BEHAVIOURAL AND EMOTIONAL PROBLEMS IN A GUGULETU SCHOOL : A PILOT STUDY

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ABSTRACT

This paper investigates teachers' perceptions of the prevalence of common emotional and behavioural problems in a black primary school in Cape Town. The rationale in undertaking this study is that there is little epidemiological data pertaining to the incidence and types of particular psychiatric disorders in African children. Also, there were concerns from the staff and students of the Child Guidance Clinic of the University of Cape Town that the facilities and services offered at the clinic are only accessible to a small sector of the community. It is thus hoped that the findings from this study would shape direction for future clinical intervention. A selected review of the relevant literature is given. The needs of the teachers are assessed by finding out the prevalence of emotional and behavioural problems, how they manifest and how teachers perceive them. This is geared towards establishing a hierarchy of priorities for common problems.

The analysis is divided into two sections; general pattern of problems and teachers' explanation of problems. Findings reveal that although the problems presented by the teachers in this study are similar to those found in developed or First World countries, teachers use different categories from those normally found in basic psychological or psychiatric texts. Categories are based on the teachers' explanations of a particular behaviour.

CHAPTER I

> "A problem child, either delinquent or maladjusted or mentally retarded is an expensive child to train and educate; but the expense is a saving in the long run as without such a training he may not only grow into a greater liability, but may constitute an actual danger to the community later on in life."
>
> (Asuni, 1970, p. 54).

INTRODUCTION

In South Africa there has been poverty of psychiatric research, especially with regard to child psychiatry. A detailed search of the literature uncovered few studies which have explored issues of developmental psychological or psychiatric epidemiology in an African context and in the specific area of the school setting. Minde (1975) points out that the recently introduced Child Guidance Clinics in Africa have generally been patient-orientated and have provided little epidemiological data pertaining to the incidence and types of particular psychiatric disorders in African children. The present study is an initial attempt towards the filling of this gap in psychological research. There is, however, a crucial need for more epidemiological studies to be undertaken in order to cover the diversity of psychiatric problems that are likely to be found, particularly in the context of widespread poverty, unemployment, political and social violence and change in social political structures.

This pilot study was carried out at Songeze Primary school, in Guguletu. Official permission to have contact with

the school was obtained from the Department of Education and Training (DET). The study arose as a result of the expressed interest of teachers at a workshop given by the staff of the University of Cape Town Child Guidance Clinic at the Good Hope College of Education. The staff and students of the Child Guidance Clinic were concerned that the facilities and services offered at the clinic were only accessible to a small sector of the community and hoped to use the pilot study to shape direction for future community clinical intervention. This was also fuelled by the discussions in psychological circles on how to make psychological services more relevant and available to a wider spectrum of the population. Because of the limited knowledge from both staff and students of the Child Guidance Clinic pertaining to the types of problems in African communities, it was felt that a pilot study geared toward assessing the needs expressed by the teachers, followed by workshops aimed at evaluating the effectiveness of intervention techniques was a good starting point. The decision to conduct the study in one school initially was in order to try and collect detailed qualitative information.

This dissertation involves assessing the needs of the teachers of Songeze Primary school (Phase 1). The main aim is to find out the prevalence of common emotional and behavioural problems in the school setting, how these manifest and how teachers perceive or understand them. (The evaluation of the effectiveness of the intervention techniques (Phase II) is dealt with in Wood (1989), a co-researcher in the study.)

The method of enquiry had the following subsidiary aims: (a) to determine what the common needs of the teachers are; and (b) establish a hierarchy of priorities for common problems. Seedat (1987) argues that in order to intervene effectively it is important to know the community's explanation of social phenomena. This knowledge he sees as vital since "peoples' attributions govern how they act, behave, and respond to intervention strategies" (Seedat, 1987, p. 3). Because the findings from the study are also to inform the development of appropriate services, we realised that this could only be achieved through the active participation of the teachers who have direct and immediate experience of the school for which the services are intended. Also, we were aware that the present existing psychological and psychiatric services were based on approaches which have their origin in Western theories.

In order not to be trapped in the Western theoretical framework, and run the risk of alienating ourselves from the pressing problems experienced by teachers at Songeze primary school, it seemed important to adopt the community psychology stance, i.e. to move away from imposing a service/cure/ solution, to affirming and empowering community members regarding their perception of needs and problems. Rappaport (1981) maintains that "social problems require that experts turn to non-experts in order to discover the many different, even contradictory, solutions that they use to gain control, find meaning and empower their own lives" (p. 5).

Over and above assisting in informing the long term clinical practice of the Child Guidance Clinic, the information gained from the study is to be used in a broader project, in that it is hoped that it will help the Child Guidance Clinic, in collaboration with the Good Hope College of Education, develop resources available to teachers in the Western Cape.

LITERATURE REVIEW

International studies in the past two decades have consistently indicated that psychological disorder in children is common in Western societies. Despite the importance of the matter, Rutter, Tizard and Whitmore (1970) contend that few attempts have been made to survey the total problem of handicapping conditions in a population of children. The Isle of Wight survey of over 2000 children probably reflects one of the most thorough studies of childhood psychopathology ever undertaken since Cyril Burt's monumental survey carried out, mainly on London children, during and after the First World War.

The Isle of Wight studies began in 1964 - 65 with a series of epidemiological studies of educational, psychiatric and physical disorders in 8 - 11 year old children. For a more intensive investigation of neurological disorders, the study of health of the children was extended to the whole age range of compulsory schooling (5 - 15 years) (Rutter et al.,

1970). The main objective of the study was to give a comprehensive picture of "handicap" in a total population of children in a defined geographic area. Furthermore, the researchers wanted to apply their findings to the question of service provision. The island population was seen as an appropriate area for this purpose.

The Isle of Wight findings are mentioned for the following reasons:

i) The survey is internationally acclaimed as a comprehensive basic study which has attempted to cover almost all childhood disorders and has fundamentally influenced the way in which childhood psychopathology is seen world-wide.

ii) Though much of the work was carried out more than two decades ago and within a Western environment, the study has greatly influenced both other researchers concerned with issues of epidemiology in childhood disorders and the strategy followed in the present study.

Because our pilot investigation was not a straight epidemiological study, but merely an attempt to understand psychological problems from the teachers' point of view, the intention in presenting some of the common childhood disorders found in the Isle of Wight studies is not to compare the two

studies, but rather to draw attention to some similarities and differences pertaining to the disorders found in both.

Overall results of the Isle of Wight studies indicate that intellectual retardation was present in 2% of children; 4% of children showed specific reading retardation and 6% had general reading backwardness. Thee groups overlapped to some extent so that altogether 8% of children showed severe intellectual or educational difficulties. Intellectual and educational difficulties as defined by the study include intellectual retardation, specific reading retardation and general reading backwardness. Intellectual retardation was found to be equally common in boys and girls; whereas reading difficulties were more common in boys than in girls. The study also elicited that most of the children with reading difficulties were not receiving any kind of special help, although many needed it. Specific reading retardation was highly correlated with basic disturbances in language development and severe retardation in reading was associated with failure in many other school subjects. Common in both intellectually retarded children and children with specific reading retardation were emotional and behavioural disorders.

In terms of psychiatric disorder, the Isle of Wight studies indicate that 7% of 10-12 year old children showed a psychiatric disorder of sufficient severity to have caused social handicap. Emotional disorders and disturbances of conduct were much the commonest conditions and occurred with about the same frequency. Whilst nail biting and thumb-

sucking were least likely associated with psychiatric disorder; neurotic symptoms, antisocial or delinquent behaviour, poor concentration and poor peer relationships were the individual items of behaviour most strongly associated with psychiatric disorder. Rutter et al., (1970) note that children with psychiatric disorders generally tended to come from unstable home environments and that only a few of these children were under psychiatric care.

Altogether 5% of children in the Isle of Wight studies had chronic physical disorders. The commonest conditions in this category being asthma and epilepsy. These were followed by cerebral palsy and orthopaedic conditions. Psychiatric disturbances (both neurotic and antisocial) were slightly above population norms in children with physical handicap. The rate of psychiatric disorder in asthmatic children was nearly twice that of the general population, but the children with epilepsy and neurological disorders showed rates of disorder three to four times that of the general population.

A glance at many of the standard texts on psychiatric disorders in Africa suggests a picture of tardiness with respect to research on childhood disorders. Robertson (1989) states that South Africa's tardiness in this respect is due to the fact that childrens' mental health problems do not usually disrupt the family or community until adolescence or even early adulthood. The concomitant rise of literature geared towards comparing types of adult disorders in Africa with those found in Western or First World countries, plus the

remarkable increase in psychiatric services as noted by German (1972) supports the above argument. In a more recent review, German (1987) notes that early estimates of prevalence of psychiatric disorder in black Africa were universally low. According to him, these findings, which were mainly based on a hospital population, supported the views that mental ill health was particularly uncommon among Africans, compared with Europeans. In order to refute the above claims, German uncovered a wealth of data from recent studies based on both clinical and hospital populations.

The general trend from the recent studies is that:

i) There is a "burden" of psychiatric morbidity in black Africa which is similar to what has been found in more developed countries.

ii) There is also evidence to suggest that morbidity rates may be even grater. The recent findings seem to go against the widely debated concept of culture-boundedness of psychiatric disorders and seem to support the view that "problems relating to mental health appear to be intrinsic to the nature of man and to reflect the impossibility of separating biological, psychological and cultural influences" (German, 1987, p. 448).

A study undertaken by Schoeman, Robertson, Wasisch, Bicha and Westaway (1989) gives a summary of psychiatric disorders

seen at four major psychiatric clinics in Southern Africa, viz. Baragwanath Hospital (Johannesburg), King Edward VIII Hospital (Durban), Valkenberg Hospital (Cape Town) and the Child and Adolescent Psychiatric Clinic in Guguletu (Cape Town). Some of the important findings which shed light on the present investigation are as follows:

1. The need for the provision of facilities for the mentally retarded and for children with learning disorders.

2. The frequent occurrence of affective disorders in childhood and adolescents.

3. The possible increase in child abuse.

4. Conduct disorders constitute one of the priority conditions in the black community.

Although the Schoeman et al., (1989) study provides insight into the nature of problems that can be found from patients coming from an African context, it was nevertheless criticized by its investigators on the basis that the sample used was biased and therefore "does not accurately reflect the incidence, prevalence and variability in structure of mental illness in the community" (ibid, p. 3). Also, they note that the nature of cases referred for psychiatric consultation differed from centre to centre and the period for information

gathering differed from unit to unit, thus making comparison difficult.

Robertson (1989) cites the same types of disorder as found by Schoeman et al., (1989). In addition, he briefly discusses some of the environmental conditions known to be detrimental to mental health in South Africa. These are:

a) Social disadvantage, which includes poverty, malnutrition, disease, lack of educational opportunities and inaccessible health and welfare facilities.

b) Exposure of young children to damaged parents. This he terms a family stress problem arising from social disadvantage, mainly associated with marital conflict, wife-battering, discontinuity in parenting, physical and sexual abuse, neglect and alcohol abuse.

c) Structural violence, and

d) Urbanisation, breakdown in traditional ways of life, migrant labour system, lack of compulsory education, etc.

For the purpose of our survey, the above-mentioned aetiological factors will help to clarify the teachers' explanation and their choice of categories which are presented in the data analysis section.

Hendricks, Woldson and Swartz took part in the Western Cape principal teachers meeting and education workshop in 1985. This was also organised by the Grassroots Educational Trust. The aim of the workshop was to explore behaviour in a changing society (Swartz, 1986). The paper drafted from the workshop, presents some of the changes noticed in children growing up in times of widespread civil unrest in the Western Cape region. In addition to documenting how children are affected by the civil unrest, some of the coping strategies that people could use in such settings are outlined. Apart from the lack of "purely" scholastic problems presumably not elicited in Swartz's paper, it is interesting to note that most of the problems described in the paper are similar to what the teachers presented as common problems in the present study and also conform to patterns widely documented in the literature on pre-school children.

Swartz and Swartz (1986) wrote a report on workshops they conducted with pre-school teachers in Cape Town under the auspices of Grassroots Educational Trust. Like the above-mentioned workshop, the aim of their workshop was to discuss the effects of civil disturbance on children. After teachers were allowed to describe their experiences and feelings, and the problems of children under their care, the researchers "formalised their knowledge of and strategies of coping with different kinds of problem behaviour, and outlined briefly some principles of child behaviour management" (Swartz & Swartz, 1986, p. 61). Findings of the workshop are outlined

under four headings: (1) Children under stress; (2) Children most vulnerable to stress; (3) Reports on childrens' behavioural problems; and (4) Common difficulties in the teaching situation. According to the teachers' reports, childrens' responses to stressful situations cover a wide range of emotional and behavioural problems. Typical signs of stress reaction noted were memory impairment, loss of concentration, hypervigilance and reduced responsiveness. Swartz and Swartz (1986) note that although some children coped efficiently with exposure to teargas and threat of violence, others did not seem to adjust as quickly and remained panicky and uncontained. According to them the vulnerability to stress of a particular child was determined by additional social factors affecting the child prior to and during the time of turmoil or civic unrest. In terms of the childrens' behavioural problems it was noted that economic factors strongly affected the presentation of some behavioural problems.

Farets-Van Buuren, Letuma and Daynes (1990) wrote an article entitled "Observation on early school failure in Zulu children". Their study involved screening 2190 children who had to repeat the school entry grades (i.e. substandard A). Their sample was taken from 25 junior primary schools in two Kwazulu townships. Their findings reveal that the high number of repeaters did not appear to be due to an excess of mentally retarded children. Three readily remediable causes of black pupils having to repeat Sub A were identified. These were:

(i) Visual defects; (ii) hearing defects (both these defects appeared in 20,3% of the children); (iii) lack of food before coming to school (this was found in 5,7% of the children). Other factors which seemed to exacerbate the problems mentioned above were the lack of preschool teaching by parents and school, very strict discipline, wide range in ages (which makes teaching difficult) and sending children to school too young. Simple intervention strategies were suggested and these are reported to have produced encouraging results.

Cartwright, Jukes, Wilson and Xaba (1981) undertook a study which surveyed the prevalence and type of learning disorder among black primary school children on the East Rand. Their findings revealed that 24% of the 7500 children surveyed were identified as having learning problems, while 8,7% had a physical or mental handicap. They conclude by stating that improving teachers' skills and reducing the number of children per class might improve the education of children with learning difficulties. Metclafe (1987) investigated learning and education disabilities in the South African context. According to her, the perceived incidence of learning difficulties within a rural black community was 21% and 25,6% in an urban community. Her findings are slightly different from Cartwright et al.'s study in that she stresses the predominance of causative factors that are environmental. "The gross inadequacy of the socio-economic structures of these children's lives accounts for the majority of identified learning difficulties" (ibid, p. 18).

The three studies mentioned above investigate problems from a school setting. Farets-Van Buren et al., (1990) identify physical defects and socio-economic factors as main causes for the high failure rate in school entry grades in a Kwazulu township. Cartwright et al., (1981) see the primary cause of learning disorders among black primary school children as a learning disability. According to their findings, the number of children with physical and/or mental handicap was three-quarters lower than those with learning difficulties. The predominance of learning difficulties in the above-mentioned study is supported by Metclafe's (1989) findings. Goodall (1972) notes that other studies done in various parts of Africa with notable exceptions - have failed to produce studies with epidemiological data.

De Bruin (1980) undertook a pilot study for an epidemiological survey whose major aim was to ascertain and examine the distribution of deviant behaviour in a normal community of children. The study was done in the Northern Natal town of Dundee, using the parent questionnaire. The data obtained from a sample of 10 - 12 year old white children was compared to data obtained from epidemiological surveys on a similar group in two well known British studies, namely the Isle of Wight Survey (Rutter et al., 1970) and the Buckinghamshire Survey (Shepherd et al., 1971). Children from this study were reported to have significantly more deviant behaviour than was the case in Buckinghamshire.

If we look at other parts of Africa, we find that like South Africa, various people in different African states have tried to address themselves to the issues pertaining to epidemiology and appropriate service provision. Minde (1975) mentions three studies which investigated child psychiatric related issues: (1) Gederblad (1968, in Minde) surveyed three complete Sudanese villages near Khartoum and found an average psychiatric morbidity of 8% amongst children aged 3 - 15 years. A further 20% of Gederblad's population of children exhibited symptoms which did not cause any acute problem and could generally be coped with by families. (2) Giel (1970, in Minde) did some work in Ethiopia, but was unable to confirm his impressions in a methodologically more vigorous study. (3) Giel and Vanluijk (1969, in Minde) and Giel, Bishaw and Vanluijk (1969, in Minde) state that children were rarely brought to rural health centres for psychiatric complaints, while a surprisingly high number of adult patients presented with primary psychotic conditions. The above findings support Robertson's (1989) statement that childrens' mental health problems do not usually disrupt the family/community until adolescence or early adulthood.

Minde's survey is in a way similar to the present study, in that it was designed to "provide some answers to questions regarding the incidence and types of psychological disturbances as found in Ugandan primary school children" (Minde, 1975, p. 49). The data from the study was required for the development of integrated child psychiatric services

and to establish how non-medical personnel could be utilised in the recognition and possible treatment of psychological disorders in children (ibid). The findings indicated that psychological difficulties are common in children living in the Southern part of Uganda.

The results of Minde's survey, like the findings of the above mentioned South African studies, were associated with easily identifiable factors in the environment. For example, frequent inconsistent discipline was seen as one cause of problems resulting from extended or multi-nuclear families. Although the scope of Minde's paper did not allow the definition of all the variables, possibly contributing to a particular relationship, he notes that the correlation between poor school functioning and poor behaviour could be accounted for by factors such as: "poor diet, low intelligence, parental disinterest, or poor hygiene" (ibid, p. 57).

"Other recent studies dealing with psychiatric problems in African children present various types of case material, but no epidemiological data" (ibid, p. 49). Lack of material dealing with emotionally induced illness in South African children is attributed to the fact that doctors are swamped by tidal waves of physical disease (Goodall, 19772). According to her, children with emotional illness may first be reported to the local medicine man rather than to a dispensary. For some, his treatment may be good psychotherapy (ibid, 1972, p. 407). There is also the problem of the shortcomings in the knowledge and skills of Western trained mental health

professionals with regard to the psychodiagnostic and therapeutic management of members of other communities as noted by Reeler (1987).

In summary then, it can be said that although the investigation of common behavioural and emotional problems in a school setting seems to be of central importance in psychiatric practice (especially as this has some implication for intervention strategies) there has not been much research done in this field in the African context. The studies that have been done are, however, useful in that they provide useful material towards the understanding of the present investigation.

CHAPTER II

METHOD

Overview

The study was designed to investigate teachers' reports of common behavioural and emotional problems of primary school children in a Guguletu school. Due to the lack of psychological services available to the Guguletu community and the position of teachers as mediators in the childrens' environment, consultation with teachers seemed potentially more cost-effective than direct intervention with children. The method of investigation involved an initial needs analysis (Phase 1) followed by a trial workshop package (Phase 2). Contents for the workshop phase was informed by the needs analysis findings. Since this dissertation deals with the needs analysis phase, it will attempt to explain how data for this phase was gathered. Information regarding the workshops can be found in Wood (1989).

Information for Phase I was collected by use of participation interviews and a questionnaire. Prior to the commencement of the interviews an informal group meeting was held with the whole staff of Songeze primary school, including the principal and a remedial advisor who visits the school on a sessional basis. The purpose of the meeting was to establish contact and gain a broad overview of problems which

the teachers experience with their pupils. An interesting part of this meeting was that during the course of our conversation with the teachers, four children were brought in so that we could observe them and get a clear idea of what the teachers were talking about. We were told that the children had repeated classes several times. The general feeling amongst the teachers was that they were mentally retarded. The above diagnosis was based on: (1) number of failures; and (2) the sizes of their heads.

Although the situation might be viewed as quite cruel and traumatic for the children who were "exhibited" to us, it nevertheless elucidated how, through years of frustration and difficulties of trying to cope with ineducable children, teachers have come to utilise certain categories to make the situation understandable to themselves, however detrimental this may be to the well-being and future of the child under question. Complaints laid down by teachers about these children include the lack of support from their parents (some because of work commitments and some because of sheer negligence). This, according to teachers, makes it impossible for these children to be referred to appropriate services. Teachers claim that some parents are unavailable for discussions regarding their children, and others simply refuse to accept that there is something wrong with the child. The teachers in such situations feel blamed, unrewarded for their attempts to help the child, and, generally impotent. The child suffers.

Participants in the Study

Songeze primary school is situated in the Guguletu township. The school has 18 classrooms and one teacher per class. Classrooms are divided as follows: 6 x Sub A's, 4 x Sub B's, Standard 1's and 2's. The total number of teachers in the school is 20. This includes the principal and the Head of Department (H.O.D.) Both the principal and the H.O.D. have no classes; this leaves 18 teachers for the tuition of ± 697 pupils. Teacher-pupil ratio is 1 : 40-45 in the junior and middle classes, i.e. Sub A, B and Standard 1 and it ranges from 1 : 30-35 in the senior classes.

After the first informal meeting, which was attended by all the teachers except two, it was decided that all interested teachers should take part in the study. This was viewed as very important, because not only were we going to ask them questions that could offer them an opportunity to gain more insight into their immediate situation; our study had an intervention as well as a consultation benefit in it, in that we also planned to give workshops in order to add to the teachers' existing coping strategies. We were also willing to render our services to be used as consultants during the workshop phase. It was stressed, however, that participation in the study should be voluntary.

In addition to the teachers, a small sample of ± five lecturers from the Good Hope College of Education was to join

the teachers' group. These lecturers were to be self-selected on a voluntary basis. Their role was to be active participant-observers and if necessary, co-facilitators in the workshop. Unfortunately the Good Hope College of Education was not represented in the bulk of the study. Only one member managed to attend our first meeting.

Research Instruments

1. Participation Interviews

The interviews were designed to elicit teachers' perceptions, causal attribution and intervention strategies regarding the common scholastically related emotional and behavioural problems of their pupils. Interviews were conducted in such a way as to allow maximum participation by participants. The main question posed was open-ended (see Appendix 1). This was done so as not to define the limits of possibilities for the participants and to enable the researchers to access the participant's own construction of the range of factors affecting behaviour and emotional problems in their pupils. The way interviews were done was intended to: (a) show that the researchers were aware of the adaptive strategies teachers have developed over the years to cope with problems; and (b) to try and avoid imposing expert professional theories and solutions upon participants, thereby ignoring important perceptions and causal attributions. Seedat (1987) emphasises

the indispensability of community opinion in the planning and implementation of community based intervention.

Because the method used involved the use of teachers as active interviewers and interviewees, participants were given enough time to talk freely, although the researchers tried to keep the interviews within defined boundaries.

In the participation interview, the interviewees/ respondents were asked to describe to each other difficult situations that they came across in classrooms, in their years of teaching, and how they understood the situation.

2. Behaviour Questionnaire

This was devised from the Rutter Child Scale A for completion by parents and Child Scale B for completion by teachers (Rutter et al., 1970) (see Appendix 2). Our questionnaire had 28 items instead of 26 as found in the Rutter Scale for completion by teachers. A majority of the questions, i.e. 23, were selected from the teachers' scale. Four items from the parents' scale were added. The four items were chosen because they tap the somatic complaints such as headaches, asthma, enuresis and encopresis. One question which taps sexual behaviour was added by the researchers for the following reasons:

i) Nowhere in the Rutter Scale is this kind of behaviour mentioned; and

ii) In our initial meeting with the teachers, problems of sexual abuse were mentioned, but none of the teachers knew whether this was happening with their children or not. The question was thus included in order to give the teachers a chance to comment more on the issue.

Although the categories used in our questionnaire are similar to those used by Rutter et al., (1970), teachers in our sample were required to indicate whether they have children who manifest with a particular behaviour, to indicate how many, to say whether this is a problem or not, and give an explanation why they think it is or it is not a problem,

e.g. Do you have children in your classroom who

(i) wet their pants? Yes ___ No ___ How many ___

Is this a problem?

Explain.

The questionnaire was included in order to pick up all the elusive emotional symptoms that are not normally picked up because they do not manifest in behavioural ways.

Procedure : Phase 1

First day: Due to time and transport constraints, interviews were conducted at Songeze primary school. Wood and the author (both intern clinical psychologists) were facilitators. Prior to going to the school we had estimated to work with teachers for two-and-a-half hours to three hours per day, but when we started negotiating for time with the teachers it became

apparent that we had overestimated, as teachers could only spare one-and-a-half hours of their time. This meant that we had to rearrange our programme. A much briefer introduction than was previously envisaged was given. The introduction included: Telling the teachers who we were, what the study was all about, what we hoped to achieve, how we were going to work and what role the teachers were expected to play. After the introduction, teachers and the one staff member of the Good Hope College of Education were asked to pair up and describe to each, either in Xhosa or English, a very difficult situation that they had come across in a classroom in their years of teaching, and say how they understood the situation.

After this was done by all members in dyads, individuals from each pair were asked to report back to the main group what they were told by their respective interviewees. All the experiences were jotted down on the blackboard by one facilitator, whilst the other one was busy asking the respondents questions.

I facilitated this part of the information gathering phase. My co-facilitator would ask questions at various points if she did not understand or wanted some clarification on a particular issue. We decided upon this in order to eliminate language problems and to create an atmosphere of openness amongst the respondents.

After receiving 20 responses (from 18 class teachers, the principal and one member of the Good Hope College of Education) participants were asked to complete the adapted

version of the Rutter questionnaire. The fact that the questionnaire is written in English made it possible for both facilitators to supervise its completion.

Between the first day and the second day, the researchers combined the participation interview list of problems with ten problems from the adapted Rutter Scale. The ten problems from the revised Rutter Scale were selected by counting all the responses from the teachers, and selecting items where more than 50% of the teachers reported experiencing a problem in that area.

Second day: On the second day, a list comprising both the problems from the interview plus problems selected from the questionnaire, was put up. Teachers were then asked to categorise the problems into groups, according to their understanding of their aetiology. Suggestions such as socio-economic, behavioural and emotional factors were given. The suggestions were given as possibilities, but not explained in any depth for fear of influencing the participants' responses. It was also stated to the participants that there are many categories that they could use over and above what was suggested to them.

During the second day, individual teachers were also asked to prioritise the problems in terms of their importance for the workshop phase. In order to do this, they had to select five categories from the participation interviews and five from the selected categories of the Rutter Questionnaire.

Out of the ten categories they had to select five categories which they would like to be dealt with in the workshop phase. All ten categories, including the ones selected for workshops, were to be written down on a piece of paper and handed over to the researchers. Our aim in letting the teachers prioritise was to get an idea of what they would like to work with in the workshops. Also, we were trying to avoid suggesting categories/problems that teachers might perceive as not so crucial. Information regarding the planning and the execution of the workshop is included in Wood (1989).

Besides the time factor, which resulted in our changing the plan for the two days, and the minor problems of language, which initially made some teachers not free to communicate, my opinion is that the interviews were useful, in that they gave the teachers a chance to articulate the problems they have encountered without feeling compelled to affirm or refute what we as interviewers would have asked in a normal interview interaction.

Although a friendly atmosphere was created so that the participants did not feel intimidated, the researchers were aware that the interview situation could cripple the spontaneity of the responses.

Some of the confounding factors (although these were not explicitly stated or dealt with in the interview situation) are that: (a) in the situation we might have been viewed as experts. This might then have played a major role in influencing the results that were obtained. The power

dynamics of experts vs. non-experts might also have influenced the basic communication between us and the participants. (b) The fact that my co-researcher is white and could only speak English, affected the response of some teachers. Although most teachers could converse in English, it became obvious that some teachers tended to withdraw, even though they were assured that it was fine if they preferred to communicate in Xhosa. Another factor which could have affected the response is that this was possibly the first time the particular group of teachers interviewed were asked to think along these lines.

CHAPTER III

DATA ANALYSIS

Section A - General Pattern (Frequencies)

Section B - Teachers' Explanation of Problems.

Data analysis for this study will be dealt with in Sections A and B. In Section A, general patterns in frequency of categories are presented. In Section B, the teachers' explanations of problems will be outlined, using as much of their verbatim account as possible. Presenting the frequency of categories will aid in establishing which categories are popular as aetiological explanations and descriptions amongst teachers and also give an idea of the commonest and most pressing problems as viewed by the teachers themselves. Giving explanations of how the teachers perceive the problem will, on the other hand, throw some light on how teachers make sense of these problems.

It is hoped that this approach will inform our intervention strategies in the long run, in that it will sensitise us to how the teachers perceive their reality as opposed to how we (as experts) perceive their reality. Seedat emphasizes that "community opinion is indispensable in the planning and implementation of community based intervention" (1987, p. 4).

FINDINGS

SECTION A - GENERAL PATTERN OF PROBLEMS

Table 1 presents the categories where only one category was chosen to explain a particular behaviour. The categories are placed in order of frequency. These range from the scholastic category, which appears four times, to lack of parental involvement, which only appears once.

A second group of categories also rated in terms of frequency ranges from negligence and heredity to mental retardation and over-protectiveness. This is presented in Table II. This group comprises multiple categories (i.e. the problems where teachers found it difficult to select one category of where it was difficult for them to limit the range of possible explanations causing a particular behaviour).

When looking at the results it is important to note that problems marked with an asterisk (*) are those that were selected from the Rutter Scale using the 50% cut-off point. The rest are the teachers' spontaneous responses to the interview question.

Of the 30 problems elicited from both the open-ended interview and the questionnaire, 17 (57%) were placed by the teachers in one descriptive aetiological category. The rest, i.e. 13 (43%) were placed in a variety of categories (see Table II). Overall there were 33,3% of problems from the revised Rutter scale; 26,7% of these are in Table I and the remainder, i.e. 6,7%, are in Table II.

Table I Frequency distribution: Single category problems

CATEGORY	FREQUENCY	NATURE OF PROBLEM
1. Scholastic	4/30 = 13%	- Child refuses to write - Can read but can't write - Child has problems differentiating letters - Child is unable to do maths
2. Behavioural	3/30 = 10%	- Child does not want to come to school *- Child bullies others and takes their lunches - Child steals other childrens' lunches
3. Social	3/30 = 10%	*- Child who truants from school *- Child disobedient *- Child tends to be on his/her own. Appears miserable and unhappy
4. Age (old/too young)	2/30 = 7%	- Child cannot recognise colours - Child can't copy words/match colours
5. Emotional	2/30 = 7%	*- Child who sucks thumb/fingers *- Child who is fussy or over-particular
6. Socio-economic	1/30 = 3%	*- Child shows sexual behaviour
7. Health	1/30 = 3%	*- Speech problem; child does not talk. Shy and nervous
8. Lack of parental involvement	1/30 = 3%	*- Absent from school for trivial reasons

Table II Frequency distribution: Multiple category problems

CATEGORY	FREQUENCY	NATURE OF PROBLEM
9. Negligence, Heredity	2/30 = 7%	*- Restless; squirmy - Naughty, bullies classmates
10. Scholastic; Low IQ; Learning difficulty	2/30 = 7%	*- Cannot apply counting to counting objects - Confuses numbers
11. Social; Behavioural	2/30 = 7%	- Sleeps in class, does not want to contribute - Fights with others - Bullies others
12. Sexual Abuse: Child Abuse	2/30 = 7%	- Child withdrawn. Teacher ? child abuse - Child raped - won't tell
13. Speech; Heredity	1/30 = 3%	- Child never volunteers information
14. Low IQ: Mental Retardation	1/30 = 3%	- Child inattentive; violent. He is promoted and is too old in his class
15. Behavioural; High IQ	1/30 = 3%	- Does not listen, naughty in class but gives right answers
16. Health; Social	1/30 = 3%	*- (Encopresis & Enuresis) Child wets and soils pants
17. Mental Retard ation; Over-protective	1/30 = 3%	- Child over-active, disturbs classmates and teachers

The tables show that there are a variety of categories that teachers gave as explanations for the problems that they encounter. It is important to note that the crucial information of how teachers perceive the problems could have been lost if we had used the Rutter Questionnaire as it was used by Rutter et al. (1970), or, if we had supplied the categories ourselves without taking into consideration that people have a wide range of explanations for particular behaviours depending on their context. Also, if we had suggested categories to the teachers we would have limited their responses. Limiting the teachers' responses could mean that we were interested in what we wanted to hear and this could have had negative effects in terms of our intervention strategies.

Some of the important points to make about Table I (see page 28) is that certain problems are categorised differently from how we "as experts" would have categorised them. For example - a child who refuses to come to school is seen as having a behavioural instead of an emotional problem. When a child is unhappy or miserable, this is attributed to social instead of emotional factors. Children who truant from school and are disobedient are also seen as being affected by social factors rather than having a behavioural problem. Sexual behaviour is seen as stemming from socio-economic factors; and a child who is absent from school for trivial reasons is (according to teachers) affected by lack of parental involvement.

Some of the differences between our perception and the teachers' perception of these problems will be clarified when we look at the teachers' explanations of the problems in Section B.

Top of the list in Table I are scholastically related problems. These are purely scholastic and predominantly come from the spontaneous responses from the teachers. Emotional problems, on the other hand, are fifth on the list. The two problems listed under this category come from the Rutter Scale. This could indicate the difficulty the teachers have in picking up and/or understanding the emotionally related problems. It could also indicate that the teachers are so overburdened with other problems that they find it difficult to relate to the children at an emotional level or to be sensitive to the children's emotional needs. This is in a way understandable when one looks at the teacher/pupil ratio and the conditions under which the teachers are expected to operate.

In Table II (see page 29) only two problems come from the Rutter questionnaire. The rest are the teachers' spontaneous response to the open-ended question.

What is interesting here is that most problems are seen as stemming from external forces over which the teachers have no control, e.g. negligence of parents, heredity, social factors, sexual and child abuse, IQ, mental retardation, health and over-protectiveness. The categorisation utilised in both Tables I and II also reflects that the teachers'

training does not equip them to identify problems in the classroom. An understanding of the categories utilised here will necessitate a thorough look at teachers' explanations of the problems in Section B.

SECTION B : TEACHERS' EXPLANATION OF PROBLEMS

My intention in this section is to present the teachers' explanation of the problems outlined in Section A. This is essential because the study was designed to elicit teachers' perceptions and causal attributions regarding the common scholastically related emotional and behavioural problems of their pupils in the school. Presenting the teachers' explanations will give an idea of how they perceived the problems and also clarify their choice of categories.

I plan to do this by firstly, giving the category, secondly, the problem as given by the teachers, and lastly, present some aspect of teachers' explanations verbatim. At the end of each problem, a short resume of impressions regarding the explanation will be given. After all the categories have been dealt with, I will present a table outlining the sources of the problems as seen by teachers. This will be followed by a brief summary of the findings.

CATEGORY 1 : SCHOLASTIC

1. Problem: Problems in differentiating letters, especially "M" and "N"; difficulty repeating what is said - parrot reading.

Explanation: "I think they need practice in writing". "They are affected by saying things in a group". "A child needs individual attention as he/she tends to mimic others in the group." "These children are usually unable to read." "They need remediation and attention from the teacher."

Here the problem is seen as a result of teaching methods, inability to read and lack of remedial help in school.

2. Problem: Child actively involved in oral work but refuses to write.

Explanation: "Because they cannot write they tend to drawn when it comes to writing." "Child who does not know how to spell." "It is a child who does not cope with school work." "Usually they are in the last group." "It could be anything."

Here teachers see the problem as due to inability to cope with school work, e.g. writing, spelling, etc.

3. Problem: Child who can read well but cannot write.

Explanation: "The problem is that the child cannot spell." "Child can recognise letters but cannot remember them." "Also they tend to write the other way round." "These children are good in memorising." "They are not retarded, but their school work is affected by writing."

The explanation here is similar to the above explanation. In addition, teachers note the problem of reversal of letters. Being good in memorizing seems to be connected to the ability to read well.

4. Problem: Standard 2 child under-age (7 years) is unable to do maths; also restless and disruptive.

Explanation: "Under age." "Unable to understand."

What is striking here is that the explanation given is vague and in general teachers seemed as if they were not sure of what the real cause was.

CATEGORY 2 : BEHAVIOURAL

1. Problem: Child (Sub A - 7 year) does not want to come to school, cries. Mother thinks child is spoilt and has tried other schools. Child always runs out of class. Other children chase her and she has no friends.

Explanation: "Social problems, e.g. child must help at home with family business." "Perhaps not much love at home." "Child could be spoilt." "Child sometimes does not understand the lesson." "They usually come when there are things that attract their attention." "Child may have difficulties in communicating with teachers and classmates." "May not have gone to pre-school, so school is very new to him/her." "Child could be over-protected at home and not allowed to have

friends." "It could also be due to hereditary factors, i.e. if the father was also like that."

The overall feeling here was that the child may be frustrated because of inability to understand certain lessons, communication difficulties and adjustment problems.

2. Problem: Child too old for class but cannot cope or keep up with younger classmates. Tends to bully others and take their lunches. Others afraid of him.

Explanation: "Age problem." "Perhaps hungry, naughty." "Does not want to bring his own lunch."

Teachers felt that children who have this problem tend to be older than classmates. The behavioural problem is explained in terms of deprivation and/or personality structure of the child. Age is seen as a contributing factor.

3. Problem: Child steals other children's lunch, although he has his own lunch.

Explanation: "Naughty", "silly child", "maybe poor and dislikes his own lunch because it does not look like others." "Greedy." "Hungry - wants to taste other childrens' food."

The explanation here is the same as above.

CATEGORY 3 : SOCIAL

1. Problem: Child who truants from school.

<u>Explanation</u>: "Too harsh teachers." "Social problems, e.g. child compares his lunch to others and finds that his is not enough - need to get a job for money." "Sometimes parents are not interested in the child's education." "Child afraid to come to school because of not having done his/her homework or because of conflict between his parent and teachers." "Bad company."

Here teachers feel they might be the cause of the problem because of harsh discipline and high expectations. They also realised that the problems have wider socio-economic and political implications. Parental lack of interest in child's education, together with conflict between teachers and parents are also mentioned.

2. <u>Problem</u>: Child disobedient.

<u>Explanation</u>: "They copy from others." "Bad company." "Negligence of parents." The problem is explained in terms of peer pressure and negligence of parents.

3. <u>Problem</u>: Child who tends to be on his/her own. Appears miserable/unhappy.

<u>Explanation</u>: "Lack of parental love." "Health problem." "Physical problem." "Child not happy at school." "Problem child, won't communicate." "Family problem. Child mentally and emotionally ill."

Teachers here were not sure of the cause. Some felt it had to do with the home atmosphere. Others felt the problem is

due to health problems, others felt it might be the school and possibly the child him/herself.

CATEGORY 4 : AGE

1. Problem: Child cannot recognise colours; cannot identify objects. Depends on others to help him.

Explanation: "Visual disturbance; worse in boys." "Mainly occurs in Sub A children." "Individual problem - child could be colour blind." "These children are usually too young, e.g. 5-6 years." "Maybe the child cannot see colours." "It could be problems with the name of the colour." "Lack of stimulation at home, although some of the children have had this stimulation." Teachers were generally not sure of the reasons for this problem. They feel that these children are not necessarily slow in their thinking.

It seems here that the teachers were not sure whether it was actually visual disturbance or the age of the child or problems with naming the colours that causes this particular problem. It would appear that age, therefore, seems to be an appropriate category to give the child the benefit of the doubt and to allow room for some improvement.

2. Problem: Child cannot copy anything nor match pictures, words or colours.

Explanation: Same as explained in the above problem.

CATEGORY 5 : EMOTIONAL

1. Problem: Child sucks thumb or fingers.

Explanation: "Nervous child." There was a dispute here as some teachers could not understand how a six-months old baby, who also sucks his/her thumb, could be nervous. "Child did not wean properly." "Bad habit."

The main category here is based on the disputed concept of "nervousness" and the fact that teachers felt that these children did not wean properly.

2. Problem: Child who is fussy or over-particular.

Explanation: "Dull child." "Child is just like that." "Slow." "Perfectionist and slow thinker."

It is interesting here to note that the explanations given for the problem do not tally well with the category. From the explanation one would expect the teachers to see a child like this as mentally deficient.

CATEGORY 6 : SOCIO-ECONOMIC

1. Problem: Child shows sexual behaviour.

Explanation: "Overcrowding." "Child imitates what happens at home." "Child may have been sexually abused." "Perhaps child is wild." "Puberty stage or adolescent issues." "Influenced by TV programmes like Dallas, Loving, etc."

Here the main themes are that of mimicking and imitating what happens at home and on the TV, mainly due to lack of privacy/overcrowding in most African homes. Sexual abuse and adolescent issues are also seen as major problems.

CATEGORY 7 : HEALTH

1. Problem: Speech problem; does not talk in front of others. Could not speak as a toddler. Shy and nervous.

Explanation: "Some kind of sickness." "Speech problems - problems with voice."

It is interesting here that the shyness of the child and the nervousness is not mentioned in the explanations. What stands out in the explanation is the word "sickness" and problems with voice. This implies that the problem is seen as suitable for medical attention. Hence HEALTH is the category.

CATEGORY 8 : LACK OF PARENTAL INVOLVEMENT

1. Problem: Child absent from school for trivial reasons.

Explanation: "Lack of parental involvement in child's education." "Influence from older children." "Socio-economic reasons - parents may keep children at home in order to help out - i.e. look after the house and take care of the young ones." "Political reasons - boycotts." "Younger children listen to the older ones when they say they are not

attending." "They are not necessarily pressurised by the older ones." "Child who finds school work not interesting."

Here socio-economic and political factors that may have caused the above problem are outlined. Lack of parental involvement though is viewed as the most important cause. It would see that teachers view parental involvement as the key solution to the above problem.

CATEGORY 9 : NEGLIGENCE ; HEREDITY

1. Problem: Children who are restless, squirmy and cannot settle to anything.

Explanation: "Social problem, family problem - child not contained - no limit setting at home." "Hyperactivity and overactivity." "They usually do not respond to reprimands." "Could be hereditary due to some organic factors - i.e. trauma at birth, etc."

2. Problem: Child naughty. Bullies classmates. Also happens at home.

Explanation: "Over protected." "Negligence." Same as explanation in the above problem.

Here teachers see the lack of containment and no limit setting as priorities. They also thought that the problem could be hereditary.

CATEGORY 10 : SCHOLASTIC; LOW IQ; LEARNING DIFFICULTY

1. Problem: Can count, but cannot apply this to counting objects.

Explanation: "Impulsivity." "No other problems with school work, just counting with objects." "Some children are under age, i.e. 4-5 years in Sub A." "These children usually do not understand quickly - slow learners." "Low IQ." "Some of these children cannot be cheated with money."

Problems here are "impulsivity", under-age and slowness in learning. The explanations given seem to cover all the above three categories.

2. Problem: Confuses numbers; writes numbers in the opposite direction. Does not understand use of counters.

Explanation: Same as explanation in above problem.

CATEGORY 11 : SOCIAL; BEHAVIOURAL

1. Problem: Child always sleeps in class. Does not want to contribute.

Explanation: "Social problem, e.g. watches too much TV and goes to bed late." "Waits for parents to return from work." "Child attends initiation ceremonies." "Lessons not interesting." "Lives in a shebeen - parents drink and they do not supervise sleeping time." "Child under-age, therefore too young for school."

Social problems mentioned here are too much TV watching - late nights. Unavailability of parents and parental supervision; lack of interest in lessons. Under-age also contributes.

2. Problem: Child who fights with others. Bullies others.

Explanation: "Child learnt that from the home environment.: "Child lives in a conflictual home where parents fight." "Child over-active." "Influenced by TV."

Teachers believe that the children who behave like this are influenced by conflictual home environments where parents fight. Also, they believe that they learn this kind of behaviour from watching violence on the screen.

CATEGORY 12 : SEXUAL ABUSE; CHILD ABUSE

1. Problem: Sub A child raped - child feels ashamed and embarrassed and is very quiet. Teacher does not know what the problem is as the child will not answer.

Explanation: "This problem happened in a school in Khayelitsha." "Usually happens when mother has a baby, so father abuses child - father rapes the child." "Teachers do not know about it as children tend to hide it."

From the explanation it would seem that teachers do not know much about this particular problem because children tend to be secretive about it. The fact that it stems from a

Khayelitsha school also means that the teachers we saw may not have had a chance to deal with this problem directly.

2. Problem: Child withdrawn - social problems. Mother does not want to talk about the problem. Teacher queries child abuse.

Explanation: Same as explanation of the above problem.

CATEGORY 13 : SPEECH : HEREDITY

1. Problem: Child who only answers when asked - never volunteers answers.

Explanation: "Shyness - lack of confidence." "Lack of knowledge - child does not know what to say." "Some whisper to others and ask them to tell the teacher." "Speech problems - stammers/stutters. Fears being laughed at by others because of the stammer." "Others comment that he/she has a "funny" voice."

Here the main explanations are shyness, lack of confidence, lack of knowledge and possibly speech problems.

CATEGORY 14 : LOW IQ ; MENTAL RETARDATION

1. Problem: Child does not pay attention; does not answer questions no matter how interesting the lesson. Child is also violent and his inattentiveness has always been a problem. He is promoted on condoned passes and is 15 years old in Standard 2.

Explanation: "Child has been at the school for a long time." "He is not interested in his school work." "He has always been like this from Sub A." "Slow-learner." "Low IQ, possible mental retardation."

Teacher sees the problem as due to lack of interest in school. According to them the problem could also be accounted for by multiple failures, lack of progress in school work and mental retardation.

CATEGORY 15 : BEHAVIOURAL ; HIGH I.Q.

1. Problem: Child does not listen and is naughty in class; gives right answers although he does not concentrate.

Explanation: "The child is gifted." "The work is not challenging for the particular child." "Child gets bored." "Wants special attention from the teachers." "Level of work in class is too low for the child."

These children are seen as gifted and therefore functioning at a higher level than their classmates. It is important to note that here teachers' explanations are centered around the gifted aspects of the child rather than the behavioural.

CATEGORY 16 : HEALTH ; SOCIAL

Problem: Child who wet and/or soil their pants.

Explanation: "Shyness - child not feeling free to ask to be excused." "Health problems." "Over-eating and drinking." "Social problems resulting in emotional problems leading to health problems - chain reaction."

Teachers saw this problem as resulting from a combination of social, emotional and health problems. They also note that the personality structure of the child and bad eating habits might contribute to the problem.

CATEGORY 17 : MENTAL RETARDATION ; OVER-PROTECTIVENESS

1. Problem: Child over-active, disturbs classmates and teachers.

Explanation: "Mental retardation and birth problems." "Mother is possibly mentally ill." "Child cannot sit still and won't take punishment." "Also child cannot write in line."

It is clear here that teachers saw this problem in terms of mental defectiveness resulting from either a traumatic birth leading to organic impairment or inherited from the mother's "illness".

PROBLEMS EMANATE FROM THESE SOURCES

SCHOOL AS AN INSTITUTION	TEACHERS	PARENTS	CHILDREN	SOCIO-ECONOMIC AND POLITICAL FACTORS
- School unable to accommodate children with different needs	- Teachers query their teaching methods	- Not interested in the child's education.	- Lack of interest	- Overcrowding
			- MR	- Influence of TV
- Accommodating young children who cannot cope with school yet.	- They also query the disciplinary methods that they use.	- Not providing a positive atmosphere for their children.	- I.Q.	- Boycotts
			- Learning difficulties.	
- Lack of remediation in the school system		- Some problems are seen as having been inherited from their parents.	- Adjustment problems	
			- Slowness	
		- Not weaning the children properly.	- Shyness, lack of confidence	
		- No limit setting.	- Visual disturbances	
			- Nervousness	
			- Adolescent stage	
			- Impulsivity	
			- Personality structure	

SUMMARY AND COMMENTS

If we look at problems presented in Section B and the explanation given to them by teachers, we note that the understanding and the categorisation of problems in our study does not necessarily follow the pattern that is usually found in the Western/First World type of environment. In the present investigation, problems that are normally associated with emotional and behavioural disturbances were placed under different categories depending on the teacher's explanation. What is also evident in our study is that teachers were more inclined to concentrate more on behavioural aspects of the problem and this informed their choice of categories. This is well illustrated by the third problem in Category 3, and also the two problems in Category 9. McGee, Phil, Silva and Williams (1983) support the above findings by stating that teachers tend to be particularly sensitive to antisocial behaviour, especially in boys. It is also important to note that neurotic symptoms, antisocial behaviour, poor concentration and poor relationship problems were not necessarily associated with psychiatric disorders. However, teachers felt that these problems needed as much attention as they tend to retard the progress of their pupils.

Although some psychosomatic complaints like Asthma and headaches were presented to the teachers in the form of the revised Rutter Scale questionnaire (see Appendix I), the teachers' choice of problems indicated that these complaints

were not the greatest worry as far as problems in that particular school were concerned.

Speech problems and neurotic symptoms were perceived as the most pressing physical disorder that needed medical attention. Overall results sow that the problems were seen as emanating from five major sources, i.e.

1. School as an institution.
2. Teachers.
3. Parents.
4. Children.
5. Socio-economic and political factors.

CHAPTER IV

DISCUSSION AND CONCLUSIONS

The purpose of this chapter is to comment on the overall patterns of problems from the perspective of the aims of the study. This will involve:

1. Looking at the general pattern of the findings and showing how these compare with other studies done in other countries.

2. Commenting on methodological issues and finally suggesting referral sources and important areas for further research.

Since the sample size was relatively small and selected from a particular geographical area in what is designated as an African context, the problems elicited may only reflect problems of that particular area and may not allow generalization of the other townships in the Western Cape region. For an example, children living in Khayelitsha (a newly constituted township comprising mostly of people from the rural areas) may vary significantly in the manifestation of psychological problems. However, a factor which might indicate the usefulness of the data collected from the present investigation (in spite of its limited scope) is that some of the aetiological factors outlined in Robertson (1989) and

Swartz's (1986) unpublished papers are comparable to the teachers' causal attributes to problems found in Songeze Primary School.

Although various constraints such as time, deadlines, educational requirements and financial problems made it impossible for the researchers to obtain another sample for comparative purposes, so as to validate the findings, it can be said that the methodology employed proved useful in that it provided a wealth of information about problems which are likely to be found in an African school setting. Information gained from both the revised questionnaire and the spontaneous response of the teachers to the interview question support German's (1972) contention that there is considerable evidence for psychiatric disorders being no less frequent in Africa than in developed countries. The above statement is further confirmed by the similarities between problems discussed in the present study with those found in the Isle of Wight studies.

Although it is difficult to compare the findings of the present study directly with those of other studies, as none has used exactly comparable criteria, the results highlight a number of outstanding points. The most striking is the use of a variety of categories by the teachers when they give their explanation of the aetiology for a particular problem. It is important to note that some of these categories are markedly different from those normally utilized in psychiatric texts and illustrate how the teachers understand or give meaning to

a particular problem. The way the teachers perceived their immediate problems was quite influential in that it enabled the researcher to move away from using the British psychiatric model in viewing the problems presented. Also, the outcome of the results clearly reflects that the study was aimed at getting the community's needs rather than our "experts" needs, which are undoubtedly coloured by certain ideological inclinations.

What stands out with the teachers' explanations is how different some are from what we are used to. Problems which we could have attributed to emotional factors without much thinking are seen by teachers as emanating from behavioural factors and vice versa.

A thorough look at the categories provided by teachers suggest that although the teachers blamed the school for some problems, the majority of the problems that they experience are perceived as emanating from external forces over which the teacher has no control. This view is reflected by the predominant use of categories like negligence, heredity, low IQ, social and health. This perception of problems as arising from external sources could be due to a number of factors, i.e.:

1. The refusal on the part of the teachers to accept responsibility for the problems that are created by the situation.

2. The overwhelming conditions under which these teachers have to work which make it impossible for them to focus more on problem children and devise possible ways of helping them; and

3. The possible limitations in the teachers' training programmes which does not equip the teachers with adequate skills to deal with psychologically related problems. Metclafe (1987), in a study on learning and educational disabilities in the South African context, also notes the high percentage of teachers who specifically mention hunger and malnutrition as causing learning difficulties in their class. She contends that the identification of the learning disabled child is made difficult by the multiple overlay of environmental variables.

The frequency distribution of problems shows that 13% i.e. the majority of the problems are seen as scholastically related. These problems are purely scholastic in nature and possibly reflect the teacher's frustration in dealing with children who cannot adequately cope with their school work. The scholastic problems in African schools are further exacerbated by the inherent educationally disadvantaging factors, inadequate psychological services, and lack of ancillary facilities to which children can be referred. These ancillary facilities include special schools for retarded

children, speech therapy and remedial classes for cases with relatively isolated problems like reading difficulty and arithmetic difficulty.

Behaviour and emotional problems in the present study are not seen by teachers to be occurring with about the same frequency, as Rutter et al.'s (1970) findings indicate. This may be due to the fact that teachers in our sample did not come across as able to relate to the childrens' emotional needs. Most of the problems that are usually seen as arising from an emotional factor were placed under the categories: behavioural, social, health and heredity. it is interesting to note that whilst the majority of scholastically related problems were explained in terms of the child's personal causative factors like lack of interest, slowness, lack of confidence, visual disturbances, etc., teachers, parents, children themselves and socio-economic factors were implicated when teachers explained the behavioural and emotional problems. Metclafe, in a paper which looked at factors affecting learning and educational disabilities in the South African context, notes that "the extent to which these personal factors can be isolated from the enormously complicated interactive variables is a problem which would be difficult to address" (Metclafe, 1987, p. 18).

In summary, the present study has clearly indicated that teachers at Songeze (like any other teachers) are experiencing a variety of emotional and behavioural problems from their pupils which they desperately need help with. These problems

are associated by them with identifiable factors in their environment. The findings also demonstrate that it is possible to get estimates of these problems with methods adapted from those developed in Western societies.

Given the above situation and the needs of the teachers, I think that rather than leaving the teachers with their implicit theories, it would be advisable to incorporate the ideas of psychological classification in their training at the training college level. This will possibly need to be negotiated with both the D.E.T. and the Good Hope College of Education. In the interim, the same kind of training could benefit the already qualified teachers at a workshop level.

Having outlined the needs as expressed by the teachers, it is important at this stage to give an indication of what is available for these teachers in the form of referral sources. Information received from the Cape Town Child Information Centre indicates that there are only nine services for behavioural and scholastic problems in Cape Town. These range from behaviour clinics, Child Guidance Centres and Educational Counselling centres. Although these centres are listed as catering for all races, it would appear that only a few African clients (i.e. children and their families) have had a chance to utilise these services.

Some of the reasons which make these services inaccessible to the African community are: their geographic location, language problems and possibly ignorance on the part

of the African population about the existence and function of these services.

Another problem could be the confusion on the part of the parent or teacher as to which problems call for referral and which problems do not. This is coupled and/or complicated by some parents' denial or refusal to accept that their child needs some psychiatric evaluation and/or intervention.

When one looks at the community under study, i.e. Guguletu, one is struck by the sparseness of the kind of services outlined above. Services that do exist in black locations in Cape Town are those that cater for the mentally and physically handicapped. Of recent origin is the Guguletu Clinic, which was introduced in 1983 and the teacher assistant teams called PIDA's, i.e. Panel for Identification, Diagnosis and Assessment, which are under the auspices of the Department of Education and Training. Although the Songeze school had a PIDA team, it was not clear to us how the team works and how many teachers were benefiting from it.

In conclusion, it will be useful to draw together some of the areas in which further research could be valuable.

1. Given that our study was on initial needs analysis followed by workshops aimed at evaluating the effectiveness of intervention techniques, it would be useful to undertake similar studies in different townships for comparative reasons.

2. A thorough analysis of how teachers perceive problems, how they understand them and how they intervene could provide useful material.

3. Also a study looking at the parents' perception of problems could provide useful material, especially with regard to intervention strategies.

Finally, I would urge the Department of Psychology and other associated disciplines to encourage more of their students to take an interest in this line of work. I would also encourage my fellow trainee clinical psychologists to consider looking at how behavioural and emotional problems manifest in different school contexts and to devise ways of helping the teachers. This should be regarded as a very important aspect of our work. I believe it is through these kinds of interventions that many childrens' future careers can be saved.

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APPENDIX I

OPEN-ENDED QUESTION:

Working in pairs, teachers were asked to:

Describe either in Xhosa or English a very difficult situation that they had ever come across in their classrooms in their years of teaching, and how they understood the situation.

APPENDIX II

QUESTIONNAIRE

Below is a list of problems which most children have at some time. Pleae tell us whether these problems occur in your classroom, how many children have them and whether you view them as problems by placing an X and a number in the appropriate box.

A. HEALTH PROBLEMS

DO YOU HAVE CHILDREN IN YOUR CLASS WHO:

		Yes	No	
1.	Often complain of headaches	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			

		Yes	No	
2.	Have Asthma or attacks of wheezing	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			

		Yes	No	
3.	Wet their pants	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			

		Yes	No	
4.	Soil or lose control of Bowels	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			

		Yes	No	
5.	Have twitches, mannerisms or tics of the face or body	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			

B. HABITS

DO YOU HAVE CHILDREN IN YOUR CLASS WHO:

		Yes	No		
1.	Are restless, have difficulty staying seated for long			How many	
	Is this a problem?			How many	
	Explain				
		Yes	No		
2.	Are squirmy or fidgety			How many	
	Is this a problem?			How many	
	Explain				
		Yes	No		
3.	Suck thumbs or fingers			How many	
	Is this a problem?			How many	
	Explain				
		Yes	No		
4.	Frequently bite nails or fingers			How many	
	Is this a problem?			How many	
	Explain				
		Yes	No		
5.	Cannot settle to anything for more than a few moments			How many	
	Is this a problem?			How many	
	Explain				
		Yes	No		
6.	Are fussy or over particular			How many	
	Is this a problem?			How many	
	Explain				

		Yes	No		
7.	Often tell lies	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				
		Yes	No		
8.	Steal	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				

C. STATEMENTS

DO YOU HAVE CHILDREN IN YOUR CLASS WHO

		Yes	No		
1.	Truant from school	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				
		Yes	No		
2.	Often destroy or damage own or other's property	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				
	Is this a problem?	☐	☐	How many	☐
	Explain				
		Yes	No		
3.	Frequently fight or quarrel with other children	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				
		Yes	No		
4.	Not much liked by other Children	☐	☐	How many	☐

Is this a problem? ☐ ☐ How many ☐

Explain ....

		Yes	No	
5.	Often worried by about many things	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			
		Yes	No	
6.	Tend to be on own - rather solitary	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			
		Yes	No	
7.	Irritable, touchy. Are quick to "fly off the handle"	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			
		Yes	No	
8.	Often appear miserable, unhappy, tearful or distressed	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			
		Yes	No	
9.	Are often disobedient	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			
		Yes	No	
10.	Tend to be absent from school for trivial reasons	☐	☐	How many ☐
	Is this a problem?	☐	☐	How many ☐
	Explain			

		Yes	No		
11.	Tend to be fearful of new things or new situations	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				
		Yes	No		
12.	Unresponsive, inert or apathetic	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				
		Yes	No		
13.	Resentful or aggressive when corrected	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				
		Yes	No		
14.	Bully other children	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				
15.	Do you have children in your class that:				
		Yes	No		
D.	EXTRA PROBLEM				
i)	Show sexual behaviour	☐	☐	How many	☐
	Is this a problem?	☐	☐	How many	☐
	Explain				

Are there any other comments you would like to make?

____

____

Signature: Ms
Date

Thank you very much for your help.

APPENDIX III

PROBLEMS EXPERIENCED BY THE TEACHERS OF SONGEZE PRIMARY SCHOOL IN THE CLASSROOM SITUATION

N.B.: THESE PROBLEMS ARE FROM THE OPEN-ENDED QUESTION PLUS THE QUESTIONNAIRE.

NOTE: Problems marked with an * (asterisk) are common responses to questions on specific Rutter Scale questionnnaire items where ≥ 50% of the teachers reported experiencing a problem in this area.

All other problems are the teachers' spontaneous responses when asked to describe the most difficult situation they have had to cope with in the classroom.

The following list states "the problem" in CAPITALS, the teachers' own explanation of the problem follows and their categorisation of the problem is presented in CAPITALS IN BRACKETS. Where more than one category was offered, where consensus was reached on the major category, this is underlined.

1. CHILD ACTIVELY INVOLVED IN ORAL WORK BUT REFUSES TO WRITE.
   Child doesn't know how to write/spell.
   (SCHOLASTIC; MENTAL RETARDATION).

2. CHILD WHO CAN READ WELL BUT CAN'T WRITE.
   Spelling difficulties, can recognise letters but cannot remember them; letter reversals, parrot reading.
   (SCHOLASTIC.)

3. PROBLEMS IN DIFFERENTIATING LETTERS, ESPECIALLY 'M' AND 'N': DIFFICULTY REPEATING WHAT IS SAID - PARROT READING.
   Child needs practice in writing: needs individual attention as he/she mimics others in the group; needs remediation and attention from the teacher.
   (SCHOLASTIC.)

4. CHILD CANNOT RECOGNISE COLOURS; CAN'T IDENTIFY OBJECTS; DEPENDS ON OTHERS TO HELP HIM.
   Visual disturbance; worse in boys; mainly occurs in Sub-A children; children too young, e.g. 5-6 years. Possible lack of stimulation at home although some of the children have had this stimulation. Don't know the reasons for this problem.
   (AGE.)

5. CHILD CAN'T COPY ANYTHING NOR MATCH PICTURES, WORDS OR COLOURS.
   Explanation as above.
   (AGE.)

6. CAN COUNT, BUT CAN'T APPLY THIS TO COUNTING OBJECTS.
Impulsivity; some children are under age e.g., 4½-5 years, however difficulty counting objects also applies to older children.
(SCHOLASTIC; LOW I.Q.; LEARNING DIFFICULTY).

7. CONFUSES NUMBERS; WRITES NUMBERS IN THE OPPOSITE DIRECTION; DOESN'T UNDERSTAND USE OF COUNTERS.
As above.
(SCHOLASTIC; LOW I.Q.; LEARNING DIFFICULTY).

8. CHILD (SUB-A, 7 YEARS) DOESN'T WANT TO COME TO SCHOOL, CRIES. MOTHER THINKS CHILD IS SPOILT AND HAS TRIED OTHER SCHOOLS. CHILD ALWAYS RUNS OUT OF CLASS. OTHER CHILDREN CHASE HER AND SHE HAS NO FRIENDS.
Social problem, e.g. child must help at home with family business. Not much love at home. Child spoilt at home. Child sometimes doesn't understand the lesson so wants to run away. Difficulty communicating with teacher and class. Child may not have gone to pre-school so school is very new. Child over-protected at home and not allowed to have friends.
(<u>BEHAVIOURAL</u>; SOCIAL; GENETIC)

*9. CHILD WHO TRUANTS FROM SCHOOL.
Too harsh teachers. Social problem e.g. child needs to get a job for money. Parents not interested in child's education. Child afraid to come to school because of not having done his/her homework. Bad company.
(<u>SOCIAL</u>; BEHAVIOURAL CAUSED BY SOCIAL PROBLEMS; EMOTIONAL; SCHOLASTIC).

*10. CHILD ABSENT FROM SCHOOL FOR TRIVAL REASONS.
Lack of parental involvement in child's education e.g., socio-economic reasons; parents may keep children at home in order to help out. Political reasons - school boycotts of older children influences younger ones. School work not interesting.
(LACK OF PARENTAL INVOLVEMENT.)

11. CHILD WHO ONLY ANSWERS WHEN ASKED - NEVER VOLUNTEERS ANSWERS.
Shy, lacks confidence; lack of knowledge; speech problems e.g. stammers/stutters.
(SPEECH; HEREDITARY).

12. CHILD DOESN'T PAY ATTENTION; DOESN'T ANSWER QUESTIONS NO MATTER HOW INTERESTING THE LESSON. CHILD IS ALSO VIOLENT AND HIS INATTENTIVENESS HAS ALWAYS BEEN A PROBLEM. HE IS PROMOTED ON CONDONED PASSES AND IS 15 YEARS OLD IN STANDARD 2.
Slow learner; low I.Q.; possible mental retardation.
(LOW I.Q.; MENTAL RETARDATION).

13. CHILD DOESN'T LISTEN AND IS NAUGHTY IN CLASS; GIVES RIGHT ANSWERS ALTHOUGH HE DOESN'T CONCENTRATE.
Gifted child; work not challenging; bored; wants special attention from the teacher.
(BEHAVIOURAL: HIGH IQ).

14. CHILD ALWAYS SLEEPING, DOESN'T WANT TO CONTRIBUTE.
Social problems (e.g. goes to bed late due to TV or waiting for parents to return from work: attends initiation ceremonies; no breakfast, lives in a shebeen; parents drink). Child under-age. Lesson is boring.
(SOCIAL; BEHAVIOURAL).

15. SUB-A CHILD RAPED, CHILD FEELS ASHAMED AND EMBARRASSED AND IS VERY QUIET. TEACHER DOESN'T KNOW WHAT THE PROBLEM IS AS THE CHILD WON'T ANSWER.
Problem in Khayelitsha. Usually happens when mother has a baby, so father abuses child; father rapes the child. Teachers don't know about it as children hide it.
(SEXUAL ABUSE: CHILD ABUSE).

*16. CHILD SHOWS SEXUAL BEHAVIOUR.
Child imitating what happens at home; may have been sexually abused him/herself; background; perhaps child is "wild"; puberty stage or adolescent issues. Influence of TV.
(SOCIO-ECONOMIC).

17. STANDARD TWO CHILD UNDER-AGE (7 YEARS) IS UNABLE TO DO MATHS; ALSO RESTLESS AND DISRUPTIVE.
Under age; unable to understand due to level of cognitive development; ignorance of parents.
(SCHOLASTIC).

18. CHILD TOO OLD FOR CLASS BUT CAN'T COPE OR KEEP UP WITH YOUNGER CLASSMATES. TENDS TO BULLY OTHERS AND TAKE THEIR LUNCHES. OTHERS AFRAID OF HIM.
Age problem. Perhaps hungry; naughty; not wanting to bring own lunch.
(BEHAVIOURAL; SCHOLASTIC; LOW I.Q.; SOCIAL).

19. CHILD WITHDRAWN - SOCIAL PROBLEMS. MOTHER DOESN'T WANT TO TALK ABOUT PROBLEMS. TEACHER QUERIES CHILD ABUSE.
As for problem Number 15.
(SEXUAL ABUSE; CHILD ABUSE).

20. CHILD OVER-ACTIVE, DISTURBS CLASSMATES AND TEACHERS.
Mental retardation and birth problems, mother has schizophrenia. Child can't sit still and won't take punishment, also cannot write in line.
(MENTAL RETARDATION; OVER-PROTECTION).

*21. CHILDREN WHO ARE RESTLESS, SQUIRMY AND CANNOT SETTLE TO ANYTHING.
Social problem; family problems - not contained and no limit setting at home; hyperactivity; over-active; organic problem.
(NEGLIGENCE; HEREDITARY).

22. CHILD NAUGHTY - BULLIES CLASSMATES. ALSO HAPPENS AT HOME.
Over protected; negligence; as above.
(NEGLIGENCE; HEREDITARY).

23. CHILD STEALS OTHER CHILDRENS' LUNCH ALTHOUGH HE HAS HIS OWN LUNCH.
Naughty; may be poor and dislikes his own lunch, wanting to taste others.
(BEHAVIOURAL)

*24. CHILD WHO FIGHTS WITH OTHERS. BULLIES OTHERS.
Lives in a conflictual home where parents fight. Child over-active. Influenced by TV.
(SOCIAL; BEHAVIOURAL).

*25. CHILD DISOBEDIENT.
Bad company; negligence of parents.
(SOCIAL).

26. SPEECH PROBLEMS; DOESN'T TALK IN FRONT OF OTHERS. COULDN'T SPEAK AS A TODDLER. SHY AND NERVOUS.
Speech problems; sickness.
(HEALTH).

*27. CHILD SUCKS THUMB OR FINGERS.
Nervous; didn't wean properly; bad habit.
(EMOTIONAL).

*28. CHILD WHO IS FUSSY OR OVER-PARTICULAR.
Child is just like that, is slow, perfectionistic and a slow thinker.
(EMOTIONAL).

*29. CHILDREN WHO WET AND/OR SOIL THEIR PANTS.
Shyness - not feeling free to ask to be excused. Health problems; over-eating and drinking; loose bowels. Dull child. Rituals not done. Social problems resulting in emotional problems leading to health problems.
(HEALTH; SOCIAL).

*30. CHILD WHO TENDS TO BE ON HIS/HER OWN. APPEARS MISERABLE/UNHAPPY.
Lack of parental love; health problem; physical problem. Child not happy at school; problems child won't communicate; family problems; child mentally and emotionally ill.
(<u>SOCIAL</u>; BEHAVIOURAL; HEALTH).