld). In this respect, the ill child is "less childlike" in the world.

In addition, the illness is a disturbing factor in his/her communication with his/her fellow persons and, therefore, in his/her being educated, and personal development. There is disturbed and defective interpersonal contact. Being ill makes its appearance in silence. The sick person is more concerned about him/herself, or lacks the energy to maintain an active relationship with the world. Illness and fatigue decrease the possibility for contact, and reduce the world by which communication is diminished, or falls away (Bonekamp). Also, the child experiences his/her illness under the eyes of fellow persons, and, by the glance of the other, he/she is thrown back onto his/her own sick body. The child tends to withdraw into him/herself because, with his/her illness, he/she becomes objectified by others.

The ill child finds him/herself in a landscape of sickbed, sickroom, and hospital. The child who is in a sickroom or is bed-ridden in a hospital is restrained in his/her exploration of reality and,

therefore, has a limited world. Besides, the hospital as an educative situation cannot be compared with the home. For the child in the hospital, the necessary communication with his/her parents is missing, as well as the trusted and secure space out of which he/she must learn to know his/her world. The child must endure the separation from his/her mother, from the rest of his/her family, and the familiar home environment, and he/she must assimilate the unfamiliar environment of the sickbed. Often, he/she expresses his/her unassimilated experiences of being ill, and of his/her correlated feelings of insecurity, loneliness, and anxiety by excessive crying, bedwetting, eating disorders, aggression, withdrawal, etc.

The following experiences often appear in the disturbed psychic life of the ill child: The initiative to explore his/her world is lacking because he/she cannot conquer the biological moment, and the related feeling of helplessness; consequently, he/she feels excessively insecure. On a childlike emotional level, he/she experiences his/her bodily impotence and being afflicted—also, in the eyes of fellow persons, and he/she is caught up in his/her own bodiliness, with the strong possibility that he/she will reject his/her own sick body. The long-term physical illness awakens in the child a general basic life uncertainty, as well as a cloudy future perspective. Because of his/her physical condition, the ill child, on a psychic level, is disposed to being self-centered, self-conscious, and sensitive. He/she is entirely aware of his/her conspicuousness and feels inferior about it. In addition, he/she feels anxiety and uncertainty, also in communicating with fellow persons. He/she seeks the sense of his/her own disability. In addition to his/her physical dependency, the ill child needs help and support regarding the acceptance and meaningful assimilation of his/her situation of distress. Consequently, many ill children also must struggle with a problem of accepting and assimilating their own physical illness.

The ill child poses a special educative task for the adults who deal with him/her. As far as teaching is concerned, the chronically ill child is placed in the hospital school. It is necessary that everyone who deals with him/her will honor a pedagogically accountable approach to him/her, i.e., doctors, nurses, physiotherapists, technical personnel, etc. The ill child must not be treated as a miniature adult patient; he/she is an educand-in-distress who has need for help and support in assimilating his/her illness. Because he/she often does not receive this help in everyday educating,

he/she is dependent on pedotherapy, as corrective educating or support to attribute positive meanings to his/her being-ill.

3.11 THE CHILD WHO IS DIFFICULT TO EDUCATE

The distinction between the child with removable educative difficulties, and the child who is difficult to educate because of a handicap which can't be eliminated is discussed in Chapter one.

Here, the concern is with the child who **has** a correctable problem because he/she is difficult to educate. Regarding this group of children, concepts are used such as the "neurotic" child*, the "emotionally disturbed" child, and the child with behavior difficulties. The present form of disturbance includes these children. Here, the child's problem is the result of child conflict, of thwarting the child's need for security, and it points to mistakes of educating, educative neglect, and experiences which the child is unable to assimilate.

These factors drive the child into a constraining position of anxiety and distress, and they provide the ground for his/her deviant behaviors. Distress, anxiety, disturbed communication, and restrained becoming are characteristic of the existence of the child difficult to educate, and his/her deviant behavior is an expression of his/her inner conflict. These are the ways he/she responds to his/her distressful situation. Through his/her deviant behaviors he/she comes into conflict with his/her parents, and environment. Then, neither the child nor his/her behaviors are acceptable. Only through educating does the child learn socially acceptable behavior. This educating must be characterized by adequate affective relationships, by making demands of self-restraint, and by the exemplification of norms and values. Through inadequate educative intervention, he/she does not learn to take fellow persons into consideration in his/her behavior.

The line of connection which holds here is schematically represented as follows:

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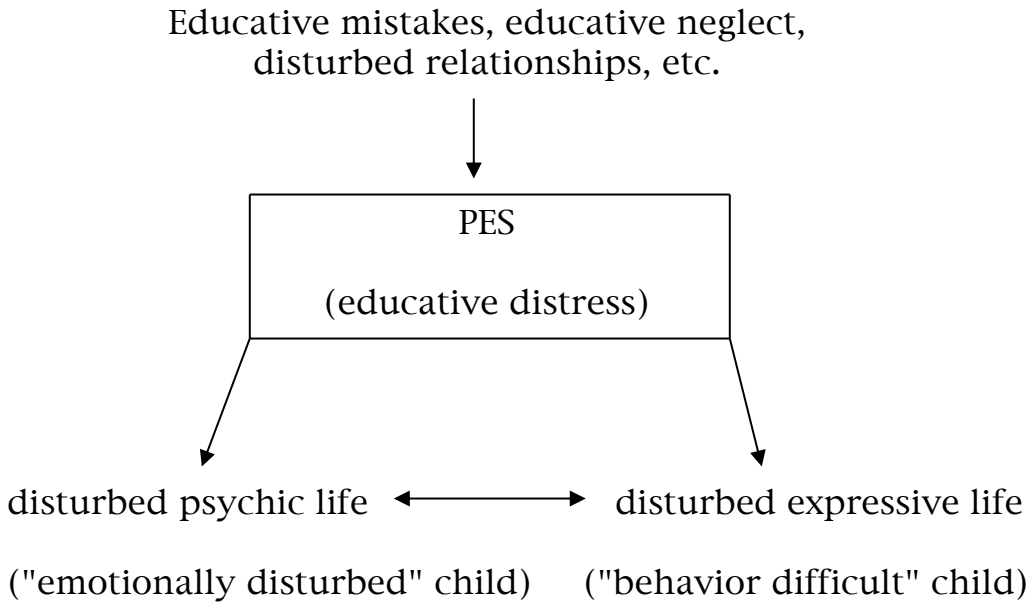
* The orthopedagogue hesitates to use the concept "neurotic" with respect to a child with a disturbed psychic and expressive life because it suggests that the child shows a psychiatric image, while here the primary concern is with the child-in-educational-distress, and the emphasis is on disturbances in educative relationships.



From the lengthy description of the essentials, and the origins of the PES in Chapter two, this image of the child who is difficult to educate ought to be clear. The following concepts raised in Chapter two hold with respect to the child difficult to educate: educative distress, disturbed child life, thwarted child psychic needs, educative neglect, disturbed communication, disturbed psychic life (anxiety, insecurity, etc.), disturbed expressive life--as defensive, fleeing, and constrained behavior, the result of educative mistakes, disturbed relationships, and inadequate family situations.

3.11.1

The deviant behaviors shown by the child-in-educative-distress can be placed in the following groups:

(a) Regression: Here the child falls back on a lower level of becoming in behaviors such as nightly bedwetting (enuresis nocturna), soiling pants (encopresis), thumb sucking, nail biting, stuttering, baby talk, etc.

(b) Isolation: The child withdraws into a private world of dreams, fantasies, and seclusion.

(c) Aggression: Anxiety leads to aggression. The secure child is not aggressive. Here, the child responds to panic with self-defense, or attack. He/she shows resistance, disobedience, impudence, wrong-

headedness, brutality, rebelliousness, an oppositional disposition, refusal of demands, protesting, etc.

(d) Being restrained: The child appears restrained, and not free in his/her behavior, achievements, and expressive life. He/she is unable to be him/herself, and to express his/her feelings in adequate ways. He/she lacks the daring to deal with new situations, and explore his/her world; also, in his/her behavior, he/she clings to the known and trusted. His/her under achievement at school essentially can be viewed as a form of deviant behavior.

(e) Being unrestrained: Because of his/her inner tension and dissatisfaction, the child's behavior is excessively violent, and uncontrolled. He/she strives for what immediately gratifies him/her and becomes aggressive when he/she meets opposition for this. For example, he/she might steal because of disappointed love, because he/she feels he/she did wrong. What he/she steals might merely be a symbol of what he/she would want to take if he/she could, but which is abstract and, therefore, can't be taken, i.e., **love.** The child also can look for trouble and, in doing so, get the intervention, attention, and "acceptance" which otherwise he/she wouldn't receive. Other forms of unrestrained behavior are lying, vandalism, truancy, sexual misconduct, etc.

With respect to the PES of the child difficult to educate, the parents are dependent on family therapy, or parental guidance for the sake of eliminating educatively impeding factors. The child is dependent on communicative pedotherapy during which his/her educative distress can be eliminated, and his/her disturbed psychic life can be corrected (see Chapter four).

3.12 THE CHILD UNPREPARED FOR SCHOOL

There are individual differences in children regarding the tempo of psychic and physical development. The growing up of some children occurs quickly; with others it is actualized more slowly. Aptitude, constitution (including the biological) and educative influences are three factors which determine the differences in developmental tempo. The orthopedagogue involves him/herself with the factors which have impeded the child's growing up, e.g., educative mistakes, educative neglect. Such factors can hinder the child's school readiness when, at approximately six-years of age, he/she becomes a school beginner. When there is almost no psychic

disturbance of the child, and no environmental defects, they do not reflect themselves in a deteriorated school achievement (Van Krevelen). When these circumstances are present for the **school beginner**, the child clearly runs the risk of achieving inadequately in school (Haenen).

The concepts **school ready, school preparation** (Rupp), **school eligible,** and **school qualified** (Haenen) indicate that the child has progressed to an adequate degree from the attunement of a preschool toddler to the attunement of a school child, as far as the surrounding reality is concerned. In his/her child-being, he/she has progressed from the "form of a little child" to the "form of a school child" (Hetzer). The toddler is still uncritical, playful, searching for what provides immediate gratification; he/she still lives emotionally in the maternal world. In contrast, the school child is more independent, he/she is less mother bound, he/she can take a position and view things critically. He/she has progressed from an emotional to a knowing attunement to reality. When a child does not actualize this progression adequately, and yet must enter the school world, concepts are used such as **not ready for school, unprepared for school,** and **school vulnerable.**

When the child is school ready or school prepared, he/she must fulfill the following criteria (following Engelmayer):

- He/she must be prepared to accept an assignment (task), and feel enough responsibility to complete it (self-collected and self-controlled).
- He/she must have good attentive concentration, can attend in class, and not let his/her attention be diverted by disturbing, external influences.
- He/she should have (on a child level) an objective, businesslike attunement to reality.
- He/she must have an "eagerness to learn"--interest in the learning material.
- He/she must be prepared to suppress his/her own impulse (urge to move, speak, etc.) according to the teacher's demands.
- He/she must have the possibility to arrive at

good relationships with the teacher and fellow pupils;
i.e., he/she must be able to join in the class situation.

- He/she must be able to obey the class rules--don't disturb, be restless, withdraw into him/herself.

School readiness is not merely a matter of intellectual development but, indeed, of the child's total personal becoming. Certainly, intelligence is a factor, e.g., a mentally deficient child will not be school ready at six-years.

The child not ready for school, because of a delayed, slow, or impeded personal development, is not ready to benefit from the teaching for which his/her cognitive potentialities are not sufficient. He/she is too childish and too playfully attuned to carry out school tasks and fulfill school requirements. His/her task awareness is not yet adequately developed.

The following can be given as some origins of being not ready for school:

(a) The child's **ability** can be an impeding factor. The course of the child's physical development can be too slow, so that he/she is not physically ready for the activities which he/she must perform at school (e.g., motor abilities to be able to write). A slow psychic-spiritual development is correlated with delayed physical development (psychic development is carried by the biological).
(b) Especially **educative** and **formative influences** can work to retard (the child's readiness). The child must be educated to school readiness, or preparedness. Through educative and social neglect, the child is not formed adequately for school readiness. He/she must have an opportunity to practice, and gain experience with a variety of materials, with completing tasks, obeying demands, and self-control. The emotional educative relationship (affective educating), within which the child finds him/herself in the first years of life, functions as an extremely meaningful preparatory influence--if he/she feels safe and secure within, and from this relationship, he/she will explore his/her world. A feeling of insecurity, and the related feeling of helplessness disturb the child's daring and restrain him/her in his/her world exploration, in his/her learning to know reality and, therefore, in his/her psychic development.

The spoiled child, e.g., doesn't learn self-control, task completion, acceptance of authority, and orderly behavior. He/she remains on the level of pleasure, instead of progressing to a level where he/she must do what reality (school) demands of him/her, and not what gives him/her pleasure.

(c) The **cultural-pedagogical level** of the child's educating is a decisive factor. The cultural atmosphere, and intellectual sphere within which the child grows up influences his/her school preparedness. It is important that the parents promote the intellectual development of their child by offering him/her adequate preschool experiences with activities such as reading to, telling stories, learning little poems, educative games, and by providing children's books, jig-saw puzzles, playing school, promoting language acquisition, by the child learning things and relating them, urging the child on to thinking activities, etc. Also, the parents' positive attitude toward school stimulates a corresponding positive attunement. If the cultural-pedagogical level is low, this means the child is being inadequately prepared for schooling.

In connection with the matter of school preparedness, Rupp* emphasizes the connection between facets of the child's educating, and his/her progress in the primary school. He considers the primary school as a criterion for deficiencies in educating, and becoming, i.e., educative deficiencies and restraints in the child's development wreak havoc on him/her in the form of vulnerability in the primary school. Rupp uses the concept school preparedness to indicate that the child can have a reasonably successful school career, that he/she is able to achieve well, that he/she can "deliver" at school. The school vulnerable child is, to a great degree, dependent for his/her school progress on the teacher, on the didactic methods, on the class size, and on other teaching circumstances.

The child unready for school has difficulty linking up with the school because he/she cannot deal with the new situations in which he/she continually finds him/herself. Because of this, school is problematic, and meaningless, and he/she signifies this with negativity and anxiety. His/her school existence is characterized by

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* Rupp, J. C. : **Opvoeding tot Schoolweerbaarheid** (Educating to prepare for schooling), Wolters-Noordhoff, Groningen, 1971.

emotional disturbances (confusion, anxiety, tension), under achievement, and behavior problems. He/she shows a negative focus on work, reading, and spelling difficulties, a dislike for school, and usually regressive phenomena, such as bedwetting.