

CHAPTER 8

EMOTIONAL AND BEHAVIORAL PROBLEMS

1. INTRODUCTION

Educating can be defined as the help given to a child on his way to adulthood. The fact that he strives toward adulthood or that he wants to be an adult makes educating possible. According to Ter Horst (1973: 54) educating is a continual conversation with a child. The words and topics change, and so does the child's role in the conversation. As he becomes older and more adult, his role increases. Although initially the educand's engagement in the conversation mainly is determined by his parents, later the educator acts as an intermediary between the child and other persons and also other contents so that his experiential world is enlarged.

All parents try to protect their children from the onslaughts of the outer world and try to be reasonable and loving parents. Even so, it happens that children find themselves in problematic situations in their young lives. Many children find it difficult at one or another stage of their lives to meet the demands and expectations placed on them by the adult world. Also, it often happens that parents have doubts about their own effectiveness as educators in their interventions with their children. However, there is a problem of educating only if the child as well as the parents find themselves in a situation that they see as limited or blocked and thus where there is no harmonious way to proceed to guide the child to adulthood.

Consequently, an educational problem is the direct responsibility of the parent (or teacher) who is concerned with and responsible for the involved child's educative guidance. To speak of a child in educational distress, the emotional and intellectual aspects of his becoming have to show a "backwardness" to the extent that it is comparable to the longitudinal level of development on which he finds himself. However, the uniqueness of each child always has to be taken into account in determining if he is deviant in his behavior and conduct.

Symptoms of deviant behavior have to be viewed as a cry of distress, a call for help. According to Pringle and Mia (1975: 75) the presence of such symptoms points to an unbearable tension

between the child and his world. They indicate that withdrawal is a more justifiable response to a degree of urgency than is aggression. According to them, aggression should be attended to quickly because it interferes with the authority of the adults. It is the task of the educational psychologist to determine if particular symptoms manifested by a child indeed are an indication of deviant behavior and thus of a disharmonious dynamics of educating and if they are not perhaps acceptable conduct of a specific child in his own unique educational situation.

The following are matters that the educational psychologist has to take into consideration in determining the authenticity of the symptoms described by the parents (i.e., to determine if there is a gap between the achieved and the achievable levels of becoming):

* The longitudinal phase in which a child finds himself: The educational psychologist has to be conversant with the various ways of behaving that can be viewed as "normal" for a child of a particular age. Thus, for example, it is expected that a 2 to 3 year old child often will wake up at night but the same behavior from an 11 to 12 year old child can lead to a suspicion that there is an underlying problem.

* The intellectual potential of a child is extremely important when it has to be determined if his particular way of behaving is deviant or not. It can be expected that the behavior of a child of above average intelligence will correspond to that of an older child and vice versa. In this respect, it would not seem abnormal if a highly gifted child of 9 years chooses to be involved with his computing or books rather than playing ball with his friends.

* The duration of a symptom can be a determining aspect in deciding the authenticity of the symptom. Many children manifest specific "symptoms" at various stages of their lives but their duration is of such a short time that they are not an indication of deviant behavior or a restrained becoming. For a symptom to qualify as an authentic one it is necessary that it be present for a long time and that it will restrain the child in the normal course of his becoming.

"Some behavior is considered deviant because it occurs too often, other behavior because it occurs too rarely. One can thus speak of excess and deficient behavior, but the various categories of childhood disorders often contain both kinds of behavior" (Kazdin et al.[in English], 1980: 394).

If a 6 year old boy wets his bed for a period of 2 to 3 weeks after his parents divorce, this will not be viewed as a deviancy. However, if this behavior lasts for a few months or even a year there can be mention of deviant behavior.

* The cultural and social position of the family and the educational aims entertained by the parents are very important in evaluating symptoms. Behavior that is viewed as acceptable and "normal" within a particular community might be viewed as an indication of behavioral deviancy in another cultural context.

* The uniqueness of each child and the particular educative situation he is in always have to be taken into account in evaluating his symptoms as deviant behavior or not. Thus, the arithmetic proficiency of a 6 year old from a family where everyone is interested in arithmetic and where there is a mathematician in the house cannot be compared with that of a boy of the same age who has not yet dealt with arithmetic.

"The emotional and behavioral disorders of childhood differ in many significant ways from the adult disorders, and the younger the child, the more marked are the differences" (Berg and Pennington [in English], 1966: 197).

To a large degree an adult can verbalize his emotions and talk about his problems while a child hardly ever seek help for his own problems. The adults who are responsible for educating a child (parents, teachers) usually take the initiative to seek help for him. In some cases a child might not even be aware of a problem and might not want to admit there is one. Child problems often are hidden and are only symptoms such as , e.g., disobedience serving as indication that there is an underlying problem. The symptoms as manifested in a child's behavior can be a matter behind which the real problems are hidden.

In Chapter 7 it was indicated that in most cases of deviant behaviors in children there is a connection between a child's meanings, as manifested in his behavior, and the relationship that exists between the various family members and especially between the child and his parents; however, the role played by genetic and congenital factors as well as physical injuries cannot be ignored in a child's deviant behavior and emotional problems. Emotional stability in individuals in particular cases is genetically determined (Van den Berg, 1967) and these genetic factors as underlying various types of behavioral deviation should not be overlooked. According to Johnson and

Medinnus (1969: 619), the role of heredity can be shown in many cases of schizophrenia. These authors refer to the research on innate factors in children and find that malnutrition and particular complications during pregnancy often lead to hyperactivity, confusion and disorientation (Johnson and Medinnus, 1969: 620). Kawi and Pasamanick (1959) have found that brain injury in the uterus or during or after birth not only result in mental retardation but also in deviant behavior. "Since brain injury results not only from tumours but also from diseases, such as encephalitis and meningitis, and from physical damage, it is a factor of relevance in the study of behavioral problems" (Johnson and Medinnus [in English], 1969: 621).

Johnson and Medinnus, 1969: 621), however, indicate that most children at one or another time have a decrease or an increase in the course of their development and that parents easily can excuse their child's comportment by placing the blame on physical factors and in doing so negate their own unique role in terms of the activities of educating him. Data from the above and other research indicate that physical factors, irrespective of whether they are congenital, innate or arise post-natally, can influence a child's behavior. Therefore, it is extremely important to thoroughly check the status of a child's health during a diagnostic investigation and the child, if necessary, be referred for additional medical study.

2. NEUROSES

2.1 Introduction

Neurotic states in children differ from those of adults in so far as children are not always aware that they have a problem or that they do not have the necessary expressive language ability to verbalize their problems. Now the question is when should a child's comportment and behavior be viewed as neurotic.

All children at times are afraid or even anxious but usually the behavior is short lived. If the behavior persists in spite of attempts to help him overcome the anxiety or if he reaches an age where his behavior no longer is appropriate for his age group, it usually is necessary to get professional help. Sometimes children are not aware that their experiences are different from those of other children and thus are not aware that they have a problem. Sarafino and Armstrong [in English] (1980: 428) view neurosis as "a

psychological impairment that involves maladaptive ways of coping with anxiety, fear or stress". According to him children's neurotic behaviors stem from the fact that the situations they find themselves in somehow are troublesome. These children usually are unhappy, anxious and reserved (Baker, 1979: 36; Suran and Rizzo, 1983: 438).

In the following section, different ways child neuroses manifest themselves are discussed.

2.2 Depression

In spite of the fact that the diagnosis of child depression is a point of contention with psychologists, generally it is accepted that depression in children is a serious behavioral deviancy with far-reaching consequences. Typical forms of child depression include the following: poor appetite, disturbed sleep, lack of energy, lack of interest, inappropriate feelings of guilt, slower thinking, heightened or reduced psycho-motor activities, thoughts of death or suicide, negative self-image, being sad or feeling helpless, withdrawing, inclined to cry, avoidance of eye contact, poor achievement in school, anxiety, tiredness, bed-wetting, behavioral problems, discontentment and irritability as well as loss of weight.

Various researchers, among whom are McConville (Ollendich and Hersen, 1983: 294) and Verville (1967: 384), have found a correlation between the characteristics of child depression and developmental phases. It was found that children between the age of 6 and 8 years who are depressed have feelings of helplessness, sadness and even hopelessness and are more inclined to withdraw than 8 to 10 year olds. In this latter group the following symptoms were found: lowered self image, feelings that they are of no value and feeling that things always will be bad for them and that they will fail at all tasks. The group of children 10 years and older showed the following characteristics: excessive feelings of guilt, passivity and also active feelings about suicide, they had a longing for someone they knew long ago and who no longer is available, extensive feelings of disappointment and sadness about a specific occurrence or incident that had happened long ago. These children then used these incidents as the reason for their depression. Children in this age group also often complained of fatigue and pain.

Glasser (1967) uses the term "masked" depression. Such children show symptoms such as truancy, temper tantrums, disobedience; they run away from home and also show psychoneurotic symptoms such as school phobia and underachievement in school. Psychophysical reactions such as headaches, stomach aches and nausea can appear.

Cytryn and McKnew (1977) discuss masked depression and add the symptom of hyperactive behavior. These authors also discuss two other categories of child depression. The first is active depressive reactions where the depression is preceded by an identifiable causative incident. The second is chronic depressive reactions. With these children the depressive pattern of behavior becomes gradually perceptible. These children also have a history of various estrangements from and losses of loved persons.

The causative factors for child depression, in most cases, are not easily identifiable. It appears that family climate plays an important role in the causative factors of depression in children. Thus, it is necessary to investigate which disharmonious educative relationships might exist between the child and his parents and to determine which essentials of educating are actualized inadequately. Educative activities that especially are encountered in child depression are those activities that as a consequence of their inadequate realization lead to feelings of helplessness, rejection, failure and also of not satisfying the demands laid down by his parents.

Other factors that can lead to depression in children are disharmony between parents, in other words, marital tensions, physical illness or the death of a family member and a poor self-image of the child. In its turn, such a poor self-image of the child influences the adult-child relationship. The role of genetic factors in depression cannot be overlooked; however, much research still needs to be done in this regard.

2.3 Anxiety

Anxiety arises in a child without there being a particular cause. Often a child interprets anxiety as if it is something in himself and doesn't look for a cause in his environment (Baker, 1979: 68; Cullinan et al., 1983: 143). Children with anxiety often appear as ashamed, timid, over-dependent and over-sensitive. Sleep

disturbances can arise and they see themselves as inadequate. The degree of sleep disturbances might differ, e.g., difficulty falling asleep, dreams, nightmares of often waking up during the night. They do not make friends easily and are not very self-aware. These children often are emotionally immature for their age and appear to be submissive, easily discouraged and cry very readily.

Psychosomatic forms of anxiety include the following (Baker, 1979: 67): poor appetite, melancholy, stomach aches, diarrhea, disturbed sleep, poor concentration and restlessness. Little children who are anxious often hold their breath for a definite time. According to Despert (1965: 164) eczema in small little children also often can be attributed to emotional problems such as anxiety.

It seems that anxiety underlies feelings of uncertainty and helplessness. The adequate realization of the essences of educating, especially those connected with trust and authority, is necessary to eliminate or neutralize these feelings of uncertainty which can lead to anxiety.

2.4 Fears

Children generally have fears. Fear is connected with a person's behaviors in a specific situation. Most children show a fear of something at one or another time in their lives (Schwartz and Johnson, 1981: 78).

Fears can take various forms but some actually are universal, instinctive and innate such as a fear of loud noises, unexpected movements, the dark and being dropped. It seems that some fears are culture-bound, e.g., the fear of spiders and snakes (Ollendich and Hersen, 1983: 287).

General fears that most children have at one time or another are fears such as separation, getting hurt, the toilet, imaginary creatures, thieves, dogs and other animals, to be alone, communicating, elevators, drowning and fire. As children become older their fears are transferred to the school and school situations as well as to social events (Ollendich and Hersen, 1983: 278; Schwartz and Johnson, 1981: 79).

Research has shown that fears of children under 8 years are bound more to the concrete, e.g., fear of objects, animals and situations in

which they can hurt themselves such as an automobile accident, falling out of a tree, etc. A possible explanation for this is that parents continually warn their children about such "dangers" and in doing so they inculcate these fears in them. It has been found that as a child grows older and can identify dangerous situations himself, in many cases the fears disappear.

In the age group 5 to 12 many of the children's fears are imaginary such as the fear of imaginary creatures like witches and dinosaurs and also for many improbable situations such as the end of the world will come (Meyer and Salmon, 1984: 325).

Research indicates that girls have more fears than boys (Sarafino and Armstrong, 1980: 430). The reason for this is probably found in our cultural view of the behavior of boys and girls. Boys are encouraged to not be afraid, to be a "man", while girls are readily comforted and protected.

2.5 Phobias

2.5.1 Introduction

A phobia is a fear reaction that is out of proportion to the situation. It cannot be consciously managed or reasoned about. It puts a limitation on a person's lifestyle (Cullinan et al., 1983: 143; Ollendrich, 1983: 277). Phobias are characterized by their persistence. Although school phobia is the most discussed regarding children, often they also have phobias regarding dentists and doctors. Other things that can lead to a phobia are, e.g., busses, dogs, cats, heights, closed areas, stores, a crowd of people and insects (Baker, 1979: 68). Schwartz and Johnson (1981: 201) discuss a study of children with phobias that found that they are much more anxious and show a greater inability to learn than children without any phobias.

2.5.2 School phobia

School phobia has to be distinguished from truancy. If a child is a truant he stays away from school and participates in other activities during school time. Usually his parents are not aware that their child is not at school. In the case of school phobia the child stays home with his parents' knowledge. School phobia and separation anxiety often go hand in hand because in most cases the child is not

afraid of school but of being separated from one or both of his parents. "These children are preoccupied with morbid fears of what will happen to their parents or themselves if they leave home. Although the fears may be rather specific, sometimes they are simply ill-defined thoughts about death and other real and unreal dangers" (Sarason and Sarason [in English], 1984: 393).

Children with school phobia often show psychosomatic symptoms such as stomach problems, nausea and headaches. According to Ross (1980) it is not unusual for these children to have fears such as of the dark or being left alone.

Kennedy (1965) distinguishes between two types of school phobia, namely, type I which is characterized by an acute attack during the beginning of teaching and usually on a Monday morning after an authorized absence from school for a short time, and type II where the onset has occurred gradually. Type II children usually are older than those of type I and the problem can crop up any day of the week. Kennedy further found that in the first case (type I) the parents of such a child communicate well with each other and they take responsibility in the home. The problem seems to be elicited by recent stressful events. In the case of type II, the parents have psychological and behavioral problems and the communication between them is not as desired. Also, in the case of type II it is difficult to identify particular events that are stressful and that have given rise to the problem. He also found that the prognosis for type I is very good.

Since school phobia and separation anxiety are so closely related, the family interactions the child participates in are very important for treating the problem. The disharmonious relationships that exist between the parents and their child have to be repaired and in doing so put the child in a position to proceed again with his usual school activities.

Bowlby (1973) distinguishes four main patterns of family interaction that can have school phobia as a consequence:

- * either the mother or the father are very anxious persons and keep their child home as a companion;
- * the child fears that if he goes to school something serious will happen to one or both of his parents;

- * the child believes that if he leaves his parents' house something terrible will happen to him; and
- * the mother or father believes that something terrible will happen to their child if he leaves the house.

In dealing with school phobia, immediate action is necessary and, indeed, for the following two reasons:

First, additional problems arise at school to the extent that he falls behind with his school work and also if he loses his school friends. Second, the medical and parental attention he enjoys serve to reinforce his behavior and this makes it enjoyable for him to stay home.

3. AGGRESSIVE BEHAVIOR

There is mention of ambiguity in defining aggression. In some cases aggressive behavior such as self-validating behavior and where a child stands up for his own rights is encouraged, but children who show aggressive behaviors such as fighting, threatening, outbursts of rage, disobedience, destructive activities, impudence, the tendency to pester others, the tendency to do what is contrary to what is expected, disrespectful use of language, beating, biting, scratching and kicking, and the tendency to throw objects at others are disapproved and such aggressive behavior is viewed as deviant.

In defining aggressive behavior the social and cultural quality of society has to be taken into account. Within Western culture sex-typed behavior already is introduced into children's play by preschool age. "... the boy who is afraid to aggress against his peers may be establishing the 'mama's boy' behavior patterns seen in later years as well as paternal rejection as a 'sissy'" (Berg and Pennington [in English], 1966: 203).

It is important that children learn to deal with their aggression and how to give expression to it in socially acceptable ways because most children show aggressive behavior at one time or another in their lives.

If it has to be determined whether a child's behavior is aggressive, factors such as the following have to be considered: his purpose in behaving this way; the effect of his behavior on the victim and the

quality of the aggressor's character; the victim and the person judging the behavior (Cullinan et al., 1983: 135).

In most cases, the originating factors for aggressive behavior in children can be found in the interaction among family members. The importance of the example that the adult members of the family present cannot be over emphasized. An aggressive and demanding father prepares the way for his son to become similar and to be described as an aggressive child.

4. SOCIAL WITHDRAWAL

These children often appear to be moody and self-conscious and do not communicate easily. They also are listless and apathetic and often engage in daydreaming and unrealistic fantasies. Because these children are so turned into themselves they gradually show a handicap with regard to their peer group at social events. "In the withdrawal disturbance ... children apparently attempt to minimize their anxiety by turning inward -- in effect detaching themselves from a seemingly dangerous world" (Coleman et al. [in English], 1980: 500).

In many cases the withdrawal clearly emerges within the first 2 or 3 weeks that a child attends preschool or elementary school. Thus it is important that an anxious and shy child enjoys attention during this period of time. Just as in the case with aggressive behavior, withdrawal ought to be viewed as an important indication that a child has emotional, social and intellectual needs that are not fulfilled (Pringle and Mia, 1975: 76).

According to Greenwood (Cullinan et al., 1983: 145) two variations of withdrawal arise, namely, non-interaction and rejection. According to this report it seems that these children also have very few well-developed social interaction skills at their disposal. They have never learned how to initiate an interaction or how to maintain one. They often appear as if they are daydreaming and give the impression that they choose to play alone. It seems that some children even are afraid of social groups. Children who are classified under the rejecting group initiate contact well but in a way that apparently repels other children. These children are annoying, will always give orders and often are jealous. These aggressive and inappropriate behaviors lead the other children to avoid them or exclude them from their activities.

In trying to determine the reasons for this behavior it is necessary to investigate the primary educative situation, the family. The interaction among family members and especially the interaction among the parents and the child are extremely important here. It might seem that because of a lack of support by his parents in their educating him a child turns to his own inner world.

The example the parents provide on social occasions must not be underestimated. The anxious, over-protective parent inhibits a child in his social development and does not allow him to practice his social skills. Inherited characteristics such as over-sensitivity, unusual musical talent, etc. can play a role and allow a child to appear as withdrawn.

5. ELECTIVE MUTISM

Elective mutism is closely related to the problem of withdrawal. In the "Diagnostic and Statistical Manual of Mental Disorders" (DSM III) a child with elective mutism is described as someone who continually avoids talking in practically every social situation in spite of having speech at his disposal and understanding the spoken language. The lack of speaking also must not be attributable to other psychological or physical defects. In addition, the speech at his disposal must be appropriate for his age. The following characteristic symptoms for this disturbed behavior are listed in the DSM III (1979); excessive shyness, social isolation and withdrawal, school refusal, oppositional behavior and the ability to communicate in non-verbal ways by nodding and shaking his head and sometimes using a few words in a monotone.

Usually these cases are first brought to the attention of professional personnel at school going age even though the deviancy started at an earlier age (Ollendich and Hersen, 1983: 243).

According to Reed (Baker, 1979: 139) there are two types of elective mutism. The first he describes as being hyper-relaxed and very negativistic and immobile. The second type shows much tension and anxiety. Reed indicates that children who show the first type are manipulative and use their mutism as a way of attracting attention or eluding assignments. The children who show the second type of elective mutism he views as children with phobias and who use the behavior to try to get rid of fears.

There appear to be a variety of opinions regarding the origin of elective mutism. The most general view is that a child who manifests the symptom manipulates specific family members in this way. By this behavior he maintains his status quo in the family and derives security from this (Child Care Quarterly, 1978: 224; American Journal of Psychoanalysis, Vol. 39, 1979).

Regarding the origin of elective mutism there still is a great deal of obscurity. An extraordinarily close bonding with the mother has been called a possible cause. Related to this is an over-dependency from the mother and regressive behavior as a defense mechanism on the child's part.

In many cases it is found that there is a family history of shyness. Others believe family members are mutually very dependent and don't offer security and safety (Baker, 1979: 138; Ollendich and Hersen, 1983: 224).

It seems that the interaction among family members, especially those between the parents and the child, are extremely important as a possible causative factor for this deviant behavior. Because the parents do not succeed in supporting a child in a way that he can become an adequate adult, the child turns into himself and his own inner world. Here the role of the example set by the parents must not be overlooked.

The over-anxious and over-protecting parent who does not allow his child to explore and discover his world inhibits him in his social activities and he does not get the necessary opportunities to practice his social skills.

The role of innate and hereditary characteristics such as extreme sensitivity and exceptional musical talent, etc. in the case of elective mutism cannot be ignored.

6. DISOBEDIENCE

The opinions of parents about what constitutes disobedience differ greatly. Behavior that is acceptable to some parents is unacceptable to others and is considered by them to be symptomatic of serious disobedience. Some parents experience the first signs of emancipation in their children and their related behavior as a threat

to their authority. Generally a compromise is possible between what the parents expect and what the child thinks is acceptable and a harmonious family life is accomplished. If the parents are fair (just) the children usually follow in these ways of fairness (Baker, 1979: 204). If there has to be a decision about whether a child is disobedient, matters such as possible illness and fatigue should always be considered.

Once again it is emphasized that the example the parents present to their child is of the greatest importance. If the parents manifest poor manners he cannot expect that his child will behave with good manners. If the words "thank you" and "please" are not part of a parent's vocabulary he cannot expect that his child is going to use these words often (if ever).

The authority relationship between parent and child has many facets. This relationship has to be built by both parties; i.e., both parent and child have an important role in this relationship. A parent cannot always remain an autocrat and dominate a child by means of a one-sided relationship and take away his entire responsibility for his actions. Understandably a child will revolt against such an autocratic way of educating. Still less can a parent give a child all responsibility for his actions. Such a defect in security only can lead a child to total confusion and a lack of discipline. It is a parent's task to bring his child to an acceptance of responsibility for his actions by means of sympathetic, authoritative guidance. No more responsibility and initiative should be expected of a child than what he can assume in accordance with his level of becoming. Yet a child needs to be continually assured of his parents' understanding and guidance. He has to acquire his security from the knowledge that his parents will not allow him to exceed the limits of proper behavior.

7. JUVENILE DELINQUENCY

The term "juvenile delinquent" legally refers to juveniles (usually under the age of 18) who have committed an act that is viewed as illegal if an adult would have carried it out. Many children labeled as juvenile delinquent are still not found guilty of violating the law but usually it is clear that if their deviant behavior is not discontinued it is unavoidable that they will come into conflict with the executors of the justice system.

Quay and Werry (1979) have distinguished four dimensions of juvenile delinquency, namely:

*** The socialized subculture of juvenile delinquents**

There are no signs of psychopathology to be noticed in these children. They appear to be normal and their delinquent behavior seems to be related to a criminal subgroup with whom they have an alliance. Other matters that apparently play a role in this group are a low socio-economic status of the homes from which the children come, unstable and disorganized home circumstances and parents with psychological and physical problems. It also is found that these children possess relatively weaker language skills (Wicks-Nelson and Israel, 1984: 275; Schwartz and Johnson, 1981: 302; Rutter, 1975).

*** The non-socialized psychopathic dimension**

These children do not appear to be members of a criminal subgroup. Tendencies noted in their behavior include defying authority, verbally aggressive utterances, an inclination proceed to assaulting behavior, an inability to benefit from approval or punishment and a lack of trust in fellow persons.

*** Neurotic-deviant delinquency**

Children who can be assigned to this group in general appear to be very shy, reserved and unhappy. There are indications that their behaviour makes them anxious and worried. These children are more subject to change and ready to accept authority. The chance that they will repeat or continue their delinquent behavior is considerably less than is the case with the other types of juvenile delinquents. The most important problems of these children appears to be psychological and emotional and it appears as if their delinquent behavior is a secondary problem.

*** The irresponsible and immature dimension**

These children easily become frustrated and often are made a scape-goat by other children. They are passive and according to Quay and Werry (1979) they are not readily accepted by delinquent peer groups. It seems that they are not in a position to deal with the demands of their environment.

Much research already has been done on the causes of juvenile delinquency. Glueck and Glueck (1959) have identified a series of family factors in terms of which delinquent behavior in groups of youths can be predicted relatively accurately. The **Glueck Social Prediction Table** associates the following factors with potential juvenile delinquency:

too strict and inconsistent parental discipline; inappropriate motherly care; parental indifference or animosity; fatherly unconcern or animosity and a lack of family bonding (poor affective bonding and very minimal shared interests).

Bandura and Walters (Ross, 1980: 132) found that the aggressive delinquent boys they studied came from families where inconsistent ways of educating were maintained, where there is mention of neglect of the boys by the fathers and where the fathers used physical means of punishment.

Sarason and Sarason (1984) found that there is a correlation between the following circumstances and juvenile delinquency:

- * rejection or a lack of security in the home;
- * the expectation that adversity will occur;
- * the exposure to anti-social roles within and outside of the home;
- * lack of support for achievement at social events and at school;
- * anti-social pressure from peer groups; and
- * poor physical and economic circumstances in the home and neighborhood.

The patterns of family interaction of boys who steal were analyzed by Reid and Hendricks (Kazdin, 1980: 393). They found that within these families there was a very low incidence of positive reinforcement between parents and child. They also found that the nature of the parent-child interaction had an influence on the type of delinquent behavior manifested by the child.

8. UNDERACHIEVEMENT

A prerequisite for adequate learning by a child is affective stability and emotional security. Thus the basis for adequate learning is created within the family.

Underachievement refers not only to children who fail but to all of those children who do not achieve according to their potentialities. This also includes the highly gifted pupil who does not achieve what can be expected of him as a highly gifted child. The role of the parents as supporters, encouragers and guides to full development and acceptance of responsibility, the role of the teaching by means of teaching and the role of the child as self-actualizer are the constituents for creating a restraining or promoting learning climate. Linking up with this, Pringle and Mia (1975: 79) explain that there is no shortcut to determining the cause of underachievement and also there is no easy solution to the problem. A thorough exploration of the interaction between parents and child and between teacher as well as a child's attributed meanings is necessary. Perhaps a child might have a need for help in re-interpreting the learning activity, the teacher or even the subject matter contents. According to Pringle and Mia (1975: 99), underachievement maintains itself in so far as a poor beginning with the learning event in school leads to chronic underachievement and the continual disappointment of the teacher.

9. EATING DISORDERS

9.1 Introduction

There are great differences in the eating habits acquired within various cultures. These differences include the age at which a child learns to feed himself, the neatness of his eating habits and the degree of parental strictness in conveying the rules and customs to their child.

The learning of eating habits by small children can be the breeding ground for later problems regarding them, but the interactions formed between parents and child regarding eating habits also can be the beginning of other emotional and behavioral problems such as the handling of authority.

Although it can be expected that problems can arise with the acquisition of eating habits, most problems are of a passing nature. In some cases the nature and duration of the problem is of such a nature that professional intervention is necessary. Some of these problems are discussed briefly.

9.2 Rumination

Children who ruminate bring food that they already have swallowed back up into their mouth by willful vomiting and chew it again. This is not related to feelings of nausea.

Although various theories about the etiology of this phenomenon are described (Wicks-Nelson and Israel, 1984: 112) still it appears merely to be a method by which a child is involved in self-stimulation and by which he directs the attention of adults to him. In extreme cases this can lead to serious digestive problems and even death. This disturbance mainly is limited to the infant or toddler phase.

It is important that learning eating habits be approached very sympathetically by parents. Parents who continually insist that children who begin to feed themselves might not make a mess or who choose to feed the child themselves to avoid making a "mess" leave their child in the lurch in so far as they do not believe that he can learn neat eating habits himself. They do not understand their infant or toddler as someone who wants to be someone himself. This has the consequence that the child becomes frustrated and rebels against the inhibiting actions of his parents. In protest he uses precisely what for them is problematic, namely, his messy eating habits.

9.3 Pica

Pica is the Latin name for a bird known to be unable to keep itself from eating everything that appears. Thus, this eating disturbance is characterized by the fact that a child eats objects not meant for human consumption. Most babies at one time or another eat dirt, little pebbles and even foliage but very quickly learn to distinguish edible from non-edible objects. The diagnosis of Pica thus usually is made after a child has reached the age of three. Among other things, these children eat dirt, frays from material, splinters of wood, ashes, heads of matches, hair, rubber, soap, paper, feces (excrement), polish and cement. This eating habit can lead to serious dental and digestive problems. Death is not excluded since it easily can happen that the children ingest toxic substances. This seems to be a problem that appears more with lower socio-economic groups and also often with mentally retarded children (Wicks-Nelson and Israel, 1984: 114; Verville, 1967: 139).

Origins of this disturbance seem to be diverse (Wicks-Nelson and Israel, 1984: 115). Initially it was thought that the children experienced a deficiency in their diets but tests indicated none. In very many cases, parental uninvolvedness and superstition play a large role.

9.4 Obesity

The most general finding of the research on obesity is that it is the result of overeating. The role of genetic factors and illness are very slight and only account for a few cases of obesity.

There are differences of opinion about when a person can be viewed as too fat but it still appears as if 20% to 30% of the population is overweight. However, there is little doubt that fat children in most cases become fat adults (Ross, 1980: 291).

There are many reasons why children are overweight. According to Ross (1980: 290), the following reasons are important: parents who reward their children with food, recollections of experiences of safety and security during earlier styles of feeding (as a baby), the example of overweight parents and obesity as a negative reinforcement to be avoided in competition with the peer group. The immediately enjoyable sensation of eating pushes this latter idea into the background (Wicks-Nelson and Israel, 1984: 118).

These causes express the child's uncertainty and insecurity within the family. Thus it will be necessary to determine the underlying disharmonious moments in order to restore the trust and understanding between parent and child so that he experiences security and safety with his parents.

9.5 Bulimia

Bulimia is the phenomenon where a person overeats and then tries to undo the eating session by vomiting and purging. This can be related to periods of serious depression. The person is aware of his eating disturbance as deviant behavior and is very much afraid that he cannot control his eating habits. These children usually are dieting and then use this method to make up for the "damage" if they have deviated from the diet. Many anorexic patients show symptoms of bulimia (Sarason and Sarason, 1984: 406).

9.6 Anorexia nervosa

Anorexia nervosa is an eating disorder that mainly appears in White Westerners. Its appearance in Blacks so far is very slight (Ollendich and Hersen, 1983: 263). The outstanding characteristic of this disturbance is the intense wish to be extremely thin. This aim is realized because the person refuses to eat. It is important to note that this refusal to eat must not be attributable to other causes such as physical ones or a lack of appetite.

The criteria presented in the DSM III (p. 69) for the diagnosis of anorexia nervosa are the following:

- * An intense fear of being overweight. The fear does not decrease corresponding to a loss in weight;
- * A disturbed body image. The person "feels fat" while being very thin;
- * A weight loss equivalent to 25% of original weight or of projected weight from a weight chart;
- * Refusal to maintain a weight that is more than the minimum weight for her age and height according to a weight chart;
- * No physical cause that can account for the weight loss.

Initially the sickness was reported only for girls and young women but now more and more boys are mentioned regarding treatment instances.

It appears that anorexic patients' childhood seemingly progressed without problems. According to parental reports they are good children who achieved well at school. All of the parents were amazed that these "model children" have problems.

The present behaviors of the patients are described as follows: it is difficult to make contact with them, they are aloof and reserved, some show hostility and are secretive and often are sad. The patients usually are restless; they choose to stand if they have to wait; they ride bicycles or jog; and they sleep little. They are preoccupied with food, even dream about it and often show great interest in the food of their family members. They often are inclined to perfectionism and work hard in academic areas; it keeps their thoughts away from food (See Ollendich and Hersen, 1983: 265; Wicks-Nelson and Israel, 1984: 121; Sarason and Sarason, 1984: 403).

Relationship problems and the related disharmonious dynamics of educating in the home seem to be the most general occasion for this problem. Researchers have found that in the families of anorexic patients there are relationship problems between the parents and child as well as tension in the parents' marriage. The program of treatment includes, besides a physician, pedotherapy, and psychotherapy for various members of the family along with family therapy (See Schwartz and Johnson, 1981; Ollendich and Hersen, 1983).

10. ENURESIS

There can only be mention of enuresis after a child has reached an age where it can be expected of him that he practice sufficient control of his bladder. According to the DSM III (p. 80) criterion this is when a child is five years old. In addition, by a 5 to 6 year old this has to occur at least two times a month and with older children at least once per month and this must not be the result of a physical problem.

Although other authors speak of enuresis in younger children (See Ollendich and Hersen, 1983: 202; Ross, 1984: 296) they present as a criterion for functional enuresis that the child had to have been dry for at least 6 months. In the case of older children who never have had a period of bladder control are referred to as having chronic enuresis or as developmentally backward. The disturbance arises more often in boys than in girls.

The causes given for enuresis in the literature include the following (Coleman et al., 1980: 510; Ollendich and Hersen, 1983: 202; Wicks-Nelson and Israel, 1984: 126): emotional problems that lead to anxiety and tension in a child, relationship problems within the family that also lead to anxiety and tension in a child and the disposition of the educators regarding enuresis. In many cases there is a family history of enuresis without genetic factors having been found. It seems that the educators do not attribute lots of importance to the "problem" and believe it will correct itself. The most recent explanation for the problem centers on the methods used to teach toilet habits to the child as well as developmental factors (Wicks-Nelson and Israel, 1984: 129).

The specification of causative factors implies a thorough analysis of the disharmonious dynamics of educating in which this child has participated. The dysfunctional parental actions that lay the foundation for a child interpreting his educative situation as full of tension and anxiety producing have to be determined.

11. ENCOPRESIS

According to the DSM III (p. 81) there is mention of primary encopresis if a child was not clean for at least one year before the age of 4 years and of secondary encopresis if the child was clean at least for one year before his fourth year. The criteria for the diagnosis of encopresis are:

- * frequent incidents where defecation occurs in an inappropriate place according to the community;
- * at least one such incident after the age of 4;
- * it must not have a physical cause.

Some authors believe encopresis can be diagnosed from the age of 2 or 3 years (See Coleman et al., 1980: 510; Wicks-Nelson and Israel, 1984: 132). As in the case with enuresis, encopresis is seen in boys more than in girls.

The reasons for encopresis often are sought in developmental disturbances or deficiencies in physical development. The faulty learning of toilet habits also must not be ignored as a possible cause of the problem. However, it appears that the relationships and interactions within the family are very important causative factors and thus the disharmonious dynamics of educating have to be gone into very thoroughly.

12. NAIL BITING AND THUMB SUCKING

The psychoanalytic theory that thumb sucking occurs because a child has not gotten enough oral stimulation from sucking is contradicted by research (Johnson and Medinnus, 1969: 252).

Many psychologists accept that thumb sucking and nail biting are symptoms of uncertainty and that a child manifests these symptoms in situations that for him provoke anxiety or that he experiences as hostile. The symptoms are used as a way to ease tension (Johnson and Kress, 1967: 252; Coleman et al., 1980: 511).

In order to remove the symptom a child has to be helped to experience himself as more certain and as more adequate. Thus, once again a thorough analysis is needed of the ways the essentials of educating are actualized and the dysfunctional activities have to be specified.

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