# CHAPTER 3

# SPECIFIC FORMS OF DISTURBANCE

## 3.1 INTRODUCTION

In the present chapter, a brief description is given of a number of disturbances or deviations in children. The great variety of deviations can be divided into different groups. The main distinction between being restrained (rectifiable deviations) and being handicapped (permanent deviations) was already made. An additional possible division is:

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

However, a number of specific deviations are independent of any possible division here and briefly are treated separately. We stress two facts 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 is handicapped or retarded in more than one respect, e.g., he is blind and mentally retarded. A spastic child usually is multiply handicapped, namely, in sensory, motor and in intellectual ways as well as in his speech.

A limited or altered educational aim and a special educational task hold with respect to each form of disturbance. Each deviant child requires an individual plan of action that must be designed and implemented in light of his particular 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 that he might find in his 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 has to contribute to the balanced development of such a child. He has to know the unique world of a deviant child. He has to know how he experiences his being handicapped or retarded, how his different world looks and how he feels about his being different in the midst of the non-handicapped and non-retarded.

A teacher also must take into consideration 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 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 particular 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** that indicates a psychic disturbance based on neurological dysfunction (inadequate functioning of the central nervous system).

The origin of this phenomenon usually is 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 that can have the consequence that 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 sensory perception he constantly fluctuates from one thing to another. He cannot direct his 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 is physically tireless. Thus, he cannot sit still when he must, e.g., in the classroom he is fidgety, he is overactive at the dinner table, etc.
**(b) fluctuating attention:** The brain damaged child cannot control his attention; he has a short attention span; he is distracted excessively. His weak ability to concentrate influences his learning activities. His behavior is impulsive--in a situation he 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 that require fine coordination of the muscles (e.g., handwriting, speech) and with the execution of rhythmic activities. A disturbed visual-motor ability is evident in

* "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.

activities where movement is "lead" 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 must always push, pull, linger, fold or bend things that attract his attention. Thus, the brain damaged child, to a greater or lesser degree, is restrained in his emotional development.

**(f) Little tolerance for frustration:** This child has difficulty assimilating failures and disappointments. He bursts into violent fits of passion if he doesn't get his way and becomes aggressive if his 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 that goes too far. On this basis they are "elusive" for the educator and difficult to be influenced pedagogically. The age mates of a brain damaged child again find his 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 cognitive development. On the basis of the psychic disturbance paired with the neurological dysfunction, he is not able to actualize his intellectual potentialities adequately. His intelligence often is average or above average, but he 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 thinking is concrete-bound and stereotypic, and abstract thinking is defective. For example, he is unable to sort into the same groups or classes things that 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 shows figure-ground problems and in his visual perception is unable to synthesize a whole from several parts. Therefore, he directs himself 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 that are 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 in order 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 circle among his failures (especially regarding learning achievements) and his discouragement, defiant attitude, poor self-concept, etc. is a strong possibility and his 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 is dependent on special instruction where the school curriculum, in form and content, makes provision for his particular problems. In addition, he is dependent on pedotherapy with respect to his 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 must be given the opportunity to be able to express himself in words, gestures, movements, music, dexterity, techniques, child drawings, and in individual and group play.

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

The following functional exercises are needed because of the multiplicity of dysfunctions that these children have to struggle

with: 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) that 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 successfully can be 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 can prepare himself to prevent hurting himself or break something during the seizure. In the **tonic phase** of the attack, he loses consciousness, his muscles become stiff and tense and he falls down. After a number of 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 that 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. Usually he doesn't fall. He only interrupts the task with which he is busy for a brief moment. Small attacks can appear 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 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 particular sensations: pain, feeling bloated, anxiety, etc. Usually the child outgrows **petit mal** epilepsy during his 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 appears confused and awkward and carries out automatic activities such as chewing, mumbling, rubbing, swallowing, smacking the lips, spinning around, bending over. He is involved in a slight twilight state within which peculiar psychic lived experiences are characteristic--illusions, hallucinations, unrealistic experiences and anxiety. Then he is extremely sensitive and violently opposes any interference.

**(d) Narcolepsy:** From time to time the child feels like he wants to sleep. He then goes into an abnormally deep sleep that is different from a loss of consciousness because the child cannot be awakened from the latter. Usually he 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 behaves strangely in class. It seems that he schemes, but he is not aware of what he 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, convulsions or loss of consciousness, but with manifestations such as physical pain, vomiting, nightmares, daily anxiety, sleep-walking, 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. On the basis 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 everyday dealings, paired with feelings of insecurity and being menaced. He has trouble with problems of assimilation regarding his handicap. He fears contact with the world because at any moment he can lose that contact. His world has changed drastically on the basis of the fact that he is constantly expecting that he will suddenly experience the convulsions and/or a loss of consciousness from a seizure in the presence of others. Later, when he regains consciousness, he lived-experiences his condition in the eyes of the other--he is embarrassed about the abhorrence, horror and trembling that his seizure awakens in others. For example, the epileptic expresses himself as follows about his defect: "I don't like falling and rolling like an animal in front of others".

The child's epileptic attunement prevents him from communicating with his world without impediment; this restrains his exploration of the world and thus also his personal becoming; it disrupts his total existence: he may not swim or bathe alone, ride a bike, use a stove or a dangerous machine, etc. His life revolves around his epileptic seizures and around the many prohibitions, the medical treatment and the attitude of others in this regard. He indeed lived experiences a feeling of being different and inferior; he feels not free and abandoned to his epilepsy. Every moment he is aware of the fact that he is an epileptic and can have a seizure. The fact that he regularly must take medicine constantly reminds him of his 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 movements. These children usually are placed in a special class or school. With the education of the epileptic child, educational mistakes such as spoiling, over-concern and rejection are a danger. In school, his weak directedness, attention-weariness, loss of consciousness, poor memory and slow psychic tempo must be taken into account--with this child, insight comes slower. His rigidity and irritability present the educator (teacher) with special requirements. In light of the problems of these children, decidedly lower demands must be made of them in school.

## 3.4 THE AUTISTIC CHILD

Autism definitely 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. On this basis, 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 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, namely, brain damage or an under-development of the brain.

### 3.4.1 Briefly, 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 is not in a position to establish a genuine, personal relationship. Also there is little or no eye contact with others, or it is evasive. It seems like he fails to see or looks past the other as if he were in deep thought. Also, he is not in a position to communicate via a gesture (mimicry), a look or a smile. He is constantly directed only to the concrete objects around him and dislikes being touched.

**(b) Withdrawal into a personal world:** On the basis of a disturbed awareness of reality, the autistic child creates a world and life of his own and exists in isolation. He cannot enter the world of another. He avoids any external intervention. He is unwilling and suspicious of broadening this narrow world and he responds to attempts to do this with anxiety, panic and aggression. He shows an urge to repetitiously be busy in his little world and limits his focus to a few things in the little world to which he desperately clings. He cannot link himself up with or orient himself outside of this impoverished world. Correlated with this, the autistic child shows an avoidance of empty spaces because he can't handle them. He flees to concrete things and is attached to particular objects. He is "glued to that which is available" (Vedder). For example, when he has to move from one corner of a room to another, he 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 has difficulty genuinely expressing his emotions except when he is angry. His face seems limp and expressionless.

**(d) Bizarre behavior:** The autistic child appears to be apathetic and without initiative. His behavior is bizarre (excessive, unusual, strange) and unpredictable. He usually is headstrong, obstinate, fickle and changeable. Also his emotional expressions are bizarre: he can stare or laugh without empathy or show excessive irrational "happiness". He shows no inner joy or sorrow. He shows no reasonable, spontaneous laughter.

**(e) Disturbed speech:** Some autistic children are mute, some have defective speech that mostly consists of repeating words or

short sentences. Echolalia also is 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 are in a position to 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 trunk for hours, putting a tress of hair between two fingers and constantly twisting it. His behavior shows a compulsivity. For example, he repeatedly will fill and empty a little box with things, or keep himself meaninglessly busy with strips of paper or is continually fascinated by rays of light that he perceives.

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

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

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

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

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

## 3.5 THE "PSYCHOPATHICIZED" CHILD

Before dealing with this form of deviation, it is necessary briefly to discuss the concept of **psychopathy.** Carp offers the following description: By a psychopathic personality is understood a personality that--mainly from deviations in its structure--shows a considerable defect in adjustment to society and even experiences lasting pain as a result of his disharmonious development.

It should be stressed that the environment as well as the psychopath himself suffer because of his 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 personality is misformed and disharmonious regarding his **life of passions, temperament and character.** The psychopath seeks satisfaction of his desires in violent ways in his behavior and therefore his behavior is unrestrained, strange, antisocial, unreliable and **sometimes** criminal. Thus, because of his 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) in order to try to escape from their feelings of unrest and displeasure. They can be inconsistent, fanatic, negativistic or anti-social in their interpersonal relationships, behavior, interests, occupational pursuits, political views, etc.
**(b) Deviant attitudes towards life values:** Some life values are exaggerated (e.g., religious fanaticism); others have no meaning for the psychopath. For example, he easily leaves his 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 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 arises autism, excessive egocentrism, hysteria, a deviant fantasy life, abnormal suspicion, etc. 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. On the basis of his misformed personal structure, the psychopathic child is a task for the psychiatrist and as such falls outside of the domain of orthopedagogics.

The concept "**psychopathicized" child** refers rather to the child reaching his psychopathicized state during his development, and it is not a congenital attunement. This phenomenon also is called acquired psychopathy, pseudo-psychopathy or "developmental" psychopathy. These mean that during his growing up the child

obtains a seeming psychopathy: he is so seriously affectively and pedagogically neglected in his first years of life that he shows a psychopathic image--he 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 on the basis 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 has a need. This lack of or defect in the emotional bond with the primary educator results in an inadequate course of emotional development. His emotional life is not stimulated. His emotionally impoverished communication with his mother means that his communication on an interpersonal level remains emotionally impoverished.

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

The above forms of neglect lead the child to show serious deficiencies in his psychic development: he is **heartless** (because of affective neglect) and **without norms** (because of pedagogic neglect). He is so **damaged** in the development of his person that he cannot adequately link up with his environment; he has never learned to do this through loving bonding and educating. His needs as a child are so badly frustrated and disappointed that he responds with unrestrained, antisocial and unprincipled behavior, which shows great correspondence with genuine psychopathic behavior. Thus, he displays the behavior of a psychopath.

In order 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 educational neglect. This is

an apparent psychopathy that, in contrast to genuine psychopathy, can be partly or entirely eliminated under favorable circumstances.

The psychopathicized child links up with his environment with difficulty; his 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 behavior. Fickleness, deformity and disharmony characterize his person. Examples of his 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 emotional life. He is understandable and influencable by education only to a minimal degree (the educator cannot get a grasp of him). It is very difficult or almost impossible to bring about an improvement in him by ordinary means of educating such as rewards and punishment. With difficulty, there can be an appeal to his conscience, or to the loving bond that ought to exist between educator and child. Because of his deviant behaviors and distorted personhood, he has difficulty joining in family life, in the classroom, peer group or society. Often a vicious circle 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 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 to be blind if his 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.

* 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).

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

In addition, the blind child finds himself in the midst of sighted people, and he has to link up with a world that is attuned to the sighted. For example, he 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 is uncertain in his dealing with things and handles them inadequately. Qualitatively and quantitatively he has less of a part in reality. He has a limited range of action. He has a lack of particular experiences, especially visual and motor (movement). This includes things that he cannot perceive by the sense of touch, e.g., the sun, clouds, stars, smoke, a bird flying; things in motion or that are too large or too small to touch; dangerous things such as fire, etc. He cannot participate in particular esthetic experiences.

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

On the basis of his 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 walking, he is hesitant, cautious, restrained, inflexible, tense. He is less mobile and also does not move fluidly. He plays less than a sighted child. For him, the space in which he moves is threatening. His trunk, neck and head show a stiffness. His head is fixedly directed straight ahead and hangs when he sits. It is directed away from a conversational partner during a discussion. His eyes arbitrarily stare into space without expression. The blind child is impoverished regarding facial and bodily expressions and spontaneous movement. Where his gross motor activities are restrained, his fine motor ability is better controlled than that of the sighted.

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

Blindness also impedes the child's personal becoming. On the basis of his blindness, he is blocked by feelings of insecurity in his exploration of and communication about the world. He lacks visual involvement with reality and doesn't know a visual relationship of understanding with persons and things. He is addressed and enticed less by visual things. Also, his acquisition of language is retarded because things and movements that he cannot see are difficult to name. His psychic development (especially the actualization of his cognitive potentialities) necessarily is under actualized. He has to interpret concrete reality via experiences of touch, and knows no optical impressions or colors. His world of imagining is impoverished and schematically constructed. In general, his experiential world is impoverished and limited. Also, he **lived-experiences** (sometimes intensely) his dependency, helplessness, inadequacy and loneliness. He lacks mimicking, gesturing and expressing feelings in associating with others. He lacks the other's look--the point of encounter between persons. Therefore, his interpersonal contact is faulty. He has to compensate by the special use of hearing. Consequently, his emotional life can become nuanced in contrast to that of a deaf child. His thinking can be abstract if he has at his 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 education 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 that these include.

**The weak-sighted child** has a vision of between 20/70 and 20/200 in his best eye after all possible medical and ophthalmologic help, or he has a serious, progressive eye defect, or he suffers an illness that seriously impairs his 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, on the basis of their limited eyesight, they cannot follow ordinary teaching but nevertheless are viewed as sighted.

The weak-sighted child finds himself 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 has a qualitatively and quantitatively lesser world, and lacks certain visual-sensory experiences. Also, he finds himself in a world attuned to the sighted. On the basis of his faulty power of visual discrimination, he lives, as it were, in a haze and **things** and **space** are less manageable for him and therefore are dangerous. He experiences space as offering limited possibilities of movement--he is uncertain about the presence of things because he can't perceive them sharply and clearly. Because he is assailed by the sensory organ most essential for communication, his contact with fellow persons is incomplete in certain respects. More than the sighted child, he depends on help and protection. A feeling that he 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 usually gets much attention, sympathy and help, the weak-sighted child is viewed as more or less "normal" and is measured by the yardstick of the sighted and often the same demands are made of him as of the sighted. It is reasoned that he can see and thus can help himself.

Also, the weak-sighted child sometimes looks unattractive (his thick glasses, e.g., give his face a strange appearance) and he doesn't always easily join in with sighted children.

The weak-sightedness restrains his psychic development and limits his 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 is more moody, restless and difficult to handle. He finds himself in a difficult situation: he can see but he also cannot see; he is superior among the blind and inferior among the sighted. His uncertainty about his role in society and his abiding fear that his defect can worsen lead to feelings of insecurity. He fears his body and future because he is uncertain what role his 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 perception of teaching material, especially with reading and writing and in his whole perception of blackboard, maps illustrations, etc. In his attempt to perceive wholes, his visual perception is diffuse.

As far as his teaching 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 is to exercise and apply as well as possible his remaining eyesight and the emphasis is on perceiving details. The weak-sighted child is sighted and he needs to be helped to improve his 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 that 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 is backward in his language acquisition is salient. Because he masters abstract concepts with difficulty, his psychic-spiritual life is defective on an abstract level. On the basis of his laborious and faulty use of language, his 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 is cut off from the world of sound, the development of his emotional life is faulty--it remains impoverished and without subtleties. He lacks the familiarity and orientation that sound provides. For example, he is unable to gauge the inner emotional voice of another (anger, sorrow, joy, warmth, etc.). He doesn't experience the rhythm, excitement or softness of music.

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

Of importance is the fact that because of his deafness his acquisition of language and speech are slow and faulty and have a restraining influence on his thinking. In his language, thinking, and in his directedness to the world, the deaf child is bound to the concrete-

perceptual. He does not have at his disposal the language (concepts) to think abstractly or to optimally actualize his cognitive potentialities. Also, in his fantasy world, he remains limited and on a perceptual level (bound to what he has seen). Thus, his psychic underactualization 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 communicates with his eyes, gestural expressions and sign language. Sign language and lip-reading are natural means of communication for him.

The following are characteristic differences of the deaf child: he expresses himself more frankly regarding his sexuality because of his isolation he does not learn to know the taboos and prohibitions of society and because his sexuality speaks to him primarily on a vital level. The deaf child is strongly disposed to feelings of inferiority and he tries hard to compensate for this sometimes with great courage and a tendency to rate himself and his achievements too high--thus he overestimates himself and shows conceitedness. He has a special fear of the strange, new or unknown. Also he is more egocentrically attuned than the hearing child. Expressions of this are greed, distrust, gullibility, envy, jealousy, impatience, etc. Thus, in general, he shows negative feelings toward fellow persons and an inability to feel the situation of another. Also, on the basis of his restrained becoming, the deaf child is somewhat infantile. He has a lack of self-control, self-understanding, self-insight and a feeling of responsibility. Often his behavior is trying, pig-headed, aggressive, or he tends to withdraw himself.

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 still some hearing remaining that, 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 or not 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 world through seeing and touching and in doing so cultivates a concrete-perceptual attunement to it. His 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 that name concrete things than words that have abstract meaning. He uses language for representing rather than thinking. Consequently, his language is more limited in scope, more impoverished, more superficial and more infantile than that of the hearing child. For him, language serves in defective ways as a means to make use of his intelligence (e.g., think) and to express his 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 preferences and rejections, etc.

In teaching the deaf child, the emphasis is on language acquisition. For his adequate psychic development, language as a symbol system and means of communicating has to 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 education, the vocational implications of his 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 disposal: he can hear if spoken to loudly, or if he has a hearing aid. Thus, he 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 cannot hear what is said, it seems as if he doesn't understand what is said. Also, he is restrained in his acquisition of speech and language; usually his speech is unclear and his 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.) that he continually confronts in reality. It must be emphasized that intelligence is only a **potentiality** that the child has to actualize with the support and guidance of his educators and by his own efforts. In many cases there is mention of a child under actualizing his intellectual potentialities to a greater or lesser degree. A child has at his disposal a particular intellectual potentiality, but because of different obstructing and blocking factors he 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 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., educational neglect, the child's attunement, his inability to concentrate, his language potentiality, his emotional attunement, and his physical attunement.

Mental retardation is a many-sided problem. As well as their intellectual deficiency, usually these children also 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 also reaches a ceiling as far as his psychic achievements are concerned. Regarding his ability for abstract thought, he 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 has to 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 has to be limited. They experience problems with particular arithmetic concepts and abstract computational work. The same holds for difficult fractions and the so-called "language-sums". On the basis of their limited abilities, school tasks have to 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 usually is paired with disturbances in his emotional life (which remains impoverished and without nuances), his 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 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 has to be limited and concrete. Teaching and educating are directed to handicrafts that 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 3-5 years; at 15 years a mental age of 5-7.5 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 in a position 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 himself in society and later as an adult is dependent on sheltered work. He can learn a limited degree of routine and discipline. Also, he can concentrate only for a short time. He has no logical thoughts, not even on a concrete level. He is disoriented regarding time, place and his own person. The imbecile child is disposed to respond to situations with excessive anger. Normative education with these children almost is 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 none but only the most simple of assignments. For that reason, they are unable to avoid risks. Most idiot children die young and 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 that 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 (similar to that of the Mongolian race, which makes this particular 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 neck is short and thick; his nose is small and broad; his handline is conspicuously different. These children are affectionate, sweet and passive as babies. They learn to stand and walk at a late stage, and also 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 others have 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 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 intellectual and motor abilities, sense organs and speech. Here the aim is to describe what being physical handicapped **means** for a child and his personal becoming:

Being physically handicapped strikes the child in his complete existence. On the basis of his physical handicap there is a loss of the obviousness of living. Where a non-handicapped child can move, play, run around, explore his world, etc., this is not possible for these children. The physically handicapped child struggles with his being handicapped. He is caught up in his own body. For him, this is a stumbling block in his exploration of his world and therefore also for his personal becoming. Also, there is mention of a **disturbed bodily lived-experience.** This means that he shows a negative attitude toward his own handicapped body. His body means conflict for him. On the one hand, his body fails him, and on the other, it is a precondition for his existence. He rejects his own body because it is unfaithful and a hostile enemy. It is difficult for him to distance himself from his handicapped body, and he experiences his being handicapped intensely on emotional levels, 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 limited physical activity and mobility prevent him from being able to play and physically explore his world adequately. For him, this means diminished life experiences, defective possibilities for contact and restrained intellectual development. His experiential world remains small, also with respect to social contact. To a great degree, he is dependent on others for his care.

Mistakes that the educator often makes with the physically handicapped child are uneasy dealing with him, over-protecting, spoiling, over-indulging, rejecting, etc. In this way, a physically invalid child easily can be educated into a mentally invalid person.

Because he experiences himself in the eyes of fellow persons as different, inferior and unaccepted, the physically handicapped child

is prone to withdrawal, social isolation and loneliness. He feels that fellow persons view him in the first place as handicapped and in the last place as a person. Thus, his experience of being different disturbs his interpersonal communication. In addition, he displays a search for acceptance in the midst of shortcomings and failures. Further, his physical limitations lead to feelings of frustration, helplessness, rage, anxiety, uncertainty, insecurity, impotence and despondency. He is self-conscious, ashamed and self-depreciating of his body. He is unable to express his disturbed feelings via his body. He responds to his conflict and frustration, in addition to the mentioned possibility of isolation, with aggressiveness by which he then tyrannizes his entire environment, or he responds with egocentrism.

The physically handicapped child searches for the sense of his life and distress as handicapped, he lived experiences his 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 handicap in order 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 the 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 impaired psychically-spiritually by the illness? What particular tasks does his being-ill hold for the child? How is the ill child's becoming adult actualized since he is disturbed in his biological moment, and his body by which he has to explore his world now is impaired by an illness?

A few examples of chronic and long-term conditions of physical illnesses that 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 body has left him in the lurch. In addition, here is mention of obviousness because what he at first could do and what his peers still can do no longer is possible for him. There are certain things he cannot or may no do. His sickness gives rise to an impotence and feeling limited and leaves him more dependent than previously.

The illness prevents the child from associating with peers as before and thus entails for him the possibility of seclusion, loneliness and boredom. Illness also means for the child pain, discomfort and disruption; and, less than the adult, he is not in a position to understand the sense of his illness, suffering and hardship.

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

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

The child's being ill limits his going out to the world and thus his exploration of and learning to know it. This also limits his dealing of things. His restricted possibilities of movement limit his 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 communication with his fellow persons and, therefore, in his 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 himself, 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 illness under the eyes of fellow persons, and by the glance of the other he is thrown back onto his own sick body. The child tends to withdraw into himself because with his illness he becomes objectified by others.

The ill child finds himself 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 exploration of reality and, therefore, has a limited world. Besides, the hospital as an educational situation cannot be compared with the home. For the child in the hospital, the necessary communication with his parents is missing as well as the trusted and secure space out of which he has to learn to know his world. The child has to endure the separation from his mother, from the rest of his family and the familiar home environment, and he has to assimilate the unfamiliar environment of the sickbed. Often he expresses his unassimilated experiences of being ill and of his 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 dare to explore his world is lacking because he cannot conquer the biological moment and the related feeling of helplessness, and consequently he feels excessively insecure. On a child-like emotional level, he experiences his bodily impotence and being afflicted--also in the eyes of fellow persons, and to a greater or lesser degree he is caught up in his own bodiliness with the strong possibility that he will reject his own sick body. The long-term physical illness awakens in the child a general basic life uncertainty as well as a cloudy future perspective. On the basis of his physical condition, the ill child, on a psychic level, is disposed to being self-centered, self-conscious and sensitive. He is entirely aware of his conspicuousness and feels inferior about that. In addition, he feels anxiety and uncertainty, also in communicating with fellow persons. He seeks the sense of his own disability. In addition to his physical dependency, the ill child needs help and support regarding the acceptance and meaningful assimilation of his situation of distress. Consequently, many ill children also have to struggle with a problem of accepting and assimilating their own physical illness.

The ill child poses a special educational task for the adults who deal with him. As far as his teaching is concerned, the chronically ill

child is placed in the hospital school. It is necessary that everyone who deals with the ill child will honors a pedagogically accountable approach to him, namely, doctors, nurses, physiotherapists, technical personnel, etc. The ill child must not be treated as a miniature adult patient; he is an educand -in-distress who has need for help and support in assimilating his illness. Because he often does not receive this help in everyday education, he is dependent on pedotherapy as corrective educating or support to attribute positive meanings to his being-ill.

## 3.11 THE CHILD WHO IS DIFFICULT TO EDUCATE

The distinction between the child with removable educational difficulties and the child who is difficult to educate on the basis of a handicap that can't be eliminated was already made in Chapter one.

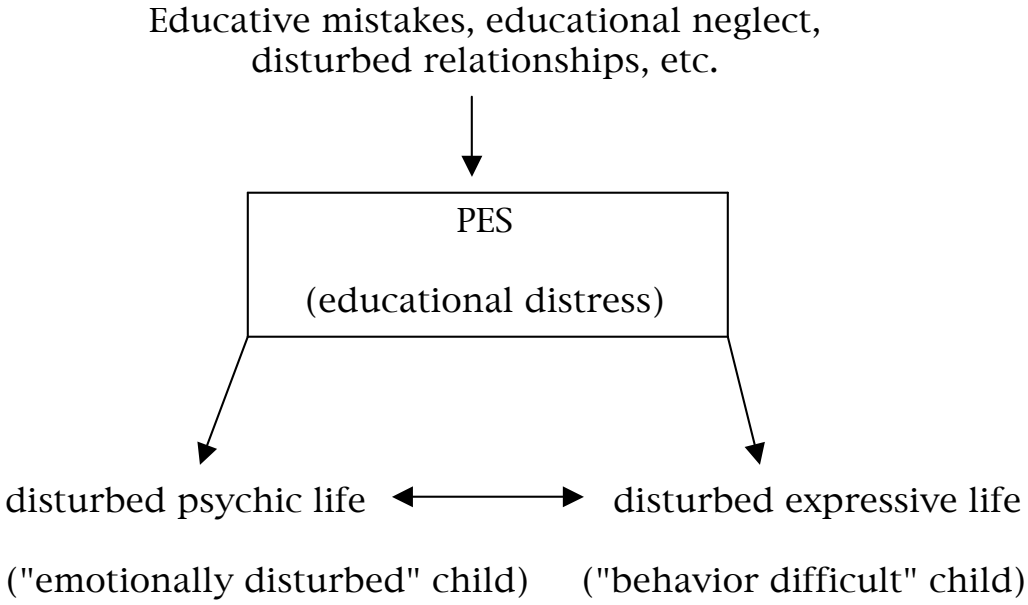
Here the concern is with the child who **has** a correctable problem because he is difficult to educate. Regarding this group of children, concepts are used such as the "neurotic" child*, the "emotionally disturbed" child and the child with behavior difficulties. The present form of disturbance includes all of 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, educational neglect, and experiences that 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 deviant behaviors. Distress, anxiety, disturbed communication and restrained becoming are characteristic of the existence of the child difficult to educate, and his deviant behavior is an expression of his inner conflict. These are the ways he responds to his distressful situation. Through his deviant behaviors he comes into conflict with his parents and environment. Then neither the child nor his behaviors are acceptable. Only through educating does the child learn socially acceptable behavior. This educating has to be characterized by adequate affective relationships, by making demands of self-restraint and by the exemplification of norms and values. Through

* 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.

inadequate educative intervention, the child does not learn to take fellow persons into account in his behavior.

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




From the lengthy description of the essentials and the origins of the PES in Chapter two, the image of the child who is difficult to educate ought to be clear. The following concepts raised in Chapter two clearly hold with respect to the child difficult to educate: educational distress, disturbed child life, thwarted child psychic needs, educational 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-educational-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 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 behavior, achievements and expressive life. He is unable to be himself and to express his feelings in adequate ways. He lacks the daring to deal with new situations and explore his world; also, in his behavior, he clings to the known and trusted. His under achievement at school essentially can be viewed as a form of deviant behavior.

**(e) Being unrestrained:** On the basis of his inner tension and dissatisfaction, the child's behavior is excessively violent and uncontrolled. He strives for what immediately gratifies him and becomes aggressive when he meets opposition for this. For example, he might steal as a result of disappointed love because he feels he did wrong. What he steals might merely be a symbol of what he would want to take if he could, but that is abstract and therefore can't be taken, namely, **love.** The child also can look for trouble and in doing so get the intervention, attention and "acceptance" that otherwise he 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 educationally impeding factors. The child is dependent on communicative pedotherapy during which his educational distress can be eliminated and his 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 educational influences are three factors that determine the differences in

developmental tempo. The orthopedagogue involves himself with the factors that have impeded the child's growing up, e.g., educative mistakes, educational neglect. Such factors can hinder the child's school readiness when at approximately six years of age he 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 present themselves for the **school beginner**, the child clearly runs the risk of achieving inadequate 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 child-being, he 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 still lives emotionally in the maternal world. In contrast, the school child is more independent, he is less mother-bound, he can take a position and view things critically. He 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 must fulfill the following criteria (following Engelmayer):

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

good relationships with the teacher and his fellow pupils; i.e., he must be able to join in the class situation well.
- He must be able to obey the class rules--don't disturb, be restless, withdraw into himself.

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

The child not ready for school, on the basis of a delayed, slow or impeded personal development, is not in a position to benefit from the teaching for which his cognitive potentialities are not sufficient. He is too childish and too playfully attuned to carry out school tasks and fulfill school requirements. His 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 is not physically ready for the activities that he 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 **educational** and **forming influences** can work to retard (the child's readiness). The child must be educated to school readiness or preparedness. Through educational and social neglect the child is not formed adequately for school readiness. He must have the opportunity to practice and gain experience with a variety of materials, with completing tasks, obeying demands and self-control. The emotional educational relationship (affective education) within which the child finds himself in the first years of life functions as an extremely meaningful preparatory influence--if he feels safe and secure within and from this relationship he will explore his world. A feeling of insecurity and the related feeling of helplessness disturb the child's daring and restrain him in his world exploration, in his learning to know reality and, therefore, also in his psychic development.

The spoiled child, e.g., doesn't learn self-control, task completion, acceptance of authority and orderly behavior. He remains on the

level of pleasure instead of progressing to the level of reality where he has to do what reality (school) demands of him and not what gives him pleasure.

(c) The **culture-pedagogic level** of the child's educating is a decisive factor. The cultural atmosphere and intellectual sphere within which the child grows up influences his school preparedness. It is important that the parents promote the intellectual development of their child by offering him adequate preschool experiences with activities such as reading to, telling stories, learning little poems, educational 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 culture-pedagogic 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 particular facets of the child's education and his 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 in the form of vulnerability in the primary school. Rupp uses the concept school preparedness to indicate that the child is in a position to have a reasonably successful school career that he is able to achieve well, that he can "deliver" at school. The school vulnerable child is to a great degree dependent for his 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 cannot deal with the new situations in which he continually finds himself. Because of this, for him school is problematic and meaningless and he signifies this with negativity and anxiety. His school existence is characterized by emotional disturbances (confusion, anxiety, tension), under achievement and behavior problems. He shows a negative focus on work, reading and spelling difficulties, a dislike for school, and usually regressive phenomena such as bedwetting, etc.

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* Rupp, J. C. : **Opvoeding tot Schoolweerbaarheid** (Education to preparation for school), Wolters-Noordhoff, Groningen, 1971.