AN INVESTIGATION INTO THE UNDERSTANDING OF CHILDHOOD PROBLEMS IN BLACK ISIZULU SPEAKERS

By

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ABSTRACT

This study investigated which childhood behaviours and emotions are considered "acceptable" and "not problematic" by Black isiZulu speaking parents and caregivers. It further investigated which childhood behaviours and emotions were considered "unacceptable" and "problematic" by Black isiZulu speaking parents and caregivers (N=97).

Data were collected by the use of the Behaviour Screening Questionnaire. The questionnaire consisted of 39 words describing the way children of 4 or 5 years feel and behave. The selection of the health domains included in the questionnaire was guided by the research on developmental psychopathology, the dimensional approach. The item format in the questionnaire was categorical: *Not concerning, concerning* and *very concerning*. The collected data were ordinal in nature, thus necessitated the utilization of non-parametric method of analysis. Data were then analyzed using descriptive statistics and inferential statistics (Chi square).

Findings indicated that 88% of the behaviours and emotions listed on the questionnaire were considered to be "unacceptable" and "problematic" by the participants in the study. These were largely the externalizing types of behaviours (57%). Thirty–two percent of these were internalizing types of behaviours and emotions. Only 11,6% of the behaviours and emotions listed on the questionnaire were considered to be "acceptable" and "not problematic" for 4 or 5 year old children. The findings of this study confirm the findings of previous research conducted both internationally and locally on the types of behaviours and emotions considered to be "problematic" and "unacceptable" as well as those behaviours and emotions considered to be "acceptable" and "non-problematic" by parents and caregivers in 4 or 5 year old children.

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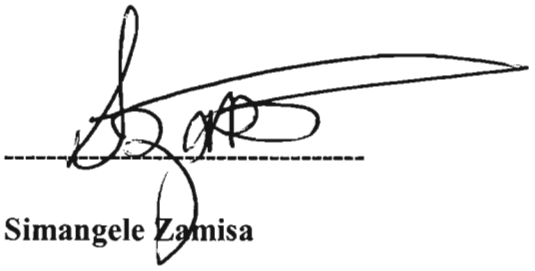
DECLARATION

Unless specifically indicated to the contrary, this thesis is the result of my own work.



Simangele Zamisa

DEDICATION

This work is dedicated to my late niece Thuleleni her spirit lives in it!

CHAPTER ONE

1.1 INTRODUCTION

This study investigated the understanding of childhood problems in a sample of black isiZulu speaking mothers and caregivers in Pietermaritzburg. It explored behaviours and emotions mothers and caregivers expect and considered to be "acceptable" in young children between the ages of 4 and 5 years, as well as behaviours and emotions they considered to be "undesirable" and "problematic". Given that professionals' views of childhood problems have been largely influenced by Western ideas, it follows that African professionals have been influenced by these conceptions of childhood problems in their training and setting (Gambu, 2000).

South Africa is a country with a highly heterogeneous population and remarkably, a country in which differences between cultural groups and ethnic groups are written into the law. Various broad and overlapping approaches have been used in South African research to create a context in which to understand manifestations of health and illness. One of these approaches uses as an explanatory device, the concept of the psychological structures of group members. Proponents of this approach would argue to differing degrees that there is a specific worldview and set of attitudes to health and illness in each South African group. Another approach attempts to locate illness and healing approaches within a broader social context. The latter is of necessity addressed in anthropological or ethnographic work. It attempts to place the understanding of illness within the ecological context Beuster (1997).

Ngubane's (1977) study on health and illness raised the issue of the distinction between natural causes of illness, illness related to sorcery and that related to ancestors. Following this line of thought, Janson (1983) argues for the necessity of differing modes of service based on differing views of heath and illness held by people. It is apparent that medical service information and Christianity have altered people's concepts of physical illness, but psychological and psychiatric illnesses are still explained in traditional terms. However, most of what is documented about childhood problems comes from research in Western cultures. Although such research is

valuable, it does not tell us enough about the diverse paths that childhood development may follow. Different cultural beliefs and values inform the way children's behaviours and emotions are conceptualized (Dawes, 1994). If our understanding of childhood problems is derived largely from Western databases, culture-specific phenomena may be misinterpreted (Luthar, Burack, Cichetti & Weisz, 1997). Twiford (1979) argues that one's attitude about behaviour is a reflection of culture-based values. Following this line of thought, Luthar et al. (1997) argue that the lens through which childhood behaviour is viewed is determined by cultural values. This informs adults' judgement of whether the behaviour is "desirable" or "undesirable". The lens through which childhood behaviour is viewed pertains to cultural assumptions about childhood, as well as to health and illness. If we view African children's behaviours and emotions from a Western perspective, we may end up misunderstanding, or even pathologizing what is otherwise non-problematic behaviour.

Hence, this study proposes the move toward emic approaches to childhood problems. Kleinman (1987) also advocates an emic approach toward childhood problems. He is critical of conceptualizing childhood problems using only the Western perspective. Unlike the current approaches to childhood problems, the emic approach uses a culture's own frame of reference and local conceptions of illness in order to understand the way cultural groups define illness. Kaplan and Saddock (1998) also argue that what renders behaviour normal or abnormal is its social significance. This is the same for all societies including the black communities of this country. If the behaviour does not meet the expectations of the society, it is regarded as abnormal. The response, which the behaviour invokes from the society, renders it either normal and acceptable or abnormal and unacceptable. Definition of disorder or deviant behaviour is based on conception of normality and deviancy which vary with class, position and socio-cultural context (Dawes, 1994).

1.1.1 Abnormality

When defining abnormality we usually tend to adopt one of many different types of approaches. One way is the use of statistical comparison. For instance a child's behaviour could be defined as abnormal because its occurrence is rare or infrequent. One of the problems with this approach is that not all rare behaviours are disordered. Another approach for defining abnormality focuses on whether a child's behaviour is associated with impairment when carrying out customary roles. In many instances illnesses can involve impairments in functioning. Abnormal behaviours can also be defined against the social norms but not all deviant behaviours are abnormal. Using social norms as a criterion for abnormality is problematic because norms change over time and are subjectively judged. There is a great need to apply the principle of cultural relativism to ideas of what is to be considered abnormal. Matsumoto (1996) defines cultural relativism as a viewpoint that suggests that the unique aspects of a particular culture need to be considered when identifying behavior. Relativism is an epistemological theory denying the possibility that there can be any objective, universally valid human knowledge. It affirms that meaning and truth vary from person to person, culture to culture and time to time (ibid.) Abnormality and normality of behaviour is culturally determined. According to Matsumoto (1996), ethnographic reports of culture-bound syndromes provide strong support for applying cultural relativism to understanding and dealing with abnormality. The recognition of culture in shaping abnormal behaviour requires that one re-examine the way assessment and treatment of individuals are done.

Cultures that differ markedly in beliefs and child rearing practices may nonetheless be very similar in the prevalence of various childhood problems, such as hyperactivity. To support this Campbell, Szumowski, Ewing, Gluck and Breaux (1982) note that children from different cultural groups with different values and child rearing practices are very similar in the prevalence of hyperactivity and related behaviours. Barkley (1981) notes that it makes sense to attempt to identify hyperactivity in young children but problems of definition are acute at their age. The author argues that studies of hyperactivity in pre-school age children often rely on both parents' and teachers' reports, which often do not agree. Crowther, Bond and Rolf (1981) suggest that

pre-school aged children are similar in prevalence and severity in *externalizing* behaviours such as aggressiveness, as well as *internalizing* behaviours such as anxiety and phobias. On the other hand, Weisz, Sigman, Weiss and Mosk (1993) note that children from different cultural groups differ markedly in the prevalence and types of problems they present. These authors suggest that the results of their study are related to the strict emphasis on compliance and obedience among the Embus in Kenya as opposed to the greater independence permitted in Western culture.

Research from a Western perspective provides valuable information about childhood problems. It also provides the basis for further research in other communities such as Black isiZulu speaking communities of this country with different child rearing practices, cultural beliefs and values. These communities are believed to conceptualize health and illness, "problematic" and "non-problematic" behaviours and emotions differently from communities who are influenced by the Western culture. The diversity of cultural beliefs and values in this country calls for an understanding of childhood problems from the communities' frame of reference and their conceptions of illness. This also calls for an understanding of child behaviour in its context.

1.2 RATIONALE FOR THE STUDY

Human behaviour needs to be viewed in the socio-cultural context in which it occurs (Segall, Dasen & Poortinga, 1990). Childhood problems should be understood within the broader family, community and cultural contexts. The interaction between these contexts places children in situations where they are caught between different sets of expectations. Firstly, the family context is the one with which professionals become more directly involved when working in agencies that offer services for children. It provides a starting point in understanding children's difficulties and the unit with which interventions are often carried out. On the other hand, the community context is concerned with what is expected and acceptable behaviour in the community. Professionals need to look at children in their own transitional space, this means that they need to look at children in relation to their families, communities and their cultural groups.
Lastly, culture has an important influence on many aspects of people's lives, including beliefs,

behaviour and emotions. According to Helman (2000), cultures are never homogeneous. Therefore, one should always avoid using generalizations in explaining beliefs and behaviours. Family, community and cultural factors should be taken into account when conceptualizing childhood problems. These factors are connected and interact with one another and this connectedness provides a reasonable understanding of childhood behaviour that may or may not appear to be a problem (Varma, 1996).

Western trained professionals and parents are aware of the cultural gulf which divides them, argues Varma (1996). Attitudes and beliefs about children's behaviour are aspects of culture and there is a great diversity across cultures (Varma, 1996). The purpose of the current study was to reach conclusions about acceptable and unacceptable behaviours of childhood in a sample of Black isiZulu speaking parents and caregivers. This information will help professionals working particularly with young children between the ages of 4 and 5 to understand their behaviours both from professional and cultural perspectives. This will further help health professionals in the understanding of culture's own frame of reference and local conceptualization of illness. Data and conclusions will inform available literature and forms of intervention in dealing with childhood problems in different cultural groups. Conclusions will be of great help in the development of services that work on problems that may interfere with children's development and learning in this country.

1.3 AIM OF THE STUDY

- The aim of this study was to establish which childhood behaviours and emotions are "acceptable" and considered "non-problematic" by Black isiZulu speaking parents and caregivers and which behaviours and emotions are "unacceptable" and considered to be "problematic" for 4 or 5 year old children in Black isiZulu speaking communities

1.4 RESEARCH QUESTIONS

The study tested two research questions:

- Which childhood behaviours and emotions are considered "acceptable" and "not problematic" by Black isiZulu speaking mothers and caregivers?
- Which childhood behaviours and emotions are considered "undesirable" and "problematic" by Black isiZulu speaking mothers and caregivers?

1.5 METHODOLOGY

A Behaviour Screening Questionnaire was adopted for the purpose of data collection. The methodology is based on the theories of childhood psychopathology, the dimensional approach. Seven domains related to internalizing and externalizing behaviours and emotions were selected for inclusion in the questionnaire. Using the Behaviour Screening Questionnaire, parents and caregivers were asked to rank behaviours and emotions listed on the questionnaire on a three-point scale: *Not concerning, Concerning* or *Very concerning.* The methodology is discussed in detail in chapter 3.

1.6 DEFINITION OF TERMS

The following terms are defined in an attempt to establish the philosophical position taken in this thesis. These terms will be used throughout this study and should not be understood in isolation.

Culture

Taylor (1871, in Helman, 2000) defines culture as a complex whole which includes the knowledge, beliefs, morals, customs and any other capabilities and habits acquired by the person as a member of a society. Helman (2000) notes that culture comprises systems of shared ideas, systems of concepts, rules and meanings that underlie and are expressed in ways that reflect how

people live in a particular society. Both these definitions agree that culture is shared by members of a particular society or community.

Childhood

Gardiner, Mutter and Komitzki (1998) define childhood as:

> The period extending from the end of infancy, about 1 to 2 years of age, to just before the beginning of adolescence, typically about the age of 7 or 12, depending on the particular culture (p.37).

In this study childhood refers to children between the ages of 4 and 5 years.

Internalizing: Refers to the behaviours and emotions which are over-controlled. These include anxiety, fear, somatic complaints, shyness, social withdrawal, sadness as well as depression (Achenbach, 1990). Theories regarding pathways to internalizing problems have generally focused on early behavioural inhibition (Mesman, Bongers & Koot 2001). This inhibition is expressed as fearfulness and anxiety during toddler years.

Externalizing: Refers to the behaviours and emotions which are under-controlled or acting out and usually place a child in conflict with the environment (Achenbach, 1990, Mash & Barkley, 1996 and, Mesman, Bongers & Koot, 2001).

1.7 OUTLINE OF THE STUDY

This chapter has introduced the study and contextualized the issue of childhood problems on three different contexts in an attempt to address the issue of understanding of childhood problems in a cultural context. Chapter 2 situates the study in its research context, drawing from existing conceptions in literature of childhood problems. Chapter 3 outlines the methodology adopted in this study. Chapter 4 presents the results. Results are then discussed in Chapter 5. Finally, Chapter 6 presents conclusions, limitations, contribution of the study, and recommendations.

CHAPTER TWO

LITERATURE REVIEW

Chapter 1 introduced the study and presented its aim as well as research questions. This chapter is organized around 5 major topics: the history of childhood problems, meanings of childhood, childrearing practices, an emic approach to childhood problems, and African views of illness. The main purpose of this chapter is to identify the gaps in our knowledge and understanding of childhood problems based on the existing literature on childhood psychopathology, using the dimensional approach. The chapter also proposes a move to emic approaches to the understanding of childhood behavioural as well as emotional problems.

2.1 THE HISTORY OF THE UNDERSTANDING OF CHILDHOOD PROBLEMS

The study of childhood problems is largely a 20th Century phenomena. Its roots are neither in adult psychiatry nor in paediatrics, but in education and psychology. The role of childhood experience in the etiology of behaviour problems was not formally recognized until the advent of psychoanalytic theory. Freud's theories remain influential in the study of childhood problems. Very early in his writings, Freud emphasized the importance of childhood experiences and emotions in shaping the adult personality (Richman, 1982). If problems of adults are traced back to early experiences, there is evidence in research that they originate from childhood experiences and for that reason, understanding childhood development is important (Sylva & Lunt, 1982).

Understanding and knowledge of childhood problems comes from a variety of sources ranging from descriptive studies to experimental research. Descriptive studies are based on the information from primary caregivers about the developmental progression of young children. These studies focus on the assessment and comparison of behaviours as a function of a child's

age, gender and socio-economic status and most importantly of the culture in which the child is growing up (Schaefer & Millman, 1981). Experimental research on the other hand provides direct tests of the hypotheses and is a better source of understanding causal relationships (Green, 1992).

2.1.1 Conceptualisation of childhood problems

The literature presents childhood problems from a Western perspective (Schaefer & Millman, 1981; Winkley, 1996; Druke, Hammer, Agras & Bryson, 1999). In a country like South Africa, there is need to integrate the perspectives of African cultures into the existing literature in order to be able to deal more effectively with presenting childhood problems. The existing literature on childhood problems mentions behaviours such as bed-wetting, hyperactivity, aggressiveness, and shyness as problems. Children presenting with these behaviours are considered as needing professional help regardless of their cultural context. The literature seems to impose inappropriate norms for Black isiZulu speaking children and fails to recognize cultural differences in which children are raised. Moreover, the literature is inadequate and insensitive to how some social environments promote and support behaviours judged problematic in other cultural settings.

2.1.2 Approaches to childhood problems

Mash and Barkley (1996) describe current approaches to childhood problems as being either *categorical* or *dimensional:*

- The categorical approach is a rule-based classification system. This is exemplified in diagnostic systems such as the Diagnostic Statistical Manual of mental disorders and the World Health Organisation's International Classification of Diseases. This approach fails to include the socio-cultural context, which is fundamental to determinations of adaptive and mal-adaptive development (Mash & Barkley, 1996). Achenbach (1990) argues that

children are often categorized according to diagnostic concepts of distinctions made by services which are not congruent with the children's actual needs. The classification of childhood problems tends to concentrate more on external behaviour than on understanding how the child is feeling or what is happening in the child's mind. The need to fit children into categories results in haggling over services, shifting of children from one service to another and being biased in assessment reports in order to match children to the categories. It leads to the denial of services when children's problems do not fit neatly into any of the prescribed categories.

- The dimensional approach, on the other hand, organizes problems based on theories of developmental psychopathology and which have reasonably strong empirical support. This approach is exemplified in the two dimensional systems of *internalizing* and *externalizing* conditions on which scales such as Behaviour Checklist and Behaviour Screening Questionnaire are based. It shares the advantage of consistency that is claimed by the categorical approach. It relies on the reports of individuals such as parents and teachers as informants on a particular child's behaviour (Mash & Barkley, 1996).

  The internalizing domain is comprised of a wide range of symptoms and syndromes. These include anxiety, fear, somatic complaints, shyness, social withdrawal, sadness as well as depression (Achenbach, 1990). Theories regarding pathways to internalizing problems have generally focused on early behavioural inhibition (Mesman, Bongers & Koot 2001). This inhibition is expressed as fearfulness and anxiety during toddler years. The externalizing domain, on the other hand is comprised of behaviours and emotions that place a child in conflict with the environment (Achenbach, 1990). Externalizing behaviours and emotions have been referred to as under controlled or acting-out behaviours (Achenbach, 1990, Mash & Barkley, 1996 and, Mesman, Bongers & Koot, 2001). According to Cummings, Ianotti, and Zahn-Waxler (1989); Rose, Rose, and Feldman (1989) cited in Mash and Barkley (1996), children presenting with externalizing types of behaviours such as destructiveness, impulsivity and non-compliant behaviour of

concern to primary caregivers as they are likely to display such behaviours during school age and this puts these children at risk of peer rejection.

During the course of their development, virtually all children present with problems to their caregivers. After the age of 3 children's social behaviour, meaning the way children behave in the society and their discipline are usually of concern to their parents. The years between 3 and 6 constitute an unparalleled time of change for children. The list of possible developmental concerns referred to in the literature is long, but there are those areas in which parents and teachers are likely to experience greater challenges (Lyman & Hembree-Kigin, 1994). These include problems or concerns such as enuresis or bed-wetting, eating difficulties; cruelty, disruptive behaviour, lying, and shyness.

2.1.3 Examples of common childhood problems

(i) Bed-wetting or enuresis

Schaefer and Millman (1981) define enuresis as the repeated involuntary discharge of urine into bed by a child of 4 years or older. On the other hand the Diagnostic Statistical Manual 4th edition (DSM-IV) (APA, 1994) defines enuresis as the repeated voiding of urine into clothes or bed. This voiding can either be involuntary or intentional in a child aged at least 5 years. For this to be considered a problem, it must occur twice weekly for at least 3 months. According to Kaplan and Saddock (1998), most children are not enuretic with intention or even with awareness. A child is at greater risk to be enuretic if the father was enuretic. Psycho-social stressors such as the birth of a sibling, hospitalization between the ages of 2 and 4 appear to precipitate some cases of enuresis (DSM-IV). Schaefer and Millman (1981) argue that enuresis is a common childhood problem and as many as 1 out of 4 children between the ages of 4 and 16 have presented with it at one time or another.

(ii) Eating problems

An eating problem in childhood is a persistent failure to eat adequately or the tendency to overeat. In DSM-IV (APA, 1994) eating problems in childhood are described as being characterized by eating disturbances that include pica and rumination. According to Schaefer and Millman (1981), eating problems are very serious and require immediate professional help, especially when a child is not eating adequately or eating too little. The authors argue that under-eating develops as a reaction to the environment and over-eating serves to make up for feelings deprivation.

(iii) Cruelty to animals and other children

Cruelty to animals or other children is a passing phase in childhood that under parental pressure is channeled into more acceptable behaviour (Druke, *et al.*1999). Schaefer and Millman (1981) define cruelty as the premeditated deriving of pleasure from hurting others or animals. These children often come from chaotic homes with aggressive parental models and some of these children show signs of brain damage.

(iv) Destructiveness

This refers to the acts of damaging or destroying property. Some children behave like this deliberately or intentionally and others do so innocently and unintentionally. Sometimes children destroy due to frustration and others do so due to hostility. Children with this kind of behaviour problem are assumed to have deep-seated internal difficulties (Schaefer & Millman, 1981).

(v) Dishonesty or Lying

This can be defined as making an untrue statement with knowledge of its falsehood and with the intent to deceive another person so as to gain an advantage or evade unpleasantness (Richman, 1982). Schaefer and Millman (1981) note that during pre-school years, children have difficulty

distinguishing fantasy from reality, as a result they are prone to self-deception, exaggeration and wishful thinking.

(vi) Shyness

Shy children avoid others and are usually timid, easily frightened and reserved. They do not take the initiative in social situations (Shaefer & Millman, 1981). This tends to be different in Black families, where a child especially a girl is encouraged to be passive. Shyness is regarded as not necessarily a problem in these families.

The abovementioned behaviours are usually attributed to biological, environmental and organic factors. However, the cultural context within which the child is brought up, and the parents' beliefs regarding health and illness are often ignored as influential factors. The shortcomings of understanding childhood problems from one perspective, usually the Western one, ignores ideas about what is normal and acceptable in a particular cultural group and what is unacceptable in another cultural group. A framework that will integrate multi-cultural frames of reference is thus called for. The Western perspective provides valuable information but it seems to be reductionistic and narrow in its approach in the present context. It uses screening instruments that are based primarily on theories of the child and does not integrate cultural perspectives or the viewpoints of the parents and teachers who at times have to use these screening instruments.

2.1.4 Assessment of childhood problems

In assessing childhood problems or any other disorder it is not easily decided what behaviours are to be regarded as normal for children especially those coming from different cultural groups. Questions about the incidence of childhood problems in South Africa have to note the particular context within which it arises. There is a range of factors both within the child and the child's eco-cultural system, which can increase the risk for developing problems. These factors include not only acute stressors but also ongoing inequalities and structural violence. In situations of violence and racism such as exist in South Africa, the risks are high (Dawes, 1994). Poverty and

violence pose serious hazards and are widely regarded as major public health threats to psychological well-being. For instance, Flanagan, (1999) found that high levels of violence are associated with high rates of behaviour problems in young children. Such behaviours include aggressiveness and fighting.

When interpreting a child's behaviour and emotional status it is important to take into account age and developmental level as well as factors relevant to specific developmental periods (Robertson & Berger, 1994). The authors continue and argue that what may appear as problem behaviour can in fact be due to temporary developmental phenomena. On the other hand the behaviour might be culturally relevant. Another source of difficulty when assessing and interpreting children's behaviour is the fact that there is generally poor agreement or none at all on a particular child's behaviour and functioning when different sources such as parents, educators or health workers are asked to rate the child's behaviour. Robertson and Berger (1994) argue that this is an indication that children's *deviant* or disordered behaviour is often a response to specific circumstances and is apparent mostly in a particular context. More than that, the perceptions and understanding of informants and the contexts in which the assessment occurs are central determinants of whether a child will be rated as having a problem or not.

This calls for the need to formulate assessment tools that are developmentally appropriate for pre-schoolers. Following this line of thought, researchers such as Castillo (1997) and Foster and Martinez (1995) have questioned the assumption regarding the universality in the conception of childhood problems based on the psychological instruments used up till now in the assessment of children. The researchers argue that existing assessment tools are inadequately standardized for ethnic minority groups. These tools impose inappropriate norms and fail to reflect the cultural groups and familial structures in which some children are raised. The validity and reliability of the various instruments used have not always been firmly established. Most of them are developed in the United States of America and the United Kingdom. The likelihood of local variations in semantics and therefore creating the need for local standardisation, even in the

English speaking developing countries, has not been systematically investigated. There is also the difficulty of deriving a valid translation of the instruments when the language of the target population is not English. There is also the possibility that instruments developed in the West will not detect indigenous expressions of illness. Finally, in developing countries, even if all these obstacles relating to the instruments could be overcome, there remains the difficulty of mounting an adequate epidemiological study in the face of inadequate financial and organisational back-up and in the face of sensitive or even disruptive socio-political circumstances (Beuster, 1997).

2.1.5 Epidemiological studies of childhood problems

Internationally, the incidence of behavioural and emotional problems of children is estimated to range from 14 to 22%. The prevalence rate for diagnosable childhood problems ranges from 8 to 10% (Mash & Barkley, 1996). Castello, Angold, Burns, Stangl, Tweed, and Erkanli (1996) found that 20.3% of children in the Great Smoky Mountains in Britain met the criteria for DSM diagnosis. The most frequently observed problems among young children were anxiety or phobias, hyperactivity and conduct disorders. Other forms of behaviour problems ranged from 5.7% to 9% and different forms of mood disturbances ranged between 1.8% and 5%. Reported prevalence estimates for specific diagnoses vary considerably and should be interpreted with caution. Besides being subject to methodological errors, prevalence rates for specific disorders within a country may vary over time as well as from community to community and even within communities (Castello, et al. 1996).

Castello's studies indicate that in developing countries there is lack of knowledge and training of primary caregivers. Also parents are frequently pre-occupied with their own basic needs for survival. Specialised services for children are in short supply. Thus the identification of childhood problems and other problems is understandably seen as not being a priority for these communities. A recent preliminary study in South Africa, using African traditional healers as informants, reported on what seem to be indigenous categories of childhood problems. This

highlights the importance of exploring culture-specific forms of illness in the South African context (Robertson & Kottler, 1993). In a research project done as part of a postgraduate thesis, Broughton (1986) used the Reporting Questionnaire for Children to screen Black children for the likelihood of childhood problems. This questionnaire was administered to 179 children aged 5 to 15 years in a random sample of households in the Durban. Of all the children screened, 69% scored positive on at least one item. The three most common symptoms were frequent headaches, bed- wetting and sleep disturbances. Also in Durban area, Loening (1990) administered the similar questionnaire to children aged 5 to 18 years. Frequent headaches were one of the symptoms rated high, soiling and bedwetting as well as fearfulness.

Another South African study conducted by Spiro and Swartz (1994) using a Behaviour Screening Questionnaire found that pre-school aged children, regardless of their socio-cultural context exhibited similar prevalence of childhood problems. Researchers further assert that the child's behaviour may be influenced by the prevailing social context. In their study of South African pre-schoolers, Spiro and Swartz (1994) found that African mothers were concerned mostly by eating difficulties. This finding contradicts the hypothesis that children from low socio-economic status families exhibit fewer eating difficulties (Newson & Newson, 1968 cited in Spiro & Swartz, 1994).

Clinic based studies are inadequate because the clinic population tend to be un-representative due to referral biases and other selective factors. These studies draw samples only from those children who are brought to the clinics (Robertson & Kottler, 1993). Whether help is sought from the health professionals, it depends on the availability of the services and whether the adult caretaker perceives the need and identifies the situation as illness-related.

The difficulty of identifying signs of psychopathology in children has been described. In developing countries there is a complex cultural and socio-political history in place. Epidemiological studies of child psychopathology are a fairly new field even in the international arena, and large-scale studies in developed countries suffer from significant methodological

flaws. The complexity of South African childhood is both daunting and challenging, and there is a pressing need for data to inform preventive and curative services (Beuster, 1997). Multi-disciplinary cohort studies in several urban and rural areas need to be undertaken to provide comprehensive information about the functioning and development towards the establishment of representative groups of South African children. Contact with indigenous healers and herbalists is also crucial in order to understand particular cultural presentations of childhood illness and to understand the forms of healing these practitioners employ in their work with children. Whether a problem exists in fact depends on the primary caregivers' view of what constitutes a problem and what is of concern about a child's behavioural and emotional manifestations (Beuster, 1997).

All the studies seem to have focused on different age groups of children but were all interested in studying childhood problems. This leaves the questions of what exactly constitutes childhood, when does childhood end and does it end at the adolescent stage or pre-school age? The following section attempts to look at what constitutes childhood as well as how the definition of childhood has changed over time.

2.2 CHILDHOOD

Gardiner, Mutter and Komitzki (1998) define childhood as the period extending from the end of infancy, about the age of 1 to 2, to just before the beginning of adolescence depending on each particular culture. Childhood is thought of as being a social construction. It is neither a natural nor a universal feature of human groups (Achenbach, 1990).

Culturally

Childhood appears as a specific structural and cultural component of many societies. Different cultural groups tend to define childhood in different ways. These definitions are influenced by cultural beliefs of what constitutes childhood (James & Prout, 1990). For instance, in Zulu tradition and other African cultures a person stays a child to his or her parents and community no

matter how old she or he is. Childhood does not end in adolescence, as it seems to in Western culture.

Changes in the conceptualisation of childhood

Attitudes about how children should be treated have changed remarkably. These attitudes as is the case in the Western view of childhood are a product of history and culture (Flanagan, 1999). In the ancient past children were treated differently. They had to take part in adults' activities. For instance, child labour was a common and acceptable practice in countries like India, but now it is against the law of that country to have a minor as an employee. Children in most countries have the right not to be abused but have the right to be cared for. Children's rights are written in to the law of each and every country. The inherent goodness of children should be respected. Children should be given freedom to develop naturally (Flanagan, 1999). Childhood provides an interpretive frame for understanding the early years of human life. The idea of childhood is shaped and determined by parental belief systems about how to bring up their children (James & Prout, 1990). Hence there is no single meaning to childhood. Each parent defines childhood based on his or her beliefs and values about what constitutes childhood. Parents draw from their experiences and knowledge of parenting and child-rearing in bringing up their children. The following section briefly outlines child-rearing, looking at the socialisation process and the role of culture in the development of the child.

2.3 CHILD-REARING

Research on childhood problems has been done by researchers such as Achenbach (1990) Schaefer and Millman (1981) and Winkley (1996). What is lacking is the focus on the lens through which adults view child behaviour. In a country like South Africa, there are diverse cultural groups with different values, belief systems and practices. Therefore, it is important to study child behaviour in its context. This presents a challenge for professionals to acknowledge that culture plays a major role in child-rearing practices. There are beliefs that may not be evidenced in direct observation of interaction between parent and child. These may be more

evident in the way a child is socialized and in the home organization (Chao, 1995). Parents' beliefs about child- rearing practices are embedded within a certain culture (Chao, 1995). Cultural variations in various domains of child rearing exert significant and different influences over the mental, emotional, social and behavioural development of children.

According to Milford (1999), within the discipline of Psychology, the child rearing values, attitudes and practices of the dominant Western culture have been considered the norm for optimal child development. These norms have been recognised and accepted as being universal for all children. This perception of child development results in the misunderstanding of the behaviours of children from other cultures. Child rearing practices are a complete function of numerous variables including parental age, childhood experiences, values, beliefs and psychological characteristics (Le Vine 1974, in Milford, 1999). According to Ogbu, (1981) child-rearing is:

> The process by which parents and other agents transmit and by which children acquire prior existing competencies required by their social, economic, political and other future adult cultural tasks. (p.6)

All societies prescribe certain characteristics that their members are expected to possess. If people are to function adequately as members of their society, they should possess socially acceptable characteristics (MacCoby, 2000). This suggests that every society has values, beliefs and conceptions about what is normal and what is abnormal in child behaviour. Children's immediate social networks vary from one culture to another, thereby influencing socialisation and enculturation patterns (Bornstein, 1991). Parental beliefs and values tend to influence child development particularly by determining context and training practices. Culture provides the conceptual framework for explaining how groups of individuals arrive at socially shaped yet personally distinctive sets of values, attributes and patterns of social behaviour (Lee & Draguns, 1999).

It is impossible to detach the child-rearing relationship between parent and child from the cultural group from which they originate. Bornstein (1991) suggests that the way child-rearing takes place is dependant on the cultural expectations of the society in which the rearing takes place. For years research has focussed on how child-rearing practices affect a child's cognitive, social and emotional development only in Western populations. The results are then applied to all children universally.

Cultural contexts in which children are reared constitute central, yet often neglected factors in developmental studies (Bornstein, 1991). Furthermore, the author argues that the influence of culture on child-rearing practices is very often overlooked. Without a cross-cultural developmental perspective, the true diversity and expanse of human behaviour cannot be grasped neither can it be known how diverse factors interact to shape the ability to think, perceive, feel and act. Cultural anthropologists have been pre-occupied with studying the culture of adults. They have neglected cultural dimensions of child rearing (Eldering, 1995).

In non-Western cultures, child rearing practices and attitudes associated with childcare and parenting, vary greatly. Parents from non-Western cultures are in fact more relaxed and informal regarding things like toilet training, feeding and nurturing. They tend to be more authoritarian regarding discipline and respect for parents and elders. There is less emphasis on separation and autonomy in comparison to Western practices (Lee & Draguns, 1999). One's culture is the primary source of information about the ways of child-rearing. Culture influences parents' goals, beliefs and responsibilities (Gruse, Hasting & Mammone, 1994, in Milford, 1999). Odetola and Ademola (1985) note that cultural values are not inherited by individuals, but are learnt through practising and acting according to the ways of a particular society. Adults' beliefs about children's capacities and needs, which are more or less, explicitly verbalized, have an impact on the way they interact with children (Sigel, 1985 in Bornstein, 1991). There are specific cultural norms underlying mother's ideas of child development, for instance, the milestones of development. These norms are closely related to the parental belief system.

Different child-rearing practices determine the way children in different cultural groups are reared. These vary from culture to culture, based on cultural beliefs and values of each community. Child-rearing methods are cultural phenomena and are related to the attitudes and necessities of each social group (Flanagan, 1999). Culturally mediated rearing practices, values and traditions and associated child rearing and socialisation practices help shape both the kinds of problem children present with when distressed. Each cultural group has its own ideas and perceptions of the child as well as of the mechanisms underlying socialization. The following section briefly outlines the socialisation process.

2.3.1 Socialization

Sylva and Lunt (1982) define socialisation as:

> The whole process by which an individual, born with behavioural potentialities of an enormously wide range is led to develop actual behaviour which is confined to a much narrower range- the range of what is customary and acceptable for him according to the standards of his group. (p.173)

According to Flanagan (1999), socialisation looks at how individuals come to be who they are. It deals with the way in which early childhood experiences shape a person's psychological nature through the process of sociability and attachment. Nsamenang (1995) argues that Western theories of socialisation tend to place a great emphasis on the promotion of autonomy. African cultures on the other hand tend to be more pre-occupied with the cultivation of social responsibility, nurturance and a communitarian spirit. In African cultures the pattern of socialisation is pragmatic, apprentice-like in nature. It is such that children are systematically *graduated* from one role position to another until they assume adult roles.

Flanagan (1999) emphasises the fact that culture is passed on through the socialisation process. This is evident in child rearing practices. Following this line of thought, LeVine (1977) argues that culture is transmitted socially rather than biologically. Also children learn culturally appropriate forms of behaviour more under the mentorship of older siblings and peers than

parents and other adults (Nsamenang, 1995). Culture no less than biology, contributes to the socialisation of children (LeVine, 1977). Knowledge from adults filters through older children who are co-participants alongside adults in the process of socialising younger ones (Tharp, 1984 in Nsamenang, 1995). Developmental phases in African cultures are based more on recognisable stages of social functioning than on chronological age in African cultures (Nsamenang, 1995).

The process of socialisation takes place early at home and moves on to the outside world such as school. At home children are usually taught manners such as saying "please" and "thank you". Parents begin to shape a child's behaviour by rewarding the good behaviours which are acceptable and desired in the community within which the child is growing up. Parents also tend to discourage those behaviours which are culturally unacceptable and undesirable in their communities. Culture plays an important role in the developmental process of children in all cultural groups. Since culture plays such a crucial role in how children are socialised, it is worth looking at its role in development.

2.3.2 Culture in development of a child

Nsamenang (1995) argues that Western theorists tend to describe human development as if it unfolds regardless of its social context. Furthermore, he notes their failure to recognise the extent to which child development is shaped and constrained by cultural restrictions. Ideas about and orientations towards children and their development emerge from cultural contexts. The way in which people conceive of development influences the way children are raised and consequently how they mature (Sameroff & Feil, 1985, cited in Nsamenang 1995). Every cultural community structures its environment and organises development in ways that are culturally meaningful to its members. According to Beuster (1997), culture is a "provider of settings" for child development. It encourages the development of certain kinds of behavioural dispositions in preference to others. Following this line of thought, Harkness and Super (1992) note that every culture promotes its folk views of human nature and how children can become competent members of their cultural communities. Nsamenang (1995) suggests that child development can

be construed as the process of fostering the acquisition of cultural values and competence.

Developmental psychologists have increasingly begun to recognise that the social setting in which children are reared is a crucial factor in their development (Eldering, 1995). The notion of folk developmental landmarks prompts theorists to conceptualise how culture influences development (Nsamenang, 1995). Human development occurs in a specific culture. African folk thought systems and organisation of life are framed by different world-views from those of Western thought systems. Developmental studies are generally formulated within the framework of Western thought systems (Sponel, 1990, cited in Nsamenang 1995). Furthermore, Nsamenang (1995) argues that developmental literature is based exclusively on Western notions of children. These notions of child development are usually seen as universal. The experiences of childhood in Black communities in other countries may not accord or correspond with that portrayed in this literature. This calls for culturally relevant theories of child development. Developmental studies across cultures are necessary to differentiate between biological universals (etics) and cultural specifics (emics). The manner in which children grow up into fully fledged members of their society and culture is subtle and complex (Jahoda, 1998). Therefore, understanding conceptions of child development from a culture's frame of reference is crucial for one to be able to treat what needs to be treated.

Development is portrayed as unremarkable, universal and inevitable. The Western perspective has influenced common sense thinking on how children are supposed to develop. Culture has been largely ignored in developmental psychology. The universal standards that are claimed to exist are in fact ways of judging Western history in a positive light and other cultures are judged and regarded as inferior. In different cultures, different behaviour is seen as ideal. In Western culture the best care for the child includes being up to date with all the recent care advice. Research in developmental psychology has been based on, and focused on Western, middle class norms. Questions relating to the ideal family, the best methods to care for children, the role that women should play as mothers, are all structured by the Western ideal. The Western history of developmental psychology has succeeded in pathologising people and behaviours that do not

coincide with the Western norms and standards. Developmental psychology needs to be deconstructed to enable contemporary understandings to challenge *its scientific certainty and grip on common sense (*Burman, 1994).

In conclusion, it is clear that culture plays a major role in development. Communities structure and organise child development in ways that are culturally meaningful to them. Thus Western perceptions of development are narrow and reductionististic. This calls for inclusion of culture in the studies of human development for it to be understood and conceptualised in the communities' frame of reference. According to Mkhize and Frizelle (2000), during the process of development an individual enters into a dialogue with a number of social and cultural voices. These voices may be composed of utterances by parents including collective groups understandings as reflected in cultural prescriptions and these are preserved in the psyche, where they engage in an inner dialogue with each other. Development then entails appropriating the various voices that one is exposed to. The following section gives a brief overview of the life of a traditional Zulu child.

2.3.3 A traditional Zulu child

According to Odetola and Ademola, (1985) the socialisation of an African child is the function of not only the parents; it is also the function of the kinsmen living with the child's parents. African child-rearing is geared towards producing a maximal number of children who would survive in order to be able to contribute to a subsistence economy and provide for parents in their old age (Milford, 1999). Zulu children grow up playing close to the homestead. The identity of each is traditionally absorbed into the group to which a child belongs. Child-rearing focuses on the facts of safety (Tyrcell & Jurgens, 1983, in Milford 1999). A traditional Zulu child is brought up being taught to conform and precocity is not admired. According to Swart, (1996) in Milford (1999), a child should be busy or active in ways that demonstrate respect for adults. A child should not be noisy and must learn from his or her siblings. Such expectations by a community from its children often lead to children being pathologized by people unfamiliar with that communities

child-rearing practices and expectations. That is, a Zulu child growing up in his or her community taught to be quiet might be diagnosed as being withdrawn.

The traditional African way of life is strongly characterized by feelings of togetherness, combined with strong emotional ties. Maximum co-operation and feelings of solidarity are the means through which a cultural identity is formed. Societal norms are enforced through feelings of guilt and shame if inappropriate behaviours occur (Odetola & Ademola, 1985). Zulu children are taught about their group's culture and taboos so that they will not violate them. In these families good and bad fortune is attributed to the activities of their ancestors whose spirits are still central to the family members' lives and these beliefs are often blended into practices of Christianity and Western medicine (Tyrell & Jurgens, 1983 in, Millford, 1999). The following section presents what is regarded as the *normal* child in existing literature.

2.3.4 A " normal" child in existing literature

The study of normal development in children and the discovery of regularities in developmental changes are beset by several sources of uncertainty. Abnormality may be thought of as deviant behaviours in a sense that it deviates from the *normal*. According to Barker (1988), a normal child should have advanced socialisation as she or he learns to live as a member of the family, between the ages of 2 and 5. "Normal" behaviour is usually the most common or typical behaviour found in the majority of the population. The criterion of abnormal behaviour is limiting since it implies that normality includes most common behaviours excluding those that deviate from the norm which may be valued by the society. There needs to be a distinction drawn between the basic characteristics of abnormal behaviours that are constant in all cultures and those features that vary because of cultural differences (Green, 1992). Following this line of thought, Lewis and Miller (1990) argue that an abnormality exists only in relation to cultural definitions of normal and abnormal. Each culture chooses a portion of the spectrum of possible human behaviour as socially appropriate, labelling as abnormal those other behaviours that would conflict with the dominant ethos. According to Wesley (1971), every culture establishes approved standards and expectations for the behaviour of its members. In addition to cultural

norms, various cultures provide standards of behaviour, which are situationally defined.

Wesley (1971) notes that increasing demands are made on children at all intelligence levels as culture becomes technically and psychologically more complicated. Togetherness and a certain amount of dependency are treasured yet independence is admired. These contrasting demands make child-rearing increasingly difficult. Parents seem to be getting more and more worried about what the notion of a normal child is. (Green 1992) argues that with toddlers, some behavioural concerns of parents are very common and should be seen as normal part of parenthood. All toddlers tend to fiddle, do not think about the future, like constant attention and often ignore what parents say. These behaviours, (Green 1992) suggests, need not be seen as problems though some children show them to a minor degree while others "*hold in their hands a full house*" (p.3).

In the past children used to spend most of their first five years at home. Now children are *paraded* in public from their earliest days and with this comes competition and worry about the normality of children (Wesley, 1971). Children between 4 and 5 years are amazed at the unbelievable acceleration of freedom that is allowed. They discover their abilities to manipulate objects, touch, take things apart and fiddle. They are amazed by their behavioural powers (Green, 1992). While children are exploring their behavioural powers, parents are worried about what they see as *abnormal* behaviour. Parents are determined to bring up their children as best as they can. Green (1992) argues that many of the behaviours that cause concern may not necessarily be a problem at all if only parents knew what is normal. According to Kaplan and Saddock (1998), a *normal* 4 and 5 year old has developed anxiety over bodily injury and loss of a loved person's approval and is sometimes disruptive. Shyness, fearfulness, jealousy and envy are also evident in this age group.

A child can be rated as normal if assessed holistically looking at his or her parental beliefs of what constitutes normality in their family, community and cultural group. What is regarded as normal in one culture can be seen as a disorder in another culture. Communities share differing

views of health and illness, and illness can take varying modes. These can only be understood in terms of a particular cultural group. Hence, the current study proposes a move towards emic approaches in the study of childhood problems, highlighting the importance of understanding local conceptions of health and illness. This approach discourages imposing norms and standards of one culture onto other cultures. The following section discusses in detail an emic approach to childhood problems in detail.

2.4 AN EMIC APROACH TO CHILDHOOD PROBLEMS

An emic approach is proposed as an appropriate paradigm for the conceptualization of childhood problems in cultural contexts. This paradigm permits and necessitates focusing research on the local conceptualization of childhood problems and culture as the primary source of psychological data (Nsamenang, 1993). According to Matsumoto (1996), emic approaches are considered culturally relative whereas etic approaches refer to universals, referring to the aspects of life that appear to be consistent across different cultures. Matsumoto asserts that *the truth is relative not absolute*, and continues to argue that this forces us to reconsider what we believe is true or not. From an anthropological point of view, relativism refers to the methodology adopted in which researchers suspend their own cultural biases in the process of trying to understand beliefs and behaviours of others in their local contexts (Gergen, 1995).

The major goal for investigating cultural influences in the understanding of childhood problems is to uncover exactly which aspects of child behaviour are emic traits and which are etic traits. People of different cultures differ with respect to most aspects of human behaviour. Each culture evolves in its own distinctive way to manage human behaviour in the most efficient and appropriate fashion to ensure survival (Matsumoto 1996). Emics and etics refer to the tension between what we know of as being universal truths versus what we know of as cultural relative truths about health and illness. These ideas represent opposite poles with regard to human behaviour. When observing behaviours and trying to interpret them, we often try to put them in either emic or etic categories. This categorization, argues Matsumoto, is itself culture-bound. The

search for the one category to which we can classify some behaviour may reflect more a Western way of thinking. This way of thought has its roots in the individualistic cultural value of searching for uniqueness in oneself and translating that search to other objects and events.

Our understanding of culture and cultural influences on behaviour will be vastly improved if we avoid tendencies to compartmentalize behaviours into one or other category and instead search for ways in which any given behaviour can be seen to actually represent both tensions. The existence of many emics is not a problem on its own. The problem is when we attempt to interpret the meanings underlying those differences. Since we all exist in our own different cultures with our own cultural backgrounds, we tend to see things against those backgrounds. We tend to interpret behaviours from our own cultural backgrounds and come to conclusions about the behaviour based on our beliefs about what constitutes appropriate behaviour.

Cross-cultural experiences have induced profound scepticism about drawing conclusions on the basis of interaction procedures being treated as if they were free of their own cultural history. Illiterate people are perceived as thinking at lower levels than their modern literate counterparts (Cole, 1997). We do not always have the ability to separate ourselves from our cultural backgrounds and biases. Matsumoto (1996) argues that making value statements and maintaining inflexible ethno-centric attitudes is not conducive to understanding children's behaviours from different cultural groups. Because culture is invisible we often latch onto other more readily observable concepts to help us explain and understand children's behaviour.

Both children and their parents think and act within their cultural frame of reference. The axioms that health professionals take from their culture's knowledge base remain implicit in the mode of how their particular theories relate to the phenomena of childhood problems. Gergen (1994) argues that indigenous concepts are largely ignored in the understanding and studying of childhood problems whereas Western concepts are accepted and welcomed without scrutiny. The health profession and Psychology maintain a distance from their cultural heritage and look down at it with suspicion. The teaching of Psychology also maintains a strong universalistic stance.

Lawson –Te (1993) asserts that Psychology is and has been a form of control derived from human intent and human action and it offers no more *truth* about the realities of non-Western people's lives than the regular reading of the horoscope page in the local news paper. According to Gergen (1995), deviations are treated as errors and problems when Black isiZulu speaking children's behaviour and emotions are looked at against the Western notions of behavioural and emotional problems. Issues are filtered through the scientific framework. Culture is often seen as irrelevant and extraneous intrusion.

In the case of universalism, the constructed theory is assumed to be culture-free and its possible cultural roots are not explicitly studied. The Western way of thinking assumes a global relevance despite its being local. It is treated as a universal mode of generating knowledge. Its dominant voice subscribes to a decontextualized vision, with an extra-ordinary emphasis on individualism and objectivity (Gergen, 1994). Cultural variations are de-emphasized. Although concepts of childhood are assumed to be universal, in reality they are deeply rooted in Western perspective and values that are assumed to be objective and they advocate rational individualistic ideals. Western perspectives are characterized by imposed *pseudoetics* not true universals.

Perdesen, Sartoruis and Marsella (1984) refer to *pseudoetics* as imposed etics whereby the perspective of one culture is imposed on another culture. The authors justify the issue of comparing one culture to others as the framework for communication. What professionals need to consider is how to differentiate disturbed behaviour from culturally acceptable behaviour. Patterns of deviance in each culture are extremely complicated especially when viewed from the perspective of an outsider. Marsella and White (1982) noted that a culturally naïve observer with the universalistic conception of childhood problems runs a risk of confounding culturally distinctive behaviour with psychopathological manifestations on the basis of surface similarities of behavioural patterns in different cultures. This creates a need to understand indigenous concepts of illness in collaboration with the Western concepts.

2.4.1 Indigenous concepts and Western concepts

Indigenous approaches to psychology arose from a need to develop legitimate perspectives and methodological tools in a culture under study, rather than depending on adopted ones (Ho, 1998 in Gambu, 2000). Approaches are indigenous to the extent that they reflect the cultural views, theories, metaphors and assumptions about the nature of people under study and in relation to their environment. These approaches aim to analyze phenomena within a cultural context employing concepts, belief systems and resources distinctive to the culture under investigation (Heelas, 1981, cited in Gambu, 2000). An indigenous approach to Psychology emphasizes an understanding rooted in an ecological context and a historical context. These approaches attempt to document, organize and interpret the understanding people have about themselves and their world. It affirms the need for each cultural group to develop its own indigenous understanding (Kim & Berry, 1993).

Gergen (1996) notes that it is apparent that science is largely a by-product of the Western cultural tradition. Mapping reality through the Western concepts has offered a *pseudo-understanding* of cultural backgrounds. When people of other cultural backgrounds are exposed to Western concepts of health and illness, they find their identities placed in question and their conceptual repertoires rendered obsolete. Odetola and Ademola (1989) propose that Western concepts of the person be revised and that a framework be developed in which people will be viewed as guardians of their culturally based assets. This calls for approaching the understanding of human action through more local modes of understanding and issues of subjectivity. This shift will allow the possibility of developing more culturally grounded and locally useful forms of knowledge. This needs to go beyond the positivist position and assert that knowledge claims in the human domain are relative to the setting in which they are developed.

There has been a mass abnormalization of people by virtue of the fact that they have been on the receiving end of the services that see them as helpless recipients of defined labels and treatments (Gergen 1996). The understanding of indigenous concepts has the potential making the health profession socio-culturally relevant and for constructing culturally valid theories. Beyond being

culturally appropriate, (Gergen 1994) argues, indigenous concepts may contribute to the revision of Western theories. The move towards an indigenous understanding of childhood problems does not imply an abandonment of Western concepts. The aim is not to generate a set of mutually exclusive, culturally based concepts that fail to regard the alternatives; rather, there is an additional need to generate different orientations that intersect and interpenetrate.

The assumption of a lawful universe of human conduct and absolute objects with context-free properties is misleading. The Western concepts lack experiential grounding in other cultures. They offer evidence that presumes that universal phenomena are not viable. Culturally sensitive research into people's behaviour in domains such as health is in desperately needed. Alternative conceptions of the person invite alternative modes of action, because the character of human action is constituted differently in various cultural contexts. Sinha (1989) argues that African psychologists face the challenge to define, re-examine and re-interpret existing data on Africa from an African viewpoint and to advance indigenous concepts. Though the African views of health and illness are not part of the current literature on childhood disorders, they are worth noting. Their existence cannot be ignored.

2.5 AFRICAN VIEWS OF ILLNESS

The African view of health and illness is systemic: it takes into account the cultural dimension that influences people's conceptions of illness. This view does not treat symptoms as presenting problems in isolation. It considers the spiritual dimension as well. This systemic view of illness is not accommodated in Western approaches. This omission includes the conceptualization of childhood problems in Black isiZulu speaking communities. Little is known about these communities' understandings and conceptualization of childhood problems and about behaviours they regard as undesirable and problematic.

Health professionals have been trained from mainly a Euro-American perspective. The socio-cultural context of the indigenous African people has been largely neglected. Beuster (1997)

argues that the tendency to over-emphasize the rational, logical and intellectual has led to considerable impoverishment of the inner life of man and is largely responsible for the sense of meaninglessness that pervades the present Western way of life. With the introduction of a traditional African view of illness, an attempt will be made to improve the current state of the health professions. Not only is it necessary to introduce the socio-cultural context of human behaviour in this country, but knowledge of the African belief systems can also point to ways in which the one sided rational view of the Western perspective can be transcended. Although the traditional African view of illness cannot be described as scientific, it nevertheless contains a complex system of symbols, codes and structures of considerable intellectual subtlety (Hammond-Tooke, 1989).

Furthermore, if health professionals are to render meaningful services to Africans in terms of diagnosis and treatment, they need to acquaint themselves with the cultural context and belief systems of African people. Ignoring the cultural background of a patient can lead not only to misunderstanding but it can also be anti-therapeutic (Buhrman, 1986). The African view of illness is more holistic than the Western one. For instance, Africans do not distinguish between physical and mental illness. They believe that physical and psycho-social systems are interconnected. They also do not distinguish between the individual and the group. They also recognize that social factors play a major role in the causation, maintenance and treatment of illness (Beuster, 1997). In this regard the scientific Western approach is inadequate, because although therapists might hold particular beliefs, they have to operate within the prescribed parameters of their trade. The indigenous African world-view is marked by a set of social realities, cultural traditions and existential imperatives. The question of "*why*" rather that "*how*" misfortunes happen is central to the African world-view. This worldview constitutes a different frame of reference from that which informs contemporary developmental psychology.

Rather than the individualistic orientation of Western society, African culture has a communal orientation. The malign influence of certain supernatural forces can be felt not only by an individual but also by other members of his or her family or community. The nuclear family, the

extended family, the community, the living and the dead as well as the relationship with God are linked in the African view of health and illness (Edwards, 1983).

2.5.1 Perceived causes of illness

From a traditional African view, external and personalized forces, such as ancestors, God and witches or sorcerers, cause illness. In the case of God and the ancestors, illness is sent as a gesture of warning to the people to fulfill their religious, cultural, moral or social duties (Beuster, 1997). Traditional African people do not believe in chance. They believe that illness occurs with a particular intention and that causes of illness can always be identified. Susceptibility to certain types of illnesses is believed to run in certain families. For instance, epilepsy, bedwetting, asthma are referred to as *ufuzo,* i.e the condition has been inherited (Ngubane, 1977).

Ancestors

The ancestors are believed to be benevolent creatures that preserve the honour, traditions and good name of a tribe or family. They play a vital role in the maintenance of good health. They do nevertheless punish their kin in situations where they are either disappointed or angered. Illness sent by ancestors serves as a warning to amend one's behaviour, and to follow culturally prescribed codes of conduct. Ancestors cause illness if important rituals and customs concerning critical life events are either neglected or incorrectly executed (Beuster, 1997). According to Buhrman (1986), ancestors also punish their descendants if particular social norms or customs are violated. Such violations could range from disrespect towards elders, to infringing on the social rights of others. Ancestors withdraw gifts of good fortune from erring descendants (Ngubane, 1977). They also make other demands on their kin. For instance, they require regular offerings such as sorghum beer and animal sacrifices and they need to be informed of new developments in the family. If their demands are not met, protection will be withdrawn and illness can occur.

Ancestors are concerned with the well-being of their descendants. When good things happen

people say *the ancestors are with us.* When misfortune happens they say *the ancestors are looking away from us* (*idlozi lisifulathele).* Without their protection the descendants become vulnerable to all sorts of misfortune and illnesses. Ancestors need to be thanked for good fortune. Events like the birth of a child in the family is reported to the ancestors by the slaughtering of a goat called *imbeleko* and this serves to request the ancestors to protect the child and to thank them for the child (Ngubane 1977)

Magical causes: Witchcraft and sorcery

Due to the reported supernatural ability to change shape or to become invisible, witches are believed to be able to commit evil deeds and cast spells without being detected by the victim. Witches are also believed to manipulate supernatural creatures to inflict illness on their enemies. Sorcerers on the other hand are believed to employ magical substances such as *muthi* or poison to impose illness on others (Beuster, 1997).

Pollution (Isinyama/umnyama)

Indigenous South Africans believe that certain conditions or situations can cause impurity that can lead to illness. Many pollution conditions are associated with the reproductive system and the situations relating to death or corpses. Impurity is also associated with miscarriages and abortion. During the state of impurity the person has to go through extensive cleansing rituals involving washing (*ukugezwa)* and purging (Beuster, 1997). According to Ngubane (1977), pollution is a mystical force that shows no somatic symptoms. For instance, a child whose parents had sexual intercourse before the child reached 3 months, (depending on the culture) may be rendered weak and susceptible to illness due to pollution brought onto the child by parents who failed to abide by the cultural norm. People are sometimes considered sick because they undergo certain life crises such as a woman whose husband dies is regarded as stricken by pollution (Ngubane, 1977) *isinyama (a shadow of darkness).*

There is also a dimension of morality in the causation of illness, which is associated with social situations. When people are properly *fortified (ukuqiniswa)* sorcery has no effect. People take necessary precautions to maintain a proper *balance* which would counter sorcery as well as any incidental environmental danger such as being hit by lightning. Morality implies maintanence of good relations with the ancestors who would otherwise withdraw their protection.

2.5.2 Traditional healing versus psychotherapy

Problems are assessed in traditional societies in terms of the social acceptability of the symptoms. Approaches to healing are largely directive and explanations of illness employed are varied and applicable to disturbances of the emotions and behaviour as much as to physical complaints. Diagnostic and treatment methods are easily accepted and respected because of the shared world-views held by healers and help seekers of health and illness (Beuster, 1997).

Healing in traditional societies is in a way similar to psychotherapy in that it comprises a shared worldview and this includes a common language. They both have common underlying themes, which are an intense, emotionally charged confiding relationship with a helping person (Cheetham & Griffiths, 1982). Traditional healing and psychotherapy both have a rationale of myth, which includes an explanation of the cause of the person's problem, which is compatible with the cultural worldview shared by the helper and the helpee. They both also employ a confiding relationship, which is frank and respectful and they both tend to be effective in the way they alleviate problems and disturbances.

The family is usually present during traditional healing. The traditional healer's access to the ancestors gives him or her a priestly role. He has the status of a priest in terms of his awareness of the will of the ancestors and the necessity for their propitiation. The healer's essence of practice is the divination of the causative factors and this is believed to occur via states of spirit possession, which refer to the communication with the ancestors who then provide answers, and important explanations of not only *how* but also *why* an illness has occurred. In many instances

the prescribed remedy or solution is recommended by the ancestors (Beuster, 1997).

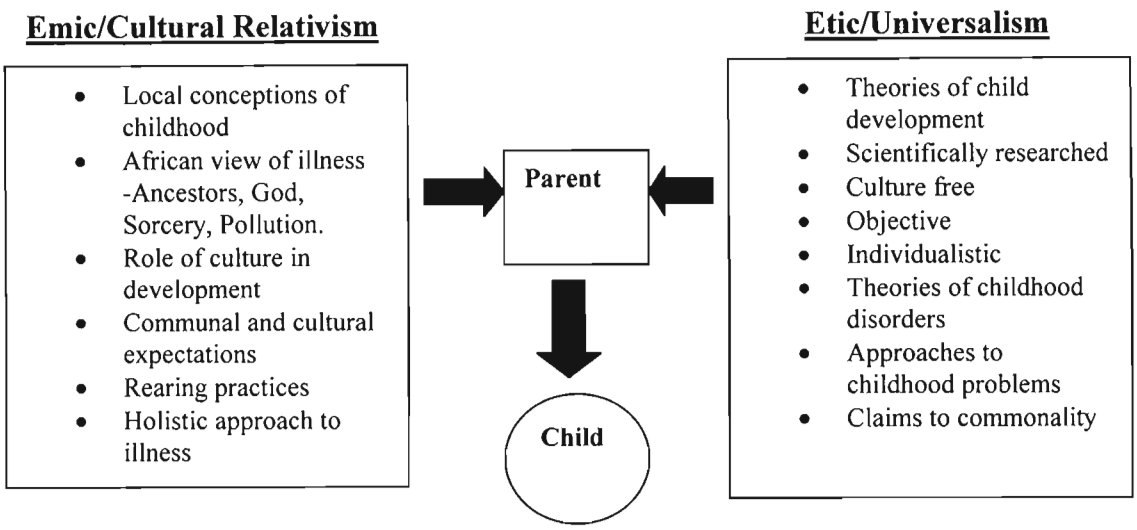
Promoting and upholding the principle that explanations and treatment should be consonant with the culture and worldview of the client is important (Cheetham & Griffiths, 1982). Western-trained professionals tend to look at non-Western cultures through the eyes of the West and they fail to comprehend significant aspects of the non- Western culture since their science does not equip them with the schemata for recognizing these. Local understandings have been largely ignored in the current literature on childhood problems. What is needed is an approach that would make it possible to integrate indigenous perspectives into mainstream science, whilst allowing for the exploration of culture-bound phenomena. Adequate understandings of human action should appreciate the meanings, purposes and intentions of people in their context (Mkhize & Frizelle, 2000). Understandings should focus on the practical nature of people's being in the world (Tappan & Brown 1982, in Gambu, 2000). In explaining a child's behaviour, the scientist already should know and does know how to categorize certain manifestations of meaning and it is often the closeness to his object that can hide the problem of how one makes sense of one another.

Understanding the other person and their life expressions should develop from the basis of experience and self-understanding and the constant interaction between them. There is a regular relation between an action and some mental content, which allows people to make probable inferences. It is necessary though to distinguish the state of mind that produces the action by which it is expressed from the circumstances of life by which it is conditioned (Campbell, Szumowski, Ewing, Gluck & Breaux, 1982). This is to say that sometimes action does separate itself from the background of the context of life.

In brief, much can be learned from the African views of illness. The relatives' tolerance towards illness ensures greater community involvement and support. Beuster (1997) argues that this secures a better prognosis. This is different from the industrialized world where disordered people are often stigmatized, institutionalized and forgotten by the society. Burhman (1986)

notes that Africans have a better understanding of the spiritual and existential needs of a person in crisis. Despite all the important and significant discoveries of Westernized science, it has alienated modern man from the deeper levels of the psyche. The fragmentation of the occidental mind causes an existential void that leads people to search for alternative realities. If the Westernized South Africans are prepared to learn from their traditional Black isiZulu-speaking counterparts, the void in some of their psyche might be filled (Beuster, 1997).

2.6 SUMMARY



2.7 CONCLUDING COMMENT

The literature presented in this chapter suggests a need for culturally sensitive approaches to the conceptualization of childhood problems. This poses a challenge to training institutions and health facilities which are still characterized by the influence of Western approaches. The review of literature highlighted a reductionistic view of childhood problems based on abstract concepts which are not universally shared. To address this, the study argued for a move towards emic approaches to childhood, particularly when approaches are applied to African communities. Adopting an approach of cultural relativism facilitates the incorporation of indigenous concepts to the understanding of childhood behaviour.

To understand people from other cultures it is crucial for researchers to seek sympathetic identification with them in terms of their own presuppositions and historical roots. Such cross-cultural understanding is equally indispensable if one seeks to communicate to those of other cultures in terms of their own categories of thought and verbal expressions. Improved ways of grasping and communicating meaning, however, does not settle the issues of objective validity. The purpose of this study was to investigate the understanding of childhood problems in Black communities and to explore which behaviours are acceptable and which behaviours are unacceptable and considered to be problems in these communities.

CHAPTER THREE

METHODOLOGY

This chapter outlines the methodology adopted in this study. According to Neuman, (1997), what makes social science scientific is its research methodology. The chapter begins by discussing the sample in the study. Thereafter it moves on to discuss sampling, data collection and data analysis procedures employed. Ethical issues are discussed thereafter.

3.1 THE SAMPLE

The sample was made up of 97 Black isiZulu speaking females. The age ranged from 16 to 65. The sample included teenage mothers and/or caregivers, grandmothers and health workers. There were also differences in the level of education. This ranged from *primary school education* (25), *secondary/ high school (including matriculation)* (35) and *post matric education* (40). Post matric applied to anyone who had completed a year-long diploma or more than this after completing matric. The study was based in two areas in Pietermaritzburg. One area was semi urban (townships) and the other area was an urban area (Scottsville, Hayfields and Bisley).

3.1.1 Sampling procedure

Sarantakos (1993) describes sampling as the process of choosing research units of the target population which are to be included in the study. He further asserts that sampling is more economical since it contains fewer people, less printed material and fewer general costs. The sample was selected using non-probability sampling, specifically, quota sampling. This type of sampling was adopted because it allows a researcher to identify categories of people (for an example, females over 16 years working with children of ages between 4 and 5 years old, as

mothers, care-givers, health workers and/or educators). This type of sampling allows a researcher to select anyone in the predetermined groups of people. This sampling procedure gives researchers the opportunity to ensure that some population differences are in the sample (Neuman, 1997). Such differences in the current study are age groups, the level at which participants are involved with the children and educational level. This technique is less strict than probability sampling and makes no claim to representativeness. It has been criticized for its alleged unrepresentativeness as well as for using quick and cheap samples. Despite its problems, this sampling procedure is cost effective, easier and much quicker than probability sampling.

3.2 DATA COLLECTION

3.2.1 Instrument

Data were collected through the use of the Behavioural Screening Questionnaire (2001). This questionnaire consisted of 39 words describing the way children feel and behave. The questionnaire was designed and developed by the Family Development Project at the University of Michigan and Head Start programmes. The Department of Human Services on behalf of the city of Detroit operates these. Selection of the health domains included in the questionnaire was guided by research on developmental psychopathology, the dimensional approach. The constructs include *internalizing* and *externalizing* conditions. These were derived from widely used clinical instruments such as Achenbach Child Behaviour Checklist, The Connors Parents' and Teachers' Rating Scale, and The Paediatric Symptoms Checklist (Achenbach, 1990). Items from these previously validated scales were supplemented with items based on the diagnostic criteria of the Diagnostic Statistical Manual- Fourth edition and other literature on childhood psychopathology. Seven domains related to internalizing and externalizing conditions were selected for inclusion in the questionnaire.

The seven domains related to *internalizing* and *externalizing* conditions include:

- Depression is a disturbance of mood involving fearfulness and sadness.

- Shyness/Social withdrawal refers to behaviours such as preferring to be alone, withdrawing from social contact, timidity and sulking combined with a generally low level of activity.
- Attention deficit involves poor concentration, restlessness, distractibility and impulsivity. This may be expressed in clumsiness.
- Somatic complaints refer to unexplained aches in the head, stomach, eyes (etc.).
- Oppositional behaviour refers to continuous disobedience, stubbornness, refusal to follow instructions and lack of trustworthiness.
- Aggression refers to persistent patterns of arguing, destroying, threatening, fighting, having temper tantrums, fighting, cruelty and displaying rage.
- Conduct disorder involves behaviours such as stealing, lying and truanting.

The item format employed in the questionnaire was a categorical format (*very concerned, concerned* and *not concerned*). Within this format the respondents indicated the extent to which behaviour or emotion was of concern to them. The words describing the way children feel and behave were printed on cards so that each word was on a separate card with numbers ranging from 1 to 39 (*see appendix A).*

The questionnaire was devised in such a way that it took into account different world-views. For instance, primary caregiver A might have felt that it was not a problem if a 4 or 5 year old to be shy or timid, on the other hand primary caregiver B might have been very concerned with such behaviour in a young child. The questionnaire was based on theories of child developmental psychopathology.

A similar instrument was employed by Leadbeater and Bishop (1994) to assess behaviour and emotional functioning of 83 pre-school aged African American children. Spiro and Swartz' (1994) study of mothers' reports of behaviour problems in 3 groups of South African pre-school children adopted a similar instrument. The results of their study revealed that preschool aged children exhibit similar prevalence of behaviour problems. This instrument was also adopted by

Lequerica and Hermosa (1995) in their study of Latino pre-school children. The instrument has been adopted both locally and internationally hence it was adopted for the purpose of this thesis which was to determine which behaviours and emotions are considered to be "problematic" for 4 or 5 year olds by Black isiZulu speaking parents and caregivers.

Responses were recorded on recording sheets which were also designed to suit the cards. The recording sheets consisted of 3 categories labeled as *very concerned, concerned* and *not concerned*. These labels referred to the children's behaviour and emotion that the respondents were questioned about. They had to rank the words describing the way children feel and behave as being very concerning, concerning or not concerning to them (*see appendix B).*

3.2.2 Translation of the questionnaire

Differences exist between cultures in the ideas of health and illness, in the levels of literacy, reading levels, and the concordance between spoken and written versions of language. Furthermore, certain features of language, such as idioms, tend to be difficult to translate (Satorius & Kuyken, 1994). Despite the complexity involved in the translation process, significant methodological gains have been made, particularly in the field of cross-cultural psychology. These allow researchers to proceed with translating instruments (John, 1996). The original questionnaire was constructed in English. It had to be translated to isiZulu to meet the needs of the target population. Translation of the instrument employed the pragmatic and the ethnographic methods of translation. Pragmatic translation focused on the accuracy of the information that was to be conveyed and the attainment of equivalent meaning. On the other hand, ethnographic translation focused on the way in which words are used in an attempt to contextualize them to the culture which uses the source and target language. This emphasizes the words chosen for the translated the version should be harmonious with the culture that speaks that language (John, 1996).

Translation posed several difficulties since the sample was selected from 2 different

communities, one from the semi-urban area and the other from the urban area. It appeared that people used different words for the same behaviours and emotions. For instance, words such as "shy" and "timid" meant different behaviours for different participants in the sample. For some Shy meant *unamahloni* timid meant *uyisinoko*, yet for others shy meant *isinoko* and timid meant *uyathithiza.* The difficulty was overcome through the assistance of other isiZulu speakers in the school of Psychology honours class. They did the translation individually. An expert in languages and the lecturer in the School of Language and Culture at the University of Natal reviewed the translated version. This was translated back to English by the researcher and other isiZulu speakers in the school of Psychology to check if it had not lost its original meaning, and to eliminate ambiguities and to ensure that meanings were locally and culturally relevant. More difficulties arose when the translated questionnaire was translated back again to isiZulu some words such as "difficulty playing quietly" was translated into *uphaphile* and the closest meaning of this in English is hyperactive. So there were two different words in the questionnaire which were meant to refer to one behaviour. This sort of problem was resolved in supervision and with other isiZulu speaking psychologists in the school of psychology at the University of Natal as well as with the help of an expert in languages in the School of Language and Culture: agreement was reached that the more commonly accepted meanings of the words were the ones to be included in the questionnaire.

3.2.3 Piloting

The purpose of piloting was to assess the comprehensibility of the Zulu questionnaire in a small sample of isiZulu speakers. It also afforded the opportunity to identify problems associated with the translation. The translated questionnaire was piloted by conducting 5 interviews with volunteers. This was to determine if the administration procedure was clear for the target population. It also meant to assess how the questionnaire could be modified for the main study and to test if the questions were accessible and appropriate.

3.2.4 Procedure for the main study

Participants were contacted individually, by word of mouth and introduced to the study. The researcher explained the study and its purposes. Participants were told that the research was part of the academic requirements of the researcher and that it would contribute to the existing literature on childhood problems by giving insight to what is considered a problematic behaviour in Black isiZulu speaking communities. It was explained to the participants that the purpose of the study was to determine which behaviours are considered to be problems and which ones are not considered problems. The researcher visited the homes and the work places of the participants who had agreed to take part in the project.

The researcher administered the questionnaire by presenting the cards individually and asking the participants to imagine that a friend had come to her and said her child was presenting with the behaviour or emotion as described by the word printed on the card. The participants were told to give their opinion with regard to the presented behaviour or emotion. Participants were asked to sort the cards into 3 different piles: pile number 3 being the "most concerning", pile number 2 being the "least concerning" and pile number 1 being the "not concerning" behaviours and emotions. After this first stage, the participants were asked to go through each pile individually ranking the cards from each pile into groups ranging from the most concerning behaviours to the least concerning. This was then entered into the recording sheets using card numbers assigned to each card individually (1 to 39). For an example of ranked cards *(behaviours and emotions)* see appendix C.

3.3 DATA ANALYSIS

The collected data were coded and entered into the data- base. It was computed using Statistical Package for the Social Sciences (SPSS) at the University of Natal. Data were ordinal in nature

and this necessitated the adoption of non-parametric analysis. Data were analyzed using descriptive statistics with the aim of presenting demographical details of the sample under study. It was further analyzed using Chi square. The purpose of the analysis was to determine if the participants differed in the manner in which they allocated the words into the three categories: *very concerning, concerning* and *not concerning*. Under the null hypothesis all words have an equal chance of being slotted into any of the three categories. Where statistically significant results were obtained, further analysis was conducted using the residuals method of analysis determine where the differences were coming from.

3.4 ETHICAL CONSIDERATIONS

The research was conducted in isiZulu, the language shared by both the researcher and the participants. This ensured that the accuracy of meaning was optimized. The participants were informed at the outset about the nature and the purpose of the study. They were given time to make informed decisions about taking part or not taking part in the study. They were also assured that the information they provided would be used solely for the purpose of the study. The issue of voluntary participation was emphasized so that the participants would take part in the study willingly, thus enhancing the quality of information provided.

Participants were contacted individually through phoning and home visits to introduce the study and its purpose. They were left with the choice to take part or not take part in the study. The researcher left her contact details so that participants could contact her to inform her of the decision to take part or not to take part in the study. Only then were appointments scheduled to administer the questionnaire. Anonymity and confidentiality were assured to all the participants. Informed consent was negotiated verbally with the participants. This was done to emphasize voluntary participation and to allow them to withdraw from the study at any point they felt uncomfortable without feeling bound by a written consent. Informed consent was obtained.

Generally, urban participants were reluctant to take part in the study. Only 21% of the total sample from the urban area took part in the study. This emphasises the ethical issue of voluntary participation. This was discussed with the participants prior to the administration of the questionnaire. Those who did not wish to take part in the study were not co-erced in any way into participating. At the beginning when the study was introduced, the participants had assumed that by taking part in the study, they might be employed. This was an issue especially for the young people aged between 16 and 39, unemployed with secondary school education. It was further explained to them that the study was part of the researcher's academic requirements and it was not going to get them employment.

3.5 SUMMARY

This chapter discussed the methodology used in the study. Characteristics of the participants were discussed. Techniques used in the collection and analysis of data were illustrated, as were the ethical considerations. The following chapter presents the results of the study.

CHAPTER FOUR

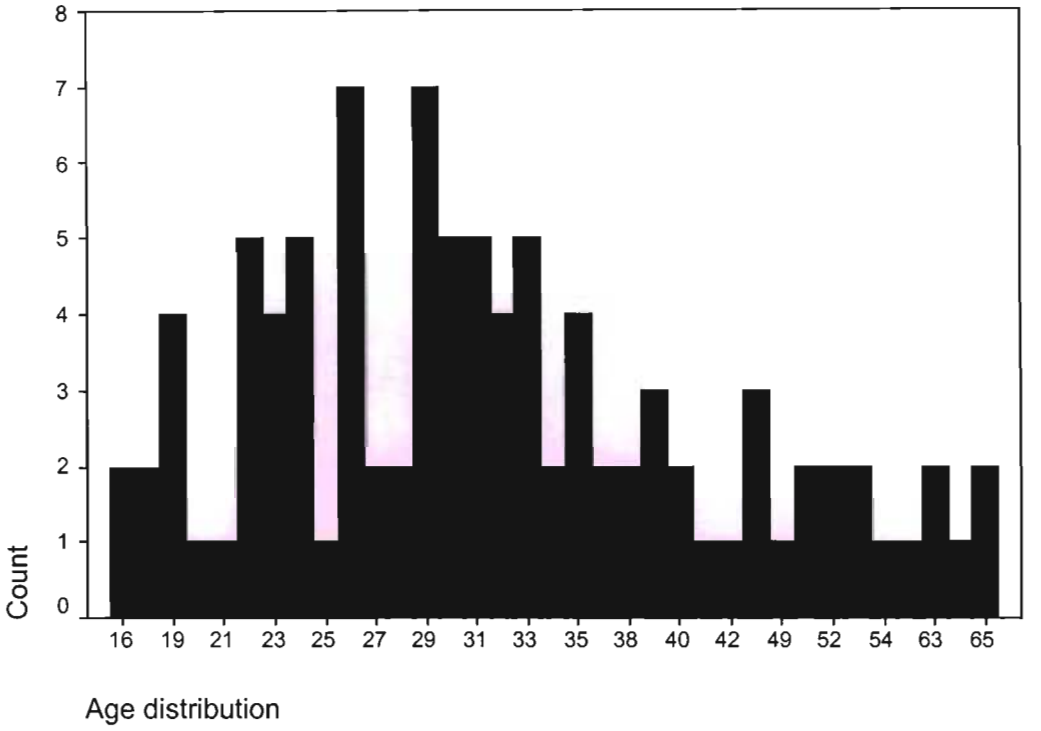
RESULTS

This study aimed at investigating which behaviours are considered "acceptable" and "not problematic" in Black isiZulu speaking communities and which behaviours are "undesirable" and considered "problems" in children aged between 4 and 5. This chapter presents the results of the study. It begins by presenting the descriptive statistics pertaining to the demographical data. This serves the primary purpose of describing the characteristics of the sample. The chapter then moves on to testing the formal research question employing inferential statistical analysis, looking at statistical significance of data and examining data in detail while drawing implication from it.

4.1 DEMOGRAPHICS

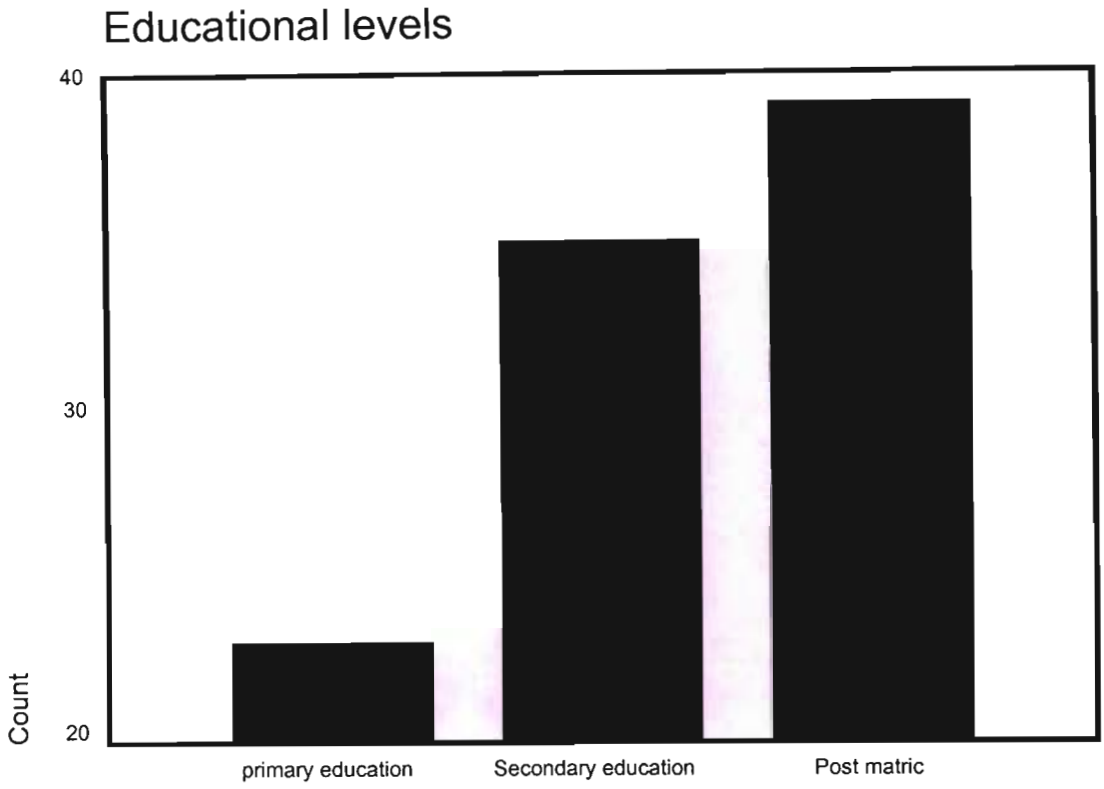
The sample was made up of 97 isiZulu speaking females. This included mothers, primary caregivers, health workers, etc. The age distribution in the sample ranged from ages 16 to 65. The mean age was 33.32. (*See Figure 1 below*)

Figure 1



There were also varying levels of education in the sample. These ranged from a primary school level of education to a post matric level of education (tertiary education: technikon, technical colleges, university, etc.). The range of educational levels is presented in graphic form in *Figure 2* below.

Figure 2



Participants were from two communities around Pietermaritzburg, one area was semi urban (Townships) and the other one was an urban area (such as Scottsville, Hayfields, Bisley). Only 21% of the participants from the urban area took part in the study. This emphasises the ethical issue of voluntary participation. This was discussed with the participants prior to the administration of the questionnaire. 79% of the population was from the semi urban area.

4.2 INFERENTIAL ANALYSIS USING CHI SQUARE TEST

The chi square test using the Statistical Package for Social Sciences (SPSS) at the university of Natal was conducted to test the research question. Under the null hypothesis, participants should not differ significantly in the manner in which they assign the words describing childhood problems within the three categories: *very concerned, concerned* and *not concerned.* Chi square

test tells the researcher about the strength of the association between variables. It also tells the researcher the probability that any association found is likely to be due to chance factors. This is a widely used and reportedly powerful way to look at variables measured at the ordinal level (Howell, 1997). In this study the chi square test was employed to test the research question by looking to see if there were any statistically significant differences in the way the participants assigned the words describing the way children feel and behave into the three different categories.

Table 1 below presents the words describing the way children feel or behave. The table presents chi-square values and the significance level for each word describing children's behaviour and/or emotions. Only those words that were statistically significant are presented.

TABLE 1: Words that were statistically significant within the categories: Very concerned, Concerned and Not concerned.

Word	Chi square value	significance level (p)
Prone to accidents	15.113	.001
Argues	6.063	.048
Temper tantrums	25.806	.000
Can't sleep	19.938	.000
Careless	10.563	.005
Clumsy	6.701	.035
Headaches	59.711	.000
Cruel to animals	11.313	.003
Destroys	15.732	.026
Can't concentrate	8.804	.012
Can't follow instructions	19.938	.000
Seem not to hear	17.063	.000
Fearful	25.753	.000
Difficulty playing quietly	10.106	.006
Impatient	7.072	.029
Impulsive	35.959	.000
Irritable	22.103	.000
Lies	6.701	.035
Lonely	9.546	.008
Moody	13.134	.001
Nervous	13.221	.001
Doesn't get along with others	18.887	.000
Plays with younger children	27.250	.000
Sad	40.474	.000
Stomach problems	72.392	.000
Whines, cries, screams	37.227	.000

4.2.1 Acceptable emotions and behaviours of childhood

As indicated previously, Table 1 presented those words that were statistically significant. However, it does not indicate where differences came from. It does not show us which behaviours and emotions were rated as not concerning which would mean those are acceptable behaviours. Hence, further analysis using the residual method was undertaken to determine where differences came from. Table 2 below presents results based on the residual method of analysis. This table gives an indication of how the parents and caregivers responses were distributed in the three categories: not concerning, concerning and very concerning. Bigger residuals, indicated in bold, show where the differences came from.

TABLE 2: Acceptable and unacceptable behaviours and/or emotions

Behaviour/Emotion	Not concerned		Concerned		Very concerned	
	Observed	Residual	Observed	Residual	Observed	Residual
Prone to accident	18	(-14.3)	29	(-2.3)	**49**	**(16.7)**
Argues	**43**	**(11.0)**	29	(-3.0)	**24**	**(-8.0)**
Temper tantrums	**11**	**(-20.0)**	31	(.0)	51	(20.0)
Can't sleep	**12**	**(-20.3)**	**46**	**(13.7)**	39	(6.7)
Careless	**24**	**(-8.0)**	**47**	**(15.0)**	25	(-8.0)
Clumsy	**29**	**(-3.3)**	44	(11.7)	24	(-3.3)
Headaches	**7**	**(-25.3)**	**23**	**(-9.3)**	**67**	**(34.7)**
Cruel to animals	**21**	**(-11.0)**	28	(-4.0)	**47**	**(15.0)**
Destroys	**14**	**(-18.3)**	**40**	**(7.7)**	**43**	**(10.7)**
Can't concentrate	**24**	**(-8.3)**	**46**	**(13.7)**	27	(-5.3)
Can't follow instructions	**12**	**(-20.3)**	39	(6.7)	**46**	**(13.7)**
Seems not to hear	**15**	**(-17.0)**	33	(1.0)	**48**	**(16.0)**
Fearful	**10**	**(-22.3)**	37	(4.7)	**50**	**(17.7)**
Difficulty playing quietly	43	(11.7)	33	(1.7)	18	(-13.3)
Impatient	**23**	**(-9.3)**	**44**	**(11.7)**	30	(-2.3)
Impulsive	**7**	**(-25.3)**	35	(2.7)	**55**	**(22.7)**
Irritable	**11**	**(-21.3)**	**47**	**(14.7)**	39	(6.7)
Lies	**24**	**(-8.3)**	29	(-3.3)	**44**	**(11.7)**
Lonely	**18**	**(-14.3)**	39	(6.7)	**40**	**(7.7)**
Moody	**16**	**(-16.3)**	**44**	**(11.7)**	37	(4.7)
Nervous	**13**	**(-19.3)**	39	(7.3)	**41**	**(9.3)**
Doesn't get along with others			37	(4.7)	**47**	**(14.7)**
Plays with younger children	56	(24.0)	22	(-10.0)	18	(-14.0)
Sad	**8**	**(-24.3)**	30	(-2.3)	**59**	**(26.7)**
Stomach problems	**6**	**(-26.3)**	20	(.0)	**71**	**(38.7)**
Whines, cries, screams	**31**	**(6.8)**	**43**	**(17.8)**	23	(-1.3)

Table 2 above presents behaviours and emotions that were statistically significant as well as the results based on the residual method of analysis which are aimed at highlighting where the differences came from. Table 1 above (section 4.2) presented the statistically significant results, words that were significant in the categories: *not concerned, concerned* and *very concerned.* This Table (Table 1) does not tell us which words were assigned to which category; hence Table 2 presents words as well as categories and the number of participants who rated each word as either not concerning, concerning or very concerning. For instance, the difference in parents' responses for argumentative children came from the residual of (**11.0**). Forty four percent of the parents and caregivers ranked this behaviour as not concerning, only 25% with the residual of (**-8.0**) considered this behaviour to be "very concerning". This suggests that parents and caregivers are less likely to be concerned with argumentative young children. For headaches the residual of (**-25.3**) suggest that parents and caregivers are less likely not to be concerned with headaches in young children.

4.3 SUMMARY

This chapter presented results based on the methodology presented in Chapter 3 of this thesis. It began by presenting results based on the descriptive statistics with the purpose of describing the characteristics of the sample. It then moved on to present the results based on the inferential statistics. This looked at the data in detail presenting the statistical significance. This was done by presenting results in response to the research questions presented in Chapter 1. The following chapter expands on these results by discussing them in relation to the literature reviewed.

CHAPTER FIVE

DISCUSSION OF RESULTS

In Chapter two, evidence was presented in support of the view that childhood problems have been studied largely in Western population. The findings about what behaviours and emotions constitute childhood problems generalized to all children, regardless of their cultural background. Culturally sensitive research in the health domain is urgently needed. Hence the current study aimed at establishing the behaviours and emotions isiZulu speaking parents and primary caregivers considered "acceptable and "non problematic" among 4 and 5 year old children. The study also investigated the behaviours and emotions considered to be "problematic" and "unacceptable" for this age group of children. The previous chapter (Chapter four) presented the results. These results were based on the research methodology discussed in Chapter three. This chapter discusses the results within the context of the literature reviewed in Chapter two. The results are discussed in relation to the aim of the current study as well as the research questions presented in Chapter one.

5.1 DEMOGRAPHICS

The sample consisted of 97 females. The age range was 16 to 65 years. The mean age was 33.32 and the standard deviation was 12.076. There were also different levels of education in the sample. These ranged from a primary school level of education (22.6%), secondary school level of education (36%) to a post matric level of education (40%). "Post matric" implied to anyone who has completed a year-long diploma or more after completing matric. Geographically, the study was based in two communities around Pietermaritzburg. One area was a semi-urban area and the other area was an urban area.

5.2 RESEARCH QUESTIONS

The study investigated two research questions:

- Which childhood behaviours and emotions are considered "acceptable" and "not problematic" for 4 or 5 year olds by isiZulu speaking mothers and caregivers?
- Which childhood behaviours and emotions are considered "undesirable" and "problematic" for 4 or 5 year olds by isiZulu speaking mothers and caregivers?

As mentioned in section 4.2, under the null hypothesis participants were not expected to differ in the way they assigned the words describing the way children feel and behave in the three categories employed in the questionnaire: *Very concerned, concerned* and *not concerned.* On the contrary, under the alternative hypothesis differences were expected in the manner in which the words were assigned to the categories. Results indicate that there were differences in the manner in which the participants assigned the words describing the way children at ages of 4 to 5 feel and behave, into the three categories.

The following sections discuss results relevant to the two research questions. It begins with the discussion of the "acceptable" behaviours and emotions and it moves on to the discussion of those behaviours and emotions that were considered to be "undesirable" and considered "problematic" for 4 or 5 year olds by the sample of Black isiZulu speaking mothers and caregivers in this study.

5.2.1 Behaviours and emotions considered "acceptable" for 4 or 5 year olds

Of the behaviours that were listed on the questionnaire only three were considered by the participants to be "acceptable" and "non-problematic" for 4 or 5 year old children in this study: "argues", "difficulty playing quietly" and "playing with younger children".

5.2.1.1 Parents' perceptions of "argumentative children"

Results indicate that argues (*uyaqophisana)* was not considered to be a "problematic" behaviour by the primary caregivers as well as parents in this study. This type of behaviour is classified under the externalizing behaviours. Wesley (1971) suggests that arguing in children is discouraged in Black families. He maintains that Black families consider arguing in children as an indication of disrespect for elders. They discourage it and children are disciplined for showing signs of disrespect for their elders. In the current study, arguing referred to oppositional behaviour of children in the ages of 4 or 5 years. Results seem to contradict Wesley's claim about African children. They indicate that Black participants in this study did not consider arguing to be a "problematic" behaviour for 4 or 5 year old children. This inconsistency in findings could be attributed to the possibility of the participants in this study not focusing on the negative aspects of the behaviour. This might be an indication of ambiguity of the intended meaning in the questionnaire. This might have led the participants into believing that the researcher was referring to arguing in general with no oppositional type of behaviour.

This finding has diagnostic and classification implications. In the literature on childhood psychopathology, argumentativeness is associated with oppositional defiant disorder (ODD). Home and Sayger (1990) cited in Winkley (1996) define ODD as a pattern of negativistic, hostile and defiant behaviour. Children with ODD commonly are argumentative with adults and frequently lose temper. The results indicate that parents and caregivers in this study were not concerned with this behaviour in young children and this lack of concern may lead to problems with classification and diagnosis of children's behaviour during the assessment process. During the assessment process a parent may report the behaviour as absent due to lack of concern or not considering it a "problem" Daledein, Vasey and Brown (1999) argue that the majority of externalizing disordered children often present with oppositional type of behaviours and these behaviours include arguing.

One possible explanation of this finding could be the fact that Black isiZulu speaking parents and caregivers in this study considered "arguing" not to be a "problem" in young children due to its non-existence as a result of the parents' and caregivers' emphasis on respect and conformity to adult authority. According to Beuster (1997) parents and caregivers focus their attention on bringing up children in ways that are culturally meaningful to them. If behaviour does not exist, it is not considered a problem.

5.2.1.2 Parents' perceptions of "difficulty playing quietly" in 4 or 5 year olds

This is one of the behaviours that were considered to be "acceptable" and "non-problematic" by 44.3% of the participants in this study. This behaviour is associated with hyperactivity in young children (APA, 1994). It is classified under the externalizing behaviours or conditions. The results of this study indicate that it not considered to be an indication of a disorder by the majority of Black isiZulu speaking parents and caregivers in this study. One possible explanation of this finding might be the fact that isiZulu speaking children spend most of their time playing alongside their older siblings and don't spend much of their playtime with their parents. This finding could also mean that parents are not concerned with this behaviour because they do not observe it. One would argue that if this behaviour is a symptom of hyperactivity in young children, it could hardly miss parents' and caregivers' attention. Even if they do, they probably have more important things to be concerned about such as feeding and clothing their children. It is not clear whether this behaviour is reported as present or not, but participants were only asked to imagine that they were asked to give their opinion about a particular behaviour. Their responses show that they are not concerned with it but do not indicate whether this lack of concern is due to non-existent or tolerance on the parents' and caregivers' part.

This finding poses the potential for misclassification of children's behaviour due to the fact that parents and caregivers do not consider this behaviour to be a "problem" in young children. The literature on childhood psychopathology presents this behaviour as a symptom of hyperactivity in young children (APA, 1994; Daledein, Vasey & Brown, 1999; Kaplan & Saddock, 1998 & Lewis

& Miller, 1990;). This behaviour does not fit the diagnosis of hyperactivity in isolation but has to happen with a cluster of other behaviours. As will be discussed in later sections other behaviours associated with hyperactivity in young children were considered to be "problematic" and "unacceptable" in young children with the exception of "difficulty playing quietly".

5.2.1.3 Parents' perceptions of "playing with younger children" in 4 or 5 year olds

Playing with younger children was also considered by the parents in this study to be "not concerning". Fifty seven percent of the participants did not consider this behaviour to be "problematic". In the literature, this behaviour is expected in Black children during the socialization process. Young children learn culturally appropriate forms of behaviour under the mentorship of older siblings and peers (Nsamenang, 1995). Following this line of thought, Tharp (1984, in Nsamenang, 1995) argues that knowledge from adults filter through older children who are participants alongside adults in the process of socializing the younger children. Playing with younger children is seen as part of the child's responsibility. They can take care of each other and "playing with younger children" promotes the socialization process. Playing with younger children in this study is cultural relative thus not considered a "problem". Children in Black families are required to participate in adults' duties; they take part in the day-to-day management of the family and home. Childcare is often a routine duty for Black children. This aspect of communal responsibility and duty is emphasized in childrearing and socialization in traditional African communities (Mkhize, 1999 cited in Pillay, Naidoo & Lockhat, 1999). This argument finds support in the work of Varma (1996) where he argues that older children in African communities are expected to participate in household duties and to care for younger siblings.

In conclusion, only 11,6% of the behaviours and emotions listed in this study were considered to be "acceptable" and "non-problematic" for 4 or 5 year old children. From a culturally relative perspective, behaviours discussed in this section are not associated with illness in Black isiZulu speaking parents and caregivers in this study. This finding finds support in the work of Dawes

(1994) who argued that the response that the behaviour evokes from the family, community and society at large renders it either "normal" and "acceptable" or "abnormal" and "unacceptable". The social significance of the behaviour and emotion renders it either "desirable" or "undesirable". The findings of this study indicate that "arguing", "difficulty playing quietly" and "playing with younger children" are not considered to be "problematic" by the participants in this study.

5.2.2 Unacceptable behaviours and emotions (Concerning and very concerning)

Findings indicate that the participants in this study considered 88% of the behaviours and emotions listed on the questionnaire to be "problematic" and "unacceptable". Results indicate that participants were concerned with the behaviours and emotions both in the externalization and internalization dimensions. These two terms refer to the classification of behavioural and emotional problems of children. These are two dimensions described by Mash and Barkley (1996) as one of the approaches to childhood problems. It is a dimensional approach in the manner it organizes childhood behavioural and emotional problems. For an instance, behaviours associated with conduct disorder are usually externalized whereas behaviours and emotions related to mood and anxiety disorders are usually internalized. A few (8.6%) of the "problems" are somatic complaints (e.g. headaches and stomach problems). These are often associated with mood disorders.

5.2.2.1 Internalizing behaviours and emotions considered to be "problematic" for 4 or 5 year olds

The findings indicate that 40% of the behaviours and emotions considered to be "problematic" and "unacceptable" by the participants in this study are those that fall under the internalizing dimension. This finding finds support in the work of the epidemiological study conducted by Spiro and Swartz (1994), which found that internalizing behaviours and emotions were cited as most concerning by the majority of parents who took part in their study in the Eastern Cape.

Likewise, the study conducted by Papps, Walker, Trimbolli, and Trimbolli (1995) found that parents reported great concern for their children presenting with internalizing behaviours and emotions such as fearfulness, sadness and unfriendliness. The authors associated these internalizing behaviours and emotions with the authoritarian methods of parenting. The internalizing behaviours and emotions considered to be "problematic" and "unacceptable" included anxiety symptoms (fearfulness and nervousness), mood symptoms (sadness, loneliness and moodiness) and somatic complaints (headaches and stomach problems).

5.2.2.2 Anxiety symptoms

Fearfulness

This is one of the internalizing behaviours and emotions considered to be "problematic" by the participants in this study. A similar finding was reported by Spiro and Swartz (1994) in their study of three groups of South African preschool children in the Eastern Cape. Likewise, the study conducted by Lapouse and Monk (1959) in Latin American children found that 43% of the mothers in their study considered fearfulness in children to be "problematic". On the other hand, Jersild and Holmes (1992) found that mothers reported great concern for their fearful 2 to 6 year olds. On average, children in the latter study were reported by mothers to be displaying fearful reactions once every 4 days.

The samples in Spiro and Swartz' study and the current study are both South African Black population. These are people who have experienced similar situations of political violence in the country. Children have been exposed to extreme amounts of violence hence have always lived in fear (Dawes, 1994). The finding by Spiro and Swartz that Black parents reported great concern with regard to their fearful young children was somehow expected in the current study. This may be attributed to the environmental tension around Black families. As Robertson and Berger (1994) argue, questions about the incidence of psychopathology in South African children have got to note not only the acute stressors but also violence in this country. Pillay, Naidoo and

Lockhat (1999) argue that it has been well established that childhood exposure to violence perpetuates behavioural and emotional problems. In a study conducted by Earls (1982) it was found that children presented with high frequency of fears which raised parents and caregivers concerns for their fearful young children.

Nervousness

This was another symptom of anxiety which was considered to be "problematic" and "unacceptable" for young children in the ages of 4 or 5 years old by the parents and caregivers who took part in this study. This behaviour is not only associated with anxiety and phobias in children but also affects their self-esteem, leading to loneliness and social withdrawal in children (Cameron, 1996).

5.2.2.3 Mood symptoms

Mood symptoms considered "unacceptable" and "problematic" by the parents and caregivers in this study included sadness, loneliness and moodiness in young children at the ages of 4 or 5 years. These are emotions and behaviours associated with depression in children. According to Winkley (1996), feelings of sadness, loneliness and nervousness are often found in children from unhappy homes as well as in those children who are faced with emotional deprivation or rejection and those who have experienced loss. According to Lewis and Miller (1990) loss of a mother due to divorce or death before age 11 is related to depression. Other forms of loss include parental psychiatric illness. This disrupts the family, interrupts the parents' psychological and physical availability and deprives the child of important protective buffering. In addition this may directly expose the child to provoking agents. The findings of the current study find support in Winkley's work, participants in this study also considered these emotions to be "problematic".

Sadness

Cytryn and McKnew (1996) note that sadness is a common symptom of depression in young children. The authors maintain that depression in childhood like in adulthood is marked by

feelings of sadness and worthlessness. It might be appropriate for an example, if a loved one dies or when a child suffers other losses, real or imagined. Findings of this study indicate that parents and caregivers considered sadness in children at the ages of 4 or 5 years old to be "problematic". This finding is in line with the literature on childhood disorders. When parents observe feelings of sadness in their young ones they usually react with love and comfort towards them (Lewis & Miller, 1990).

Loneliness

Loneliness in children at the ages of 4 or 5 years of age was considered to be "problematic" and "unacceptable" by the parents and caregivers in this study. This behaviour is associated with mood disorders in young children. At preschool age a child is not expected to be lonely, she or he should be able to entertain herself or himself with or without company (Campbell, 1986). Findings of this study find support in the work of Wesley (1971) where the author argued that loneliness is widely distributed and severely distressing. He further maintains that loneliness is a painful and frightening experience that children will do particularly anything to avoid. It appears from the findings of this study that it is indeed a frightening experience observed by parents and caregivers in their young children thus "very concerning" to them.

Moodiness

Moodiness is defined in literature as the emotional lability (Wesley, 1971; Winkley, 1996 & Daledein, Vasey & Brown, 1999). This behaviour is manifested through the sudden changes in the mood (*mood swings*) (Kaplan & Saddock, 1998). Parents and caregivers in this study considered moodiness to be "problematic" and "unacceptable" in young children. Children presenting with this behaviour are in danger of losing their friends at kindergarten and might end up being lonely and isolated as a result become depressed.

5.2.2.4 Somatic complaints

The somatic complaints considered to be "problematic" and "unacceptable" by the parents and caregivers in this study for 4 or 5 year old children included headaches and stomach problems. These somatic complaints are usually associated with mood and anxiety disorders in children. This finding finds support in the study conducted by Loening (1990) of children aged 5 years. In his study he found that parents were concerned with frequent headaches in children. A similar finding was reported in Broughton's (1986) study, there were three most concerning symptoms in young children and among those were frequent headaches. Other studies (Garber, Zeman & Walker, 1990; Pearce, 1978; Weinberg, Rutter, Sullivan, Penick & Dietz, 1973 cited in Daleiden, Vasey & Brown, 1999) indicated that symptoms of depression in childhood include headaches and frequent headaches in children were cited as a major problem by parents in the aforementioned studies. Somatization seems to be a major concern for parents and caregivers in previous studies as well as the current study. One possible explanation for this is the fact that young children lack the ability to talk about their emotions and thus present with physical pain (Lewis & Miller, 1990; Daledein, Vasey & Brown, 1999; and Campbell, 1986). Parents tend to react immediately to their children's physical complaints. These are directly associated with sickness in young children and generally not associated with psychological disturbances. Research has indicated that somatization is another sign of psychological problems in African and Indian cultures (Kleinman, 1987).

This section presented the internalizing behaviours and emotions that were considered to be "unacceptable " and "problematic" for 4 or 5 year olds by the parents and caregivers in this study. Only five of the behaviours and emotions were considered "problematic" in the internalizing dimension. The following section discusses the externalizing behaviours and emotions that were considered to be "problematic" and unacceptable by the participants in this study.

5.2.2.5 Externalizing behaviours and emotions considered to be "problematic" for 4 or 5 year olds

With regard to externalizing behaviours and emotions 57% of the behaviours and emotions were considered "problematic" and "unacceptable" for 4 or 5 year old children by the participants in this study. These fall under two known conditions: Conduct disorder, Oppositional Defiant Disorder (ODD) and hyperactivity.

5.2.2.6 Conduct symptoms considered "problematic" in 4 or 5 year old children

Results indicate that 30.4% of the behaviours and emotions that were considered "problematic" by the parents in this study are conduct symptoms. The essential feature of conduct disorder is a repetitive pattern of behaviour in which major age appropriate societal norms are violated. This disorder is common in childhood and adolescence. According to Kaplan and Saddock (1998) this disorder is common in children of parents with antisocial personality disorder. Behaviours which were considered to be problematic by parents and caregivers in this study include destructiveness, lying, cruelty and temper tantrums.

Destructiveness

This is usually manifested by destroying property either of others or oneself. In most children it arises as a defense against unbearable feelings of insecurity (Lewis & Miller, 1990). The literature attributes this behaviour to frustration and hostility. Children presenting with this behaviour are assumed to have deep-seated internal difficulties (APA, 1994). About 80% of the parents in this study considered this behaviour to be "unacceptable" and "problematic". Masten (1988) found that some children especially boys become destructive due to stress and parents' in this study were reported to be concerned with this type of behaviour in young children.

Lying

This was also considered problematic by the sample in this study. Richman (1982) defines lying as making untrue statements with the intention to deceive another person so as to gain an advantage. Following this line of thought, Druke, Hammer, Agras and Bryson (1999) and Schafer and Millman (1981) note that during preschool years, children have difficulty distinguishing fantasy from reality, as a result they are prone to self deception, and lying without the intention to deceive or hurt another person. This seems to be one of the behaviours that primary caregivers are concerned about and consider it to be "problematic"

Cruelty

Schaefer and Millman (1981) define cruelty as the premeditated deriving of pleasure from hurting others or animals. These children often come from chaotic homes. This behaviour is associated with conduct disorder in young children. It is reported to be more prevalent among boys than among girls (Kaplan & Saddock, 1998). Daledein, Vasey and Brown (1999) argue that children brought up in chaotic homes, negligent conditions generally become angry and unable to develop the tolerance for frustration. They tend to take out their anger and frustration on others or animals. This behaviour has negative results in building peer relationships in preschool and at school, these children are likely to be feared and socially isolated by other children in their surrounding. Parents and caregivers in this study also considered this behaviour to be "problematic" and "unacceptable" in young children. Not only does it interfere with their relationships with other children, but it also affects parent-child relationship (Cytryn & McKnew, 1996).

Temper tantrums

Tantrums can be an indication of fear or of anger. This behaviour tends to be frequent in preschool years. It might be due to frustration for not being able to meet all the parents' demands,

this coupled with the ambivalent feelings towards the beloved yet demanding parent may provoke the episodes of losing control. Parents on the other hand are concerned with tantrums in young children and consider this behaviour to be "unacceptable". Daledein, Vasey and Brown (1999) argue that toddlers with tantrums are overwhelmed by their anger, as they have not yet developed the emotional ability to deal with it.

In brief, Winkley (1996) argues that many children present with transient episodes of socially unacceptable behaviour and its persistence leads to the parents' concern and later the diagnosis of conduct disorder. This section has discussed behaviours and emotions which are associated with conduct disorder in young children and these were considered to be " problematic" and "unacceptable" by the parents and the caregivers in this study. The following section discusses behaviours and emotions associated with hyperactivity in young children that were considered to be "unacceptable" and "problematic" by the sample in this study.

5.2.2.7 Hyperactivity symptoms considered to be "problematic" in 4 or 5 year old children

Impulsivity

This behaviour was considered by 56% of the participants to be "very concerning" and considered by 37% to be "concerning". Only 7% reported not to be "concerned" with this behaviour. Impulsivity is associated with hyperactivity in young children (APA, 1994) and is classified under the externalizing dimension. Papps *et al.* (1995) found that impulsivity is associated with permissive methods of childrearing where parents rarely attempt to control their children's behaviour and make few demands on them. Impulsivity is a failure to stop and think before engaging on a task. By age 3 and 6 years of age children should be able to cooperate and are expected to pay attention for sustained period in order to complete tasks.

Carelessness and Clumsiness

Parents of preschoolers who are hyperactive are reported by Weiss and Hechman (1993) to be concerned with carelessness, clumsiness, and inability to pay attention and restlessness in young children.

Impatient

Results of this study indicate that parents and caregivers are concerned with the difficulty waiting turns in young children. This type of behaviour is associated with Attention-Deficit/Hyperactivity Disorder the impulsive type (APA, 1994). It has the potential to affect their relationship with other children.

Lack of concentration

The findings of the study conducted by Alessandri (1992) indicate that parents were concerned with the inability to concentrate in young preschool children. This behaviour places children in danger of developing Attention-Deficit/Hyperactivity Disorders later in their school years.

Inability to follow instructions

Campbell, Szumowski, Ewing, Gluck and Breaux (1982) found that hyperactive children raised concern for the educators. These are the children who are most likely to be classified as hyperactive and later develop learning difficulties due to their inability to follow instructions. This behaviour is often coupled with inability to sustain attention; failure to finish assigned tasks and these children often do not seem to listen when spoken to (Kaplan & Saddock, 1998).

Accident-prone

This is another behaviour considered to be "problematic" by parents and caregivers in this study. Apart from its potential danger of physically hurting the child, it also has the potential to be destructive in a child's life. Due to their impulsivity and inability to delay gratification, these children are often prone to accidents (Daledein, Vasey & Brown, 1999; Kaplan & Saddock, 1998).

Epidemiological studies of preschool age children (Crowther, Bond & Rolf, 1981; Richman, Stevenson & Graham, 1982) indicate that parents and educators are likely to be concerned about a range of behaviour problems including aggression, inattention and over activity. Similarly, Fischer, Rolf, Hasazi and Cummunigs (1984) reported high ratings on measures of externalizing behaviours and emotions. Findings of this study indicated that educators were mostly concerned with externalizing behaviours than internalizing ones. A similar finding is evident in this study: 57% of the behaviours and emotions considered to be " problematic" are externalizing ones. Similarly, findings of the study conducted by Keiley, Bates, Dodge and Pettit (2000) found that mothers and caregivers were reported to be concerned with the externalizing type of behaviours in young children. Likewise, in a study conducted by Keiley, Lofthouse, Bates, Dodge and Pettit (2003) found that both parents and educators reported great concern and difficulty with preschool aged children presenting with externalizing behaviour symptoms.

Campbell *et al.* (1982) found that externalizing conditions are relatively stable over time and are more likely to emerge and persist in the context of an unsupportive environment. A similar finding was reported in the study conducted by Campbell and Ewing (1990) where the authors found that externalizing problems show considerable longitudinal stability and this raises concern for primary caregivers and parents. Campbell, Ewing, Breaux and Szumowski (1986) found that parents from families with stress and negative controlling behaviours were concerned with mostly externalizing problems in preschool aged children. A similar finding is reported in Richman's (1982) study where parents and primary caregivers were reported to be concerned

with impulsive, inattentive and active preschoolers. As a result some of these parents were reluctant to enroll their "problematic" young children to the preschools due to their concern for their children's inability to get along with other in a group situation. On the other hand, Hinshaw (2002) argues that externalizing behaviour patterns show a moderate to strong stability over time. Surface manifestations of the underlying externalizing propensity often change with development. Externalizing behaviour patterns are a concern for both parents and educators but sometime seem to be over-stated. These behaviour patterns should be conceptualized in a developmental framework.

The literature explains most of the externalizing behaviours and emotions in terms of the environment in which a child is brought up. Schaefer and Millman (1981) argue that this is due to the homes where there are aggressive parental figures. The authors maintain that during the process of developing, virtually all children present with concerns and the list of such concerns is endless. There are those areas in which parents and educators are likely to experience greater challenges. In this study results indicate that the behaviours and emotions discussed above are considered to be "problematic" and are great challenge to primary caregivers in this study.

The results also show significant differences in the perceived severity of certain behaviours and emotions. For instance, when looking at Table 2 in section 4.2.1, it is apparent that for the behaviours such as "*seem not to hear*" 49% of the participants in this study considered it to be "concerning". "*Stomach problems*" was considered by 73% of the participants in this study to be "problematic". Forty five percent of the participants were concerned with "*headaches*" in the preschool aged children. All these childhood problems were considered to be "concerning" by primary caregivers. But there are those behaviours and emotions that were concerning to the majority of the participants in this study. This is in line with Winkley (1996)'s argument that some behaviours and emotions are likely to be of more concern than others. For an example, parents with children growing up in poverty are likely to overlook behavioural and emotional problems and focus their attention on getting means to feed and clothe their children, as a result childhood problems might be reported as not existing due to economic hardship (McLoyd, 1990).

A study conducted by Spiro and Swart (1994) on 3 groups of South African preschool children found that on average fewer Black parents report behaviour problems in their youngsters compared to White and Coloured mothers. In support of this finding the authors argue that the lower prevalence of behaviour and emotional problems reported by African mothers is simply a result of these mothers not recognising the problem as present [focusing their attention to their most urgent needs].

The literature on the disorders of childhood is based exclusively on research conducted with Western children. Researchers seem to be of the opinion that childhood disorders are universal, hence they generalize research findings from Western to local African populations. Findings of this study support the findings of previous research done internationally and locally, this study gives an indication of the commonalities between the Western belief system and African belief system about the types of behaviours and emotions that are considered to be problematic by parents as well as caregivers. Like, Luke. Leung, Shone and Mak (1991) this study suggests a certain degree of universality of behaviours and emotions considered to be "problematic" and "unacceptable" in preschool age. There were differences too, for an example: "arguing", "difficulty playing quietly" and "playing with younger children" were not considered to be "problematic" by Black isiZulu speaking parents and caregivers in this study.

On the other hand, such results open the way for speculation that differences in the conceptualization of childhood problems may be over estimated. Although there are few published studies of behavioural and emotional problems in South African preschool aged children, there is evidence suggesting that there are no significant differences in the kinds of behaviours and emotions parents consider to be "problems" in young children. A South African study conducted by Spiro and Swartz (1994) found that preschoolers, regardless of their cultural context exhibit similar prevalence of childhood problems. A similar finding is reported in the study conducted by Earls (1982) in West Indian children and British children, the author found that despite the national, cultural and demographic family differences, the prevalence and parents' concerns for behavioural and emotional problems in children was similar. Differences in

cultural conceptualization and socialization goals result in different expectations of how children should behave or express their emotions and subsequently influence parents' reports on psychological screening questionnaires. Other studies (Kastrup, 1977; Papps *et al.* 1995, cited in Winkley, 1996) report similar prevalence in childhood behavioural and emotional problems and these findings are in close agreement with those reported in this study. The findings of this study indicate that parents and caregivers are concerned with behaviours and emotions considered to be problems in literature of childhood disorders.

Findings indicate that the sample in this study did not differ from previous research in the types of behaviours and emotions considered to be "problematic" and "unacceptable" in 4 or 5 year old children. The literature suggests that Africans have their own worldview of what causes illness and how illnesses are treated (Ngubane, 1977). It is beyond the scope of this thesis to look at the forms of treatment options for black isiZulu speakers but it is worth mentioning that though they do not differ significantly from their Western counterparts in the types of behaviours and emotions they consider to be "problematic", their worldview on what causes illness and problematic behaviour seem to differ remarkably. The kinds of response to problematic behaviours and emotions rest on the parents' knowledge and experiences of how to deal with "problems" of that nature. The situations posed to parents in this study were hypothetical and the responses of the participants were not to the behaviour itself but were mere beliefs about what they would do under the circumstances. Findings do not fully support the expectations based on the literature reviewed and the expectations of the current study. One clear example of this is the failure to find that Black isiZulu speaking parents differ in the kinds of behaviours they consider to be "problematic" from what is presented in literature. Participants in this study considered 88% of the behaviours and emotions that were listed on the questionnaire to be "problematic" and "unacceptable" in 4 or 5 year old children.

The controversy about normality and abnormality of behaviours and emotional states of young children is still an issue still to be tackled in research. The current criteria of abnormal behaviours and emotions is limiting since it implies that normality involves most common

behaviours and emotions. This criterion excludes those behaviours and emotions which may deviate from the norm but valued by the society. One example in this study is the fact that "*difficulty playing quietly*" is one of the symptoms of hyperactivity in young children (APA, 1994). This behaviour deviates from normality, yet black isiZulu speaking parents and caregivers in this study did not consider it to be a problem.

This section has discussed results relevant to the aim of this study as well as the research questions which meant to establish which behaviours are "acceptable" and not considered "problems" and which ones are "unacceptable" and considered "problems" by Black isiZulu speaking parents and caregiver in this study. It is apparent that both internalizing and externalizing behaviours tend to be of great concern for the primary caregivers and this is in line with the reviewed literature on childhood problems. There is evidence that parents and caregivers are concerned with behaviours and emotions both from the internalising dimension as well as the externalising dimension.

CHAPTER SIX

The purpose of this study was to establish the behaviours and emotions that are considered "acceptable" and considered "non-problematic" and the behaviours and emotions that are considered "undesirable" and "problematic" in Black isiZulu speakers in and around Pietermaritzburg. The study adopted the approach of cultural relativism (emics) versus universalism (etics) looking at the African views of health and illness, specifically at local conceptualization of health and illness regarding childhood behavioural and emotional problems.

This study investigated two research questions:

- Which childhood behaviours and emotions are considered "acceptable" and "non-problematic" for 4 or 5 years olds in Black isiZulu speakers,
- Which Childhood behaviours and emotions are considered "undesirable" and "problematic" for 4 or 5 year old children by Black isiZulu speaking parents and caregivers?

Data were collected using the Behaviour Screening Questionnaire which consisted of 39 words describing the way children feel and behave. These were labeled on individual cards with numbers ranging from 1 to 39. This questionnaire was developed by the Family Development Project, the University of Michigan and Head Start programmes. Ninety-seven isiZulu speaking females were interviewed. Each participant was asked to imagine that a friend came to her and said that her 4 or 5 year old is behaving in the way that was labeled on the card and rank it as either not concerning, concerning or very concerning. Data was ordinal in nature, thus necessitated non-parametric method of analysis (Howell, 1997). Chi square test and the residual methods of analysis were employed.

6.1 SUMMARY OF CONCLUSIONS ABOUT RESEARCH QUESTIONS

The findings of this study indicate that parents and caregivers are concerned with behaviours both from the externalizing and internalizing domains. The results also suggest that there is a difference (8.6%) in the types of behaviours and emotions considered to be "acceptable" and not "problematic" by Black isiZulu speakers: argues, difficulty playing quietly and playing with younger children.

The data presented in this study were developed from primary caregivers, health workers, parents, etc on childhood behaviour and emotional problems. Although these reports may be the best source of information on childhood problems, it must also be considered that what the sample under study consider as significant problems in children can be influenced by cultural beliefs and social values of their communities. Culture plays an important role in determining what is to be rendered a problem and what not.

6.2 LIMITATIONS OF THE STUDY

The data presented in this study were collected from a small number of primary caregivers and parents and this poses some limitations:

- The behaviours and emotions listed on the questionnaire were developed from the Western psychological literature, for example the DSM. Future studies should begin with in-depth qualitative research to elicit behaviours and emotions from the population of interest and compare these with those available in the literature.
- Data collected are from a small sample and therefore generalization may be problematic, a larger sample might render useful results which may be generalized to larger populations
- The sample under study was largely from semi-urban area and consisted of fairly young people and the urban population was under-represented with the rural communities not included at all in the study due to unavailability on the part of the participants and unwillingness of others especially in urban areas, to take part in the

study.

6.3 INDICATIONS FOR FURTHER RESEARCH

It is recommended that in future researchers use a systematic sampling procedure so as to allow for comparisons, looking for age related differences, educational related differences as well as geographical related differences. Further research using complementary methodology is recommended. Complementary methodology might involve open-ended interviews where parents would be asked about their etiological explanations and possible reactions to behaviours and emotions they consider problematic.

6.4 CONTRIBUTIONS OF THE STUDY

- The study has contributed methodologically. This is the first study to apply a Zulu version of the Behaviour Screening Questionnaire to investigate the types of behaviours and emotions considered to be "acceptable" and "non-problematic" as well as those behaviours and emotions considered to be "unacceptable" and "problematic" for 4 or 5 year old children in black isiZulu speaking communities in South Africa. The use of the Zulu version of the questionnaire allowed the participants in this study to give their opinions without doubting their understanding of the concepts presented in the questionnaire.
- The study also contributes to the body of knowledge that black isiZulu speakers in semi-urban and urban areas are no different to their Western counterparts with regard to behaviours and emotions they consider problematic. It was worth investigating which behaviours and emotions these communities consider problematic. Literature has noted that other behaviours may be unacceptable in one culture and welcome without scrutiny in another culture. This study has shown that most behaviours presented as childhood problems in literature, are also seen through the same lens in black isiZulu speaking communities with the exception of three behaviours: "argues",

"difficulty playing quietly" and "playing with younger children".

- The study focused on the area which has not been explored empirically in South African pre-school aged children except for few studies such as the one conducted by Spiro and Swartz (1994), but the sample in their study was Xhosa speakers. The current study has been the first to focus on 4 and 5 year old isiZulu speakers within the South African context.

In conclusion, this chapter presented summary of conclusions about research questions, moved on to presenting limitations of the study, indications for further research and finally presented contributions of the study to the body of literature of the studies of childhood problems.

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APPENDICES

Appendix A : Questionnaire: English version.

Card1 Accident prone	**Card 2** Argues	**Card 3** Has temper tantrums
Card 4 Can't sleep	**Card 5** Careless	**Card 6** Clumsy
Card 7 Complains of headaches	**Card 8** Cruelty to animals	**Card 9** Cruelty to others
Card 10 Dependent	**Card 11** Destroys others' things	**Card 12** Disobedient
Card 13 Does not like and is unable to do tasks that require close attention	Card 14 Does not seem to listen or follow instructions (not deliberately)	**Card 15** Does not seem to listen when spoken to

Appendix A : Questionnaire: Zulu version

Card 1 Ujwayele ukulimala (uwisa izinto, uzithela ebantwini noma angqubuzeke kubona)	**Card 2** Uyaphikisana, uyaqophisana	**Card 3** Unolaka, uba neziqubu zolaka
Card 4 Uyaqwasha akakhoni ukulala	**Card 5** Ubudedengu, akanakekeli, akaqaphelisis, akacopheleli	**Card 6** Unobudlabha, ubuyena nendlela enza ngayo izinto
Card 7 Ukhononda ngobuhlungu bekhanda	**Card 8** Unonya ezilwaneni, unesihluku ezilwaneni	**Card 9** Unonya noma isihluku kwabanye
Card 10 Ukhonze kakhulu ukwenzelwa izinto; unombela kwabadala, unamathela kwabadala	**Card 11** Ucekela phansi izinto zabanye	**Card 12** Uyihlongangandlebe, akahloniphi, akalaleli
Card 13 Akathandi futhi akakwazi ukwenza umsebenzi odinga ukucophelelisisa noma ukubhekisisa	**Card 14** Ubukekea sengathi akalaleli noma akayilandeli imiyalelo (lokhu akakwenzi ngesibomu noma ngenhloso)	**Card 15** Ungathi akalaleli, akabonakalisi ukulalela uma kukhulunywa naye
Card 16 Unenkinga yokudla. Ukhetha ukudla, udla kancane noma kakhulu	**Card 17** Unokwesaba	**Card 18** Uyayobayoba, akuvumi ahlale anganyakazi

Card 19 Unenkinga ukudlala ngesizotha	**Card 20** Akanaso isineke, ujwayele ukuphula ulimi, ukuphazamisa	**Card 21** Unesihluthuhluthu. Wenza izinto ngaphambi kokucabanga
Card 22 Unenhliziyo encane, ushesha acasuke, unyukubele	**Card 23** unomona	**Card 24** Unamanga
Card 25 Unesizungu	**Card 26** Umoya wakhe ushintsha isigubhukane. Ungathi ujabule, uyambona usedangele ukuphazima kweso	**Card 27** Unetwetwe, unengebhe, uthuka kalula, usabiswa ubala
Card 28 Akakwazi ukuzwana noma ukuphilisana nezinye izingane	**Card 29** Uncama ukudlala nezingane ezincane (kunaye)	**Card 30** Ulusizi, udangele
Card 31 Unamahloni, unovalo	**Card 32** Uqala ukulwa	**Card 33** Unenking yokuphathwa isisu
Card 34 Unenkani ukhandalimtshelokwakhe	**Card 35** Uyasongelana, uyesabisa	**Card 36** Uthinta izinto ongukamele azithinte
Card 37 Uyachama uma elele	**Card 38** Uyatetema, uyakhala, uyaklabalasa	**Card 39** Uyathanda ukuzihlalela yedwana, inkomo idla yodwa

Appendix B: Recording sheet

Recording sheet: Card Sort
Date:
ID#
Recorder:

RANK ORDER #	VERY CONCERNED	CONCERNED	NOT CONCERNED
39			
38			
37			
36			
35			
34			
33			
32			
31			
30			
29			
28			
27			
26			
25			
24			
23			
22			
21			
20			
19			
18			
17			

Recording sheet: Card Sort [p2]

Date:
ID#:
Recorder:

RANK ORDER#	VERY CONCERNED	CONCERNED	NOT CONCERNED
16			
15			
14			
13			
12			
11			
10			
9			
8			
7			
6			
5			
4			
3			
2			
1			

Appendix C: An example of ranked cards

Recording sheet: Card Sort
Date:
ID#
Recorder:

RANK ORDER #	VERY CONCERNED	CONCERNED	NOT CONCERNED
39	3		
38	12		
37	18		
36	35		
35	32		
34	11		
33	2		
32	23		
31	36		
30	4		
29	21		
28	30		
27	34		
26		27	
25		9	
24		28	
23		33	
22		19	
21		10	
20		24	
19		6	
18		17	
17			

Recording sheet: Card Sort [p2]

Date:
ID#:
Recorder:

RANK ORDER#	VERY CONCERNED	CONCERNED	NOT CONCERNED
16		15	
15		18	
14		13	
13		5	
12		39	
11		22	
10		14	
9		16	
8		26	
7		1	
6		7	
5		20	
4			29
3			31
2			38
1			37