Abstract

The life cycle of human being is divided into different stages. Childhood, adolescence, adulthood and old age. Each period has its characteristic adjustment problems and disorders. However, childhood disorders are given greater importance than other periods, on the assumption that unless they are detected and treated early, they pose severe problems in later life. Several classifications have been proposed in relation to childhood disorders. Freud attempted a developmental model based on the psychoanalytical theory. This model suggests a number of criteria such as status of the child’s age defences, their adequacy for their age, and manner in which the sexual and aggressive drivers are handled. A child can be rated on these different aspects and the degree of their problems assessed.

1. Introduction

A statistical approach at classification was made by Achenbach in 1966. According to him there are two clusters of abnormal traits (internalizing and externalizing factors) symptoms like nausea, withdrawal tendencies and phobia, which have an underlying internal conflict, he put under the internalizing factor, and behaviour like stealing, truancy, etc., under the externalizing factor. Another classification followed is in terms of major and minor disorders. Among major disorders, autism, runaway reaction, delinquency, etc., are included. Disorders like bed wetting and thumb sucking are called minor disorders. In this lesson the following classification of childhood disorders has been adopted.

- Habit disorders
- Conduct disorders
- Neurotic disorders
- Psychotic disorders

Habit disorders include transient symptomatic reactions of children to some immediate situation or internal emotional conflict. Habit disorders are characterised by simple repetitive
activities. Examples of such activities are nail biting, thumb sucking, and enuresis, masturbation, feeding problems, speech disorders, motor disorders and sleep disorders.

Conduct disorders refer to those adjustment reactions that are manifested by disturbances in the child’s social conduct or behaviour. Truancy stealing, sexual offences, hyperkinetic reaction, un-socialized aggressive reaction etc., are some of the examples. These disturbances may occur at home, in the school, or wherever the child has a need to act out his tensions.

Neurotic disorders refer to some transient reactions which are manifest primarily in physical or emotional symptoms that are generally considered neurotic. Examples of this category are phobia, withdrawal and over action.

Psychotic disorders of adults are also seen in children, but with a different clinical picture. These psychotic disorders may have a strong genetic basis and hence an early on set, and may cause severe disturbances.

2. Types of Disorders

Speech Disorders

Among speech disorders seen in children, delayed speech and stuttering are important. The child’s early life is characterized by frequent crying, followed by babbling which makes an important period in speech development. An indicator of speech development is increase in the usage of words. For e.g.: in the first two months children use about seven to eight sounds, which by two and half years increase to 27. It only by the tenth month that a child by the age of two to half years. By the third year child learns the ‘rules’ of language construction and starts speaking in sentences.

Speech development can be delayed or hindered due to several causes organic (for example, mental retardation, aphasia, autism etc…), psychological (emotional disturbances, lack of stimulation, separation from mother, etc.), Social (social class, bilingualism etc.).

Stuttering refers to the interpretation of the fluency of speech through blocked, prolonged or repeated words, syllables, or sounds. Many people stutters occasionally under specific conditions, say, while addressing a gathering for the first time or while facing an interview. Stuttering is also report to run families. Stutterers also found to show abnormality in E E G Patterns.

Feeding Disorders

The human infant is most helpless of all living beings. He must depend on others for his food. Therefore, his experience connected with feeding has important effect on his behavior immediately as well as in later years. Feeding symbolizes love and care. It can also be associated with anxiety and dissatisfaction, leading to disorders like bulimia, anorexia nervosa and pica.

Bulimia is excessive eating resulting in obesity as the symptom. The criterion of obesity in children is the excess weight of 25 percent above the normal weight for children of the same age, sex and height. An obese child is often subjected to ridicule by other children. This causes a feeling or rejection in the child, which in turn results in over eating. Thus the problem becomes a vicious circle.

Anorexia nervosa refers to the inability or the refusal to eat. This condition often leads to severe malnutrition and sometimes even to death. This disorder is generally found to be the result of conflict with parents, especially with the mother, who is forced to plead with the child to eat. Therefore, therapy for this disorder involves the family of the child also.

Pica is disorder characterized by persistent and indigestion of inedible substances at an age when the child is able to discriminate between edible and non-edible substances. In this disorder, substances
taken in by the children include charcoal, clay, buttons, paper, clips etc. The important reasons for this are poor nutrition and broken home conditions both of which are common problems among the poor.

- **Encopresis**
  
  Encopresis is the inability to control bowel movements, resulting in defecation (bowel movement) in clothing, in the bed, or on the floor. Encopresis is diagnosed in children who are at least 4 years old, although frequently children younger than 4 also cannot control their bowels. Encopresis more commonly affects boys than girls.

- **Enuresis**
  
  The term enuresis is defined as lack of bladder control at an age when such control is usually achieved. There has been no scientific study regarding the age of bladder control in children. Clinicians fix the age between 3 and 8 years. Again, there are differences in arriving at the criteria for the diagnosis of enuresis. Enuresis is much more common in boys than in girls. Enuresis is two kinds chronic and regressive. In the chronic kind the child does not have control over his bladder and wets his trousers irrespective of whether it is day or night. In regressive enuresis bladder control which has been achieved abandoned. This is may be due to the sudden onset of stress (e.g. the birth sibling) which arouses the feeling of jealousy and insecurity. Regressive enuresis is usually transient.

- **Sleep Disorders**
  
  Sleep disorders in children are similar to those seen in adults, namely restless sleep, nightmares and somnambulism. While night terrors are common sleep disorders in children, they are not found in adults. Nightmares occur any time during the night and do not involve much dramatic physical responses or verbal actions. When awakened the child becomes calm soon and is able to remember and narrate the dream.

  Sleep disturbances are common, and is very often preceded by stealing, such children often show a family background characterised by conflicts, negligence, poverty etc. They are called ‘run form’s’. Some children, on the other hand, who may seek more comfort in the company of their peers than in their family, forms gangs and run away. They are called ‘run to’s’ as they are running toward an external source of pleasure. Run away reaction is more common among males than females. However, there is an increasing tendency for running away among girls in the present time for reasons like bearing illegitimate children, marrying boys whom their parents disapproved of and the glamour of big cities. However, it is common only among the lower strata of society.

### 3. Unsocialised Aggressive Reaction

The definition of the term Unsocialised aggressive behavior or reaction depends on the age of the child. A child of three years by rolling on the floor, screaming, throwing his hands and legs about, expresses aggressive reaction. But he does not harm anybody or anything. On the other hand, the behavior of another boy of twelve years who throws stones at a passing bus makes cause damage to person and property. The behavior of the later may be termed as unsocialised aggressive behavior. The seriousness of the conduct disorder thus depends on the child’s age and maturity. The former includes behaviour traits like cruelty, disobedience, revenge fullness, tantrums etc. the latter includes acts like damaging public property; hurting others etc. this is more prevalent among boys than girls.

- **Phobia**
  
  A child’s fear is called phobia when the child is morbidly preoccupied with the source of the fear and begins analyzing his activities to avoid it. Children generally fear cats, dogs, furry animals, darkness etc. The most disturbing disorder however is ‘school phobia’ in which the child develops
extreme anxiety over going to school. Some important causes for this disorder are fear of separation from the mother or fear of being teased by other children, a strict teacher, being poor at some subjects, difficulty in concentration etc.

- **Autism**

Autism is the inability to relate to people or to situation. Autistic children are often mistaken for quite children because they do not place any demands on their parents. After infancy they do not form attachments with people but instead become dependent on mechanical objects. Autistic children lack the power to communicate. A child starts speaking by babbling in the early stages of development. This is less frequent in autistic children. They also have sensory problems and some autistic children are diagnosed as deaf because they never respond to sound. They are also found to be negativistic, turning their backs on others or activity resisting them.

- **Sleep Walking (Somnambulism)**

Statistics are meagre but it would appear that some five percent of children experience regular or periodic sleep walking episodes. The child usually goes to sleep in a normal manner but arises during the second or third hour thereafter and carries out some act, (Taves, 1969). This walk may take him to another room of the house or even outside, and may involve rather complex activities. He finally returns to bed and in the morning members nothing that has taken place. During the sleep walking, the child’s eyes are partially or fully open, he avoids obstacles, hears when spoken too, and ordinarily responds to commands such as to return to bed.

The causes of sleep walking not fully understood. Kales et al. (1966) have shown that sleep walking takes place during NREM (now rapid eye movement) sleep, and hence presumably doesn’t represent the acting out of the dream, as is commonly believed. In general it would appear that sleep walking is related to some anxiety-arousing situation that has just occurred or is expected to occur in the near future.

- **Nail-Biting**

Probably about a fifth of all children bite their finger nails at one time or other. The incidence appears to be highest among stutterers, children reared in institutions and children confronted with stressful demands. Although about as many girls as boys bite their nails at early ages, male’s out number females in later age groups, apparently because females are more interested in grooming. Nail-biting typically occurs in situation associated with anxiety and for hostility, and appears to be a method of tension reduction that provides the individual with “something to do”; thumb-sucking is probably similarly motivated. It represents a learned maladaptive habit that is reinforced and maintained by its tension reducing properties.

- **Tics**

A tic is a persistent, intermittent muscle twitch or spasm, usually limited to a localized muscle group. The term tic is used rather broadly to include blinking the eye, twitching the mouth, licking the lips, shrugging the shoulders, twisting the neck, clearing the throat, blowing through nostrils, grimacing and many other responses. In some instances, as in clearing the throat, the individual may be aware of the tic when it occurs, but usually he performs the act so habitually that he does not notice it. In fact, he may not even realize that he has a tick unless someone brings it to his attention. Tics occur most frequently between the ages of six and fourteen.

Tics that involve movements are called *motor tics* and those that are sounds are called *vocal tics*. Tics can be either simple or complex, although tics may have an organic basis; the great majority are psychological in origin usually stemming from self-consciousness or tension in social situations.
Unfortunately, the individual’s awareness of the tic often increases his tension in social situations because others can so readily notice it. Tics have been successfully treated by means of drugs, psychotherapy, and conditioning techniques.

4. Treatment And Prevention

Both treatment and preventive programs in our society are highly inadequate. There are varieties of methods for modifying maladaptive behaviour and also childhood disorders i.e. psychotherapy techniques like simple extinction, systematic desensitization, Aversion therapy, positive reinforcement, marital therapy, group therapy and institutionalization. Also,

1. Establishment of comprehensive family oriented health programmes, includes, day care and early Childhood education, health services.
2. Development of realistic programmes to eliminate racism, which handicaps so many children.
3. Establishment of a national child health care programme.
4. Development of a system for the early identification of children with special needs is very essentials for the upliftment of the children with various behaviour disorders.

5. Conclusion

Recent developments with regard to technological advancements and improvements to diagnostic methodologies have enabled researchers to study childhood disorders as never before. As a result, we now have a much greater understanding of these disorders. Furthermore, this research has facilitated the development of several highly effective treatments for childhood disorders that are evidenced-based. As research continues, these treatment approaches will be further refined. It is the duty of teachers and parents to have an idea and awareness of these disorders. Therefore, we can state with confidence there is hope and relief for people affected by these disorders, including their family members and loved ones.

References