CHAPTER 8
EMOTIONAL AND BEHAVIORAL PROBLEMS

1. INTRODUCTION

Educating can be defined as the help given [by adults] to a child on his/her way to adulthood. The fact he/she strives toward adulthood or 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/she becomes older and more adult, his/her role increases. Although, initially, the educand's engagement in the conversation is mainly determined by his/her parents, later the educator acts as an intermediary between the child and other persons, and other contents so his/her 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 which they see as limited or blocked and, thus, where there is no harmonious way to proceed to guide the child to adulthood.

Hence, an educative 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 educative distress, the emotional and intellectual moments of his/her becoming must show a "backwardness," to the extent that they are comparable to the longitudinal level of development on which he/she ought to e. However, the uniqueness of each child must always be considered in determining if he/she is deviant in his/her behavior and conduct.

Symptoms of deviant behavior must be viewed as a cry of distress, a call for help. According to Pringle and Mia (1975: 75), such symptoms point to an unbearable tension between the child and his/her 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 the 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 they are acceptable conduct for a specific child in his/her own unique educative situation.

The following are matters which the educational psychologist must consider 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 a child is in: The educational psychologist must be conversant with the various ways of behaving which 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 wakes up at night, but the same behavior from an 11- to 12-year-old child can lead one to suspect there is an underlying problem.
* The intellectual potential of a child is extremely important when it must be determined if his/her way of behaving is deviant. It is expected the behavior of a child of above average intelligence corresponds 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/her computing or books rather than playing ball with his/her friends.
* The duration of a symptom can be a determining aspect in deciding its authenticity. 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 must be present for a long time and restrains the child in the normal course of his/her 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 divorced, this is not viewed as a deviancy. However, if this behavior lasts for a few months or even a year, it can be 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 which is viewed as acceptable and "normal" within one community might be viewed as an indication of behavioral deviancy in another cultural context.

* The uniqueness of each child and the educative situation he/she is in always must be considered in evaluating his/her symptoms as deviant behavior.   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/her emotions and talk about his/her problems, while a child hardly ever seeks help for his/her own problems. The adults who are responsible for educating a child (parents, teachers) usually take the initiative to seek help for him/her. 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 an indication 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 is indicated that, in most cases of deviant behaviors in children, there is a connection between a child's meanings, as manifested in his/her behavior, and the relationship which exists among and between the various family members and, especially, between the child and his/her 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 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 in deviant behavior. "Since brain injury results not only from tumors 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 during their development, and that parents can easily 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/her. Data from the above and other research indicate that physical factors, irrespective of whether they are congenital, innate, or arise postnatally, 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 they have a problem or do not have the necessary expressive language ability to verbalize their problems. Now the question is when a child's comportment and behavior should be viewed as neurotic.

All children at times are afraid or even anxious, but usually the behavior is short lived. If the behavior persists despite attempts to help him/her overcome the anxiety, or if he/she reaches an age where his/her behavior no longer is appropriate for his/her 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 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 them, children's neurotic behaviors stem from the fact that the situations they are 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 are manifested are discussed.

2.2 Depression

Even though 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, bedwetting, 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. They find 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 are 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 show the following characteristics: excessive feelings of guilt, passivity and active feelings about suicide, they have 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 use 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 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 gradually becomes 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/her parents, and to determine which essentials of educating are actualized inadequately. Educative activities which are especially encountered in child depression are those activities which, because of their inadequate realization, lead to feelings of helplessness, rejection, failure, and of not satisfying the demands laid down by his/her parents.

Other factors which 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 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 him/herself and doesn't look for a cause in his/her environment (Baker, 1979: 68; Cullinan et al., 1983: 143). Children with anxiety often appear as ashamed, timid, overdependent, and oversensitive. Sleep disturbances can arise, and they see themselves as inadequate. The

degree of sleep disturbances might differ, e.g., difficulty falling asleep, dreams, nightmares or often waking up during the night. They do not make friends easily and are not very self-aware. These children are often 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 related to 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 take various forms, but some 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, which 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 shows 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 is found that, as a child grows older and can identify dangerous situations him/herself, in many cases the fears disappear.

In the age group 5- to 12-years, many of the children's fears are imaginary, such as the fear of imaginary creatures like witches and dinosaurs, and 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 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 which 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 have phobias regarding dentists and doctors. Other things which give rise 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, which found that they are much more anxious and show a greater inability to learn than children without phobias.

2.5.2 School phobia

School phobia must be distinguished from truancy. If a child is a truant, he/she stays away from school and participates in other activities during school time. Usually, his/her parents are not aware their child is not at school. In the case of school phobia. the child stays home with his/her 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/her 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, i.e., 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 find 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 specific events which are stressful, and which have given rise to the problem. He also finds 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 which exist between the parents and their child must be repaired and, in doing so, enable the child to proceed again with his/her usual school activities.

Bowlby (1973) distinguishes four main patterns of family interaction which can result in school phobia:

* either the mother or the father are very anxious persons and keep their child home as a companion;
* the child fears if he/she goes to school, something serious will happen to one or both parents;
* the child believes if he/she leaves his/her parents' house, something terrible will happen to him/her; and

* the mother or father believes something terrible will happen to their child if he/she 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/she falls behind with his/her schoolwork, and if he/she loses his/her school friends. Second, the medical and parental attention he/she receives, serve to reinforce his/her behavior, and this makes it enjoyable to stay home.

3. AGGRESSIVE BEHAVIOR

There is ambiguity in defining aggression. In some cases, aggressive behavior, such as self-validating behavior and where a child stands up for his/her own rights, is encouraged, but children who show aggressive behaviors such as fighting, threatening, raging outbursts, disobeying, acting destructively, being impudent, tending to pester others, doing what is contrary to what is expected, using language disrespectfully, beating, biting, scratching and kicking, and tending 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 must be considered. 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 must be determined whether a child's behavior is aggressive, factors such as the following must be considered: his/her purpose in behaving this way; the effect of his/her 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).

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In most cases, the originating factors for aggressive behavior in children are found in the interaction among family members. The importance of the example the adult members of the family present cannot be overemphasized. 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, 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 to themselves, they gradually show a handicap regarding 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 receives attention during this period. 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 which are not fulfilled (Pringle and Mia, 1975: 76).

According to Greenwood (Cullinan et al., 1983: 145), two variations of withdrawal arise, i.e., noninteraction and rejection. According to this report, these children also have very few well-developed social interaction skills. 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 are even afraid of social groups. Children who are classified under the rejecting group initiate contact well, but in a way which 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 or exclude them from their activities.

In trying to determine the reasons for this behavior, it is necessary to investigate the primary educative situation, i.e., the family. The interactions 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/her parents in their educating him/her, a child turns to his/her own inner world.

The example the parents provide on social occasions must not be underestimated. The anxious, overprotective parent inhibits a child in his/her social development and does not allow him/her to practice his/her social skills. Inherited characteristics, such as oversensitivity, 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, despite having speech at his/her 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/her disposal must be appropriate for his/her 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 nonverbal ways by nodding and shaking his/her 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. He describes one as being hyperrelaxed and very negativistic and immobile. The other type shows much tension and anxiety. Reed indicates that children who indicates that the first type is 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 are 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/she maintains his/her status quo in the family and, in doing so, he/she feels secure (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 overdependent 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 interactions 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 fail in supporting a child in a way which he/she can become an adequate adult, the child turns in him/herself and his/her own inner world. Here, the role of the example set by the parents must not be overlooked.

The overanxious and overprotecting parent, who does not allow his/her child to explore and discover his/her world, inhibits him/her in his/her social activities, and he/she does not get the necessary opportunities to practice his/her social skills.

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

6. DISOBEDIENCE

The opinions of parents about what constitutes disobedience differ greatly. Behavior 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 must 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, they cannot expect their child will behave with good manners. If the words "thank you" and "please" are not part of a parent's vocabulary, he/she cannot expect his/her child is going to use these words often (if ever).

The authority relationship between parent and child has many facets. This relationship must 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/her entire responsibility for his/her actions. Understandably, a child revolts against such an autocratic way of educating. Even less so, a parent cannot give a child all responsibility for his/her actions. Such a defect in security can only lead a child to total confusion and a lack of discipline. It is a parent's task to bring his/her child to an acceptance of responsibility for his/her actions by means of sympathetic, authoritative guidance. No more responsibility and initiative should be expected of a child than what he/she can assume in accordance with his/her level of becoming. Yet, a child must be continually assured of his/her parents' understanding and guidance. He/she must acquire his/her security from the knowledge that his/her parents will not allow him/her to exceed the limits of proper behavior.

7. JUVENILE DELINQUENCY

Legally, the term "juvenile delinquent" refers to juveniles (usually under the age of 18) who have committed an act which 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) distinguish four dimensions of juvenile delinquency, i.e.:

* 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 which apparently play a role in this group, are a low socioeconomic status of the homes from which they 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 to engage in 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 behavior 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 appear 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 scapegoat 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 able to deal with the demands of their environment.

Much research 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 youth 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) find that the aggressive delinquent boys they studied came from families where inconsistent ways of educating are maintained, where there is neglect of the boys by the fathers, and where the fathers use physical means of punishment.

Sarason and Sarason (1984) find 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 antisocial roles within and outside of the home;
* lack of support for achievement at social events and at school;
* antisocial 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 find that within these families, there is a very low incidence of positive reinforcement between parents and child. They also find that the nature of the parent-child interaction has an influence on the type of delinquent behavior manifested by the child.

8. UNDER ACHIEVEMENT

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 also to those children who do not achieve according to their potentialities. This 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 teacher, 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 under achievement, and 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, are necessary. Perhaps, a child might have a need for help in reinterpreting the learning activity, the teacher or even the subject matter contents. According to Pringle and Mia (1975: 99), underachievement is maintained in so far as a poor beginning with the learning event in school leads to chronic under achievement, 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 him/herself, 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 such that professional intervention is necessary. Some of these problems are discussed briefly.

9.2 Rumination

Children who ruminate bring food which they already have swallowed back up into their mouth by willful vomiting and chewing 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/she directs the adults' attention to him/her. 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," and leave their child in the lurch in so far as they do not believe he/she can learn neat eating habits him/herself. They do not understand their infant or toddler as someone who wants to be someone him/herself. This has the consequence that the child becomes frustrated and rebels against the inhibiting actions of his/her parents. In protest, he/she uses precisely what for them is problematic, namely, his/her messy eating habits.

9.3 Pica

Pica is the Latin name for a bird known to be unable to keep itself from eating everything which appears. Thus, this eating disturbance is characterized by a child eating 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 nonedible 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 which appears more with lower socioeconomic groups, and 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 indicate none. In very many cases, parental noninvolvement, 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 to restore the trust and understanding between parent and child so that he/she experiences security and safety with his/her 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/her eating disturbance as deviant behavior and is very much afraid that he/she cannot control his/her 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 which 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 which is more than the minimum weight for his/her age and height according to a weight chart;
* No physical cause which can account for the weight loss.

Initially, the sickness was reported only for girls and young women, but now increasingly more boys are receiving treatment.

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

The present behaviors of the patients are described as follows: it is difficult to encounter 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 must 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 find 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 enuresis after a child has reached an age where it can be expected that he/she practices sufficient control of his/her bladder. According to the DSM III (p. 80) criteria, a child must be at least five years old. In addition, with a 5- to 6- year-old, this must 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 which lead to anxiety and tension in a child, relationship problems within the family which also lead to anxiety and tension in a child, and the educators' attitudes about 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 which lay the foundation for a child interpreting his/her educative situation as full of tension and anxiety must be determined.

11. ENCOPRESIS

According to the DSM III (p. 81) there is 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/her 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 must be looked 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 a child manifests these symptoms in situations which, for him/her provoke anxiety or which he/she experiences as hostile. The symptoms are used to ease tension (Johnson and Kress, 1967: 252; Coleman et al., 1980: 511).

To remove the symptom, a child must be helped to experience him/herself 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 must be specified.

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