EMOTIONAL HANDICAPS TO LEARNING IN TWO CULTURES*

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SUMMARY

Deteriorating academic performance in schoolchildren may be due to emotional rather than intellectual causes, but these are not always recognized. The problem is likely to be of increasing importance in African children in Rhodesia as the general level of education rises.

Emotional problems in 11 European and 16 African schoolchildren are compared. Although no firm conclusions can be drawn, the evidence suggests that the same conceptual framework may be used for both groups; that physical symptoms may present more often in African children; and that 'over-driving' and peer group rejection may be more common psychopathological factors in African children.

The incidence of psychiatric problems in children is not accurately known, partly because there are no generally acceptable criteria of abnormality; the most frequent 'abnormalities' of child behaviour are, in fact, normal stages of development which have been extended in time or significance.[1] Nevertheless, problems are very common. A recent study by New York University of 1 034 Manhattan children selected at random indicated that 12% showed marked to severe psychiatric impairment.[2] Planning for psychiatric services in Britain is based on the estimate that about 2% of all schoolchildren will need psychiatric treatment every year, but recent reports have called for greatly increased investment in physical and professional resources for dealing with disturbed children.[3]

Although emotional problems frequently give rise to disturbed behaviour both at home and within the classroom, the continual monitoring of the child's school career may sometimes bring to light deteriorating academic or social performances before other symptoms become obtrusive. Parents often fail to recognize the true nature of their child's disability and it is frequently assumed that the child is 'not trying'. On the contrary, the child may be well aware that he is not functioning as usual and bewildered as to why this should be so despite his increased effort. Exasperated parents often resort to increased discipline and extra lessons in attempts to drive the child harder. Further deterioration results until—as a last resort and without much hope—the help of the doctor is enlisted.

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With the increasing educational opportunities for African children who form more than half the African population,[4] it is inevitable that educational problems of this kind will be seen with increasing frequency.

The purpose of this paper is to compare groups of African and European children and, although the groups are too small for any firm conclusions, to suggest tentatively that the same conceptual framework is valid for both, despite important clinical differences.

CLINICAL GUIDELINES

The picture which confronts the doctor is very variable but the following broad diagnostic categories were used in the present study:

1. Psychological Discomfort

(a) *School phobia.* This is manifested as truancy, refusal to attend school or repeated absences because of minor ailments. Acute and chronic forms can be differentiated.[5]

(b) *Depressive states.* These are often difficult to diagnose as the presenting symptoms may be entirely misleading, e.g. vague abdominal pain,[6] and the assessment of depressed mood on interview is not very reliable.[7]

(c) *Anxiety states.* Children's fears are commonly related to a distinct object with subsequent stimulus generalization. Abnormal fears may be derived from other children or adults and, if unrelieved, lead to hysterical features which complicate the picture. Emphasis on the somatic components is common, particularly in girls.

(d) *School inadequacy.* This is manifested as lack of interest in school, a disinclination to study, lack of application and compensatory identification with other children with educational problems. Alternatively, the child may react by acting out aggression and expressing it as defiance, rudeness or general negativism.

2. Cognitive Inefficiency

This is manifested as an inability to think clearly or use occupational or social skills.

3. Disturbance of Bodily Function

There may be loss of weight, headache, persistent diarrhoea, etc.

4. Deviation from Social Norms

Statistical correlations of behaviour patterns with situational factors have revealed three broad categories of

social maladjustment:[8]

(*a*) An unsocialized aggression syndrome characterized by defiance of authority, initiatory fighting, cruelty, malicious mischief, assaultive tendencies and guilt feelings.

(*b*) An unsocialized delinquency syndrome characterized by bad companions, staying out late at night, habitual truancy from school or home, furtive and co-operative stealing, gang activities.

(*c*) An overinhibited syndrome characterized by sensitiveness, seclusiveness, shyness, anxiety and submissiveness in social situations. There is isolation from the peer group with silent unobtrusive behaviour at school and preoccupation with solitary entertainment and fantasy at home.

CLINICAL STUDIES: EUROPEAN CHILDREN

During the 12 months from August 1967 to July 1968, 43 children were referred to the Bulawayo Child Guidance Clinic. Eleven of these, referred because of difficulties at school, form the group of this section; they were otherwise unselected.

Psychological testing was undertaken by a psychologist using the South African Individual Performance Scale and Interest Profile, but all were treated by myself.

There were 10 boys and 1 girl. The ages of the boys ranged from 6 to 16 years; four boys were under 12 years and the remaining 6 aged 14 - 16 years. The girl was aged 7 years.

One boy was thought to be suffering from temporal lobe epilepsy which caused episodes of altered consciousness, with academic deterioration, despite an IQ of 101. Two other boys were thought to be handicapped by low intelligence; one had an IQ of 79 and the other had considerable reading difficulty and no concept of number despite two years in K.G. 2. This latter boy also had obvious right/left disorientation and marked anxiety. Among the remaining 8 patients deteriorating schoolwork was the sole symptom in only one case; the others all had multiple difficulties.

The only girl was described as showing nervous behaviour and lacking confidence while the 6 boys showed symptoms such as aggression; telling lies; smoking; hostile, resentful behaviour at home; destruction of toys; running away from home; running away from school; loss of friends; and association with 'undesirables'.

Psychological testing was done in 6 of the 8 cases. Intelligence quotients ranged from 86 - 120 with only two under 100. The Interest Profile revealed a very low motivation in 3 cases, a strong desire for acceptance by the peer group in one case, and emotional inadequacy and stereotyped responses suggesting fear of freedom in the girl.

There was one case each of school phobia, depression, school inadequacy and cognitive insufficiency respectively. Two cases suffered from anxiety, while the remaining 2 cases showed the unsocialized aggression syndrome.

Among the 6 boys in the 14 - 16 years age-group, symptoms had been present for 1½ years in one case and for more than 2 years in the remaining 5. These findings suggest that parents took little notice of their sons' disturbances until impending career choice or examination precipitated a crisis.

Psychopathology

In two boys, both aged 15 years, there were easily identified sources of stress. In one case, the mother had divorced an alcoholic father early in the boy's childhood; in the other, the boy had been adopted by elderly immigrant parents of Central European origin who had little grasp of the mores of contemporary adolescent society.

In the case of the boy with the right/left disorientation, there was an obvious neurotic tendency in the mother, including three suicidal attempts; the brother was epileptic.

The mother of the only girl described herself as nervous and highly strung; the father idolized his daughter and as a consequence the child was overindulged and overprotected.

In the remaining 5 cases, all boys, neurotic traits were detectable in the mothers of four; two had been previously married but divorced, and one had required psychiatric treatment. The last mother described herself as volatile and quick-tempered and the father as 'unstable', by which she meant not in the least interested in his son and inconsistent in his discipline; the marriage was unhappy with poor sexual adjustment.

Only one boy appeared to have a fairly stable family background, but he was having difficulty in being accepted by his peer group; he was suffering from a depressive illness.

Treatment and Outcome

Institutional placement was recommended for one of the boys with impaired intelligence; the other was not treated. The epileptic boy was treated for 6 months but showed no improvement. Two others did not attend after the first interview but the remaining 6 were followed up for 1 - 2 months. Two were given antidepressant drugs in addition to psychotherapy. One patient showed no improvement after 2 months, but the remaining 5 responded satisfactorily.

CLINICAL STUDIES: AFRICAN CHILDREN

There is no clinic specifically for African children in Bulawayo but the children are seen at the Psychiatric Clinic at Mpilo Central Hospital. A search of the clinic records between June 1966 and October 1969 brought to light some 16 children in whom failure at school was an important part of the clinical picture, although rarely the reason for the patient's being referred. Unfortunately, many records were incomplete and had to be discarded.

Two of the children were already inpatients at the time they were referred to the clinic; a further 5 were subsequently admitted for investigation and treatment.

Patients

There were 12 girls and 4 boys. Ages ranged from 8 to 17 years, but only two, both girls, were under 10 years; the boys were aged 10, 14, 16 and 17 years respectively. Of the remaining 10 girls, four were aged 10 - 12 years, five 13 - 15 years and one was 16 years.

One girl was still in Sub B, 2 girls and 3 boys were undergoing secondary education, while 1 boy and the remaining 9 girls were in junior school; there were chil-children in Standards 1, 2, 3, 4 and 6 respectively.

Clinical Assessment

The pattern of presenting symptoms was very different from that of the European children. The boys aged 14 and 17 years respectively were brought because of poor performance; the other case—a girl of 8 years—had been mentioned as having performed poorly at school, but the primary reason for bringing her to the clinic was nocturnal enuresis. One boy and one girl, both aged 10 years, presented with persistent truancy but all the remaining 10 children presented with psychosomatic symptoms; in every case the illness had been of sufficient severity to prevent the child attending school. Three girls presented with fainting attacks and two with loss of voice. Both the girls with aphonia had been seen by an ENT surgeon who was satisfied that the condition was of psychological origin, although in one case the symptoms had been moulded by a previous attack of laryngitis with loss of voice.

Three girls presented with one each of the following symptoms: abdominal pain, pain in the legs and arrhythmic twitching of arms and shoulders. One boy presented with chest pain and palpitations but there was a previous history of nocturnal enuresis.

Three patients were thought to be handicapped by low intelligence. One boy aged 14 years was referred because he had failed his mid-year examinations miserably and was clearly out of his depth in Form I. One girl in Standard 4 was taken home with severe abdominal pain accompanied by screaming and throwing herself about and followed by an episode of unconsciousness; her electro-encephalogram was normal. The third patient was a girl of 10 years who had spent 4 years in Sub B, during which time she had played truant repeatedly. She was also given to lying and stealing and from time to time complained of hearing voices; her EEG was normal.

The remaining 13 patients were classified into the following diagnostic categories: psychological discomfort —school phobia (3), depression (3), depression with hysteria (2), anxiety (2), dissociated state (1), and disturbance of bodily function—2 cases. One of the girls classified as 'school phobia' presented with self-mutilation—cutting herself with a razor blade, poking stones into her ears, etc.—in a transparent attempt to avoid school.

The girl of 14 years classified as 'dissociated state', presented with loss of voice, but had previously suffered from dizziness and fainting at school and pathological lying; no obvious depression or anxiety was detected and it was difficult to fit her into the usual diagnostic categories.

The girl who presented with twitching of the arms and shoulders was thought to be suffering from anxiety. Muscular dystrophy was considered as a diagnosis, but creatinine studies were normal.

Psychopathology

Obvious family disruption was found in 5 cases. In the case of the girl who mutilated herself, both parents were deceased and she had been abandoned by her relatives; she was placed in a boarding school as being in need of care and protection.

In one case, the father died when the child was 2 years old. In another case the mother, a nurse, had been on a study course in Britain for a year. In the remaining two cases the parents were separated; in one of these cases, the stepfather was also overindulgent, and in the other the grandmother tended to drive the girl at school. Less obvious disturbance of family life was found in three other cases. One girl had a dominant mother who made maternal affection conditional on good academic performance, while another girl aged 15 years had a burgeoning sexual awareness which distracted her from her studies. The third case was the girl with aphonia classified as 'dissociated state'. Her father was known to be an habitual drinker and her mother spent much of her time lying in bed unable to speak; there appeared to be an element of psychic contagion.

Three of the 4 boys showed evidence of strong rejection by the peer group, leading to social isolation. In the remaining four cases, the child was clearly overdriven; that is, the parents insisted upon an academic performance beyond the child's capacity. In two of these cases the standard was set by a more successful sibling.

Treatment and Outcome

Seven children were treated in hospital and three of these were discharged within a week. Two were girls treated with cerebral stimulation for aphonia; both recovered their voices and were discharged after psychotherapy aimed at providing insight into the emotional nature of the illness. The third patient was the girl with pains in her legs of 4 months' duration; after initial psychotherapy she improved dramatically and was discharged after 3 days. Of the remaining 4 inpatients, one remained in hospital for 2 weeks while the other three remained 4 - 6 weeks. Two were treated with antidepressants and one with a minor tranquillizer in addition to psychotherapy; only one was treated with psychotherapy alone. All were improved at the time of discharge.

In the 9 children treated as outpatients, the outcome was not recorded in 3. Of the remaining 6, 2 were treated with phenothiazines in addition to psychotherapy; one improved after a week but the other showed no improvement after 2 weeks. Three others received antidepressants as well as psychotherapy; they were followed up for 2, 6 and 12 weeks respectively and all showed improvement. The last case was an overdriven boy who was managed adequately by parental counselling.

DISCUSSION

At one time considerable emphasis was laid on maternal deprivation in the genesis of emotional disorders in children,[9] but more recent work has cast doubt on whether the physical absence of the mother is so important; no statistically reliable association between a delimited period of separation from mother and subsequent abnormality has been demonstrated.[1] Rather, the quality of the relationship between the child and its parents seems to be more important. In order to develop satisfactorily the child needs an emotionally secure environment, and the three pillars of security are acceptance, affection and consistency.[5] The single traumatic incident is thought to be of little significance; the child is not likely to come to permanent harm unless there is persistent reinforcement because of adverse parental attitudes.[10]

Particularly adverse parental attitudes are: (*i*) overt rejection—characterized by neglect, severe punishment

and avoidance of contact; (*ii*) perfectionism—characterized by disapproval, fault finding and coercion; and (*iii*) overprotection—characterized by spoiling, nagging, overindulgence or hovering domination.

Unsatisfactory relationships between the parents tending to affect the children secondarily include social incompatibility, frequent quarrelling, husband's lack of consideration, or a marriage forced or disapproved of by relatives. Recent studies in various cultures have confirmed these basic tenets. In a study of neurotic children in Hong Kong,[11] adverse maternal attitudes—particularly overprotection and perfectionism—poor emotional relationships between parents and high neuroticism in the mothers were all found to be significant.

In a recent Australian study,[12] the development of neurotic disorder at an early age appeared to be associated with parental disharmony, cold and strict parents or parental mental illness. The importance of mental or physical illness in the mother was confirmed in a British study.[13]

Mothers of Swedish children with faecal soiling[14] tended to be overanxious; coercive pot-training was common but discipline was often inconsistent. The children were lacking in self-assertion and rarely had the normal period of defiance at 2 - 3 years.

It must be reiterated that the smallness of the groups precludes any firm conclusions, but the African children in this study seemed to fit the pattern found elsewhere fairly readily although it must be conceded that school attendance itself may have been a homogenizing influence on the two groups; also living in an urban area may have had a similar effect. The preponderance of girls in the African group as compared with the European may have been due to the propensity of girls to produce psychosomatic symptoms, which are more readily recognized by parents as requiring medical treatment. It follows that doctors dealing with African children must be wary of inexplicable headaches, vague pains or fainting attacks, particularly when they occur only at school.

Peer group rejection at school appeared more often in African children. It is tempting to suppose that the nature of African family life may be important in this respect. Since the children are usually brought up in an extended family, parental substitutes are usually available and deprivation should be comparatively uncommon. Thus peer group rejection might be expected to exert comparatively greater influence.

On the whole, African children seem to be relatively undisciplined in early years as compared with their European counterparts. However, once at school the parental desire for status leads to 'perfectionist' attitudes which, in turn, tend to produce lack of self-confidence and obsessiveness in the child.

Although a diagnosis of deviation from social norms was not made in any of the African children, retrospective analysis showed that three of the boys rejected by the peer group had this kind of history, but it was not until other symptoms supervened that they were brought for treatment. These other symptoms were loss of concentration (depressive reaction), running away from school (school phobia) and recurrent absences for minor physical complaints (school phobia) respectively.

Better knowledge of local social norms and earlier recognition of the social isolate should improve diagnosis and therapeutic possibilities.

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