Available Online at http://iassr.org/journal
2013 (c) **EJRE** published by
International Association of Social Science Research - IASSR

ISSN: 2147-6284
European Journal of Research on Education, 2013, 1(2), 10-31

European Journal of Research on Education

Emotional disorders

Ayla Akbaş *

Assist. Prof., Kocaeli University, Faculty of Education, İzmit, Kocaeli, Turkey

Abstract

In this study, individuals with a psychological or emotional disability is defined in addition to people who experience problems when building, developing and maintaining balanced and effective relations with themselves and their environments, and who consequently have problems in their developments. Their treatment and education are also discussed. Psychological disability may be caused by biological, psychological, social-economic, physical, bodily, genetic and educational factors. It is necessary to take certain measures in childhood before psychological and emotional problems advance. The individuals' ability to live a healthy and effective life is closely related to their psychological health. Psychological and emotional disabilities lead to unhappiness and despair for the individual, and to maladjustment and decreased productivity for the society. A person who is described as disabled is someone who experiences difficulties in adapting to social life and in meeting his/her daily needs because of losing physical, mental, psychological, sensory and social abilities at various degrees, and who requires protection, care, rehabilitation, consultancy and support services. Accordingly, disabilities have been categorized as orthopedic, visual, auditory, language and speech, mental, psychological and emotional disabilities and chronic diseases. Various sources have been examined in relation to the psychological-social situations of individuals with psychological and emotional disabilities and certain suggestions have been made with regards to making treatment, education and guidance services available to them.

Keywords: Emotional disorders, emotion, normality, abnormality, guidance services

1. Introduction

People with psychological or emotional disorders are individuals who experience problems when building, developing and maintaining balanced and effective relations with themselves and their environments, and who consequently have problems in their developments. Psychological disability may be caused by biological, psychological, social-economic, physical, bodily, genetic and educational factors. It is necessary to take certain measures in childhood before psychological and emotional problems advance. The individuals' ability to live a healthy and effective life is closely related to their psychological health. Psychological and emotional disabilities lead to unhappiness and despair for the individual, and to maladjustment and decreased productivity for the society. Who should be described as a disabled person? A disabled person is someone who experiences difficulties in adapting to social life and in meeting his/her daily needs because of losing physical, mental, psychological, sensory and social abilities at various degrees, and who requires protection, care, rehabilitation, consultancy and support services. Accordingly, disabilities have been categorized as orthopedic, visual, auditory, language and speech, mental, psychological and emotional disabilities and chronic diseases.

According to formal definitions, in order to benefit from the rights and services granted to the disabled, a person's disability ratio must be 40% or more in medical reports which conform to the "Regulation on disability criteria, classification and medical commission reports given to disabled people" published on 16.07.2006 in the Official Gazette No. 26230. In special education services, this ratio may be applied as 20% (Republic of Turkey,

* *E-mail address*: dr.ayla.akbas@gmail.com

Ankara Governorship; 2010). Children whose developmental and educational needs are so different that they cannot be met in regular conditions are defined as "privileged children" (Enç et al.; 1975). Discussions continue among doctors, psychologists, educators, psychological consultants, and special education experts as to the definition of the "disabled".

2. Definition

There is no agreed-upon definition of psychological health. When describing the psychological and emotional dimensions of a disabled person, it is necessary to compare them with normal emotional development. There is no consensus as to the reasons for emotional behaviors and behavioral disorders (e.g. abnormal behaviors, aberrant behaviors). Institutions about disabled individuals use their own terminology, as a result of which different definitions emerge because of their own emotional causality assumptions. There are certain similarities between emotional and other differences (mental disability, learning difficulties, behavioral disorders, etc.). Emotional disorders which are not severe and harmful may be temporary and can be considered as problems that arise with age when they are considered within framework of the individual's development. Expected behavior models may exhibit cultural differences and variations within the norms. Therefore, it might be difficult to diagnose the emotional and behavioral disorder of a child precisely. Whatever the reason is, it is necessary to recognize and define children with emotional disorders. It is necessary to know the factors that cause emotional disorder and to find a common definition. Such a definition will make it easier for us to distinguish children with emotional disorders from those without them. Since a valid and reliable definition must be based on scientific criteria, it will be possible to distinguish individuals with emotional disorders from normal individuals.

2.1. What is normality?

In a rapidly changing and complex society, it is more difficult to define normality than defining abnormality. If the personality traits help a person to build good relations and win a place in the society, if he is well-adjusted with himself and the society, then he is considered normal. In other words, individuality, creativity and self-actualization define a healthy personality. Despite the fact that there is no consensus on the definition of a healthy personality, emotional health must be evaluated according to the qualities listed below. Instead of making a clear-cut distinction between a mentally healthy individual and an individual with mental disorder, it is necessary to consider the qualities which the normal individual has more and at a higher level in comparison to a person who is diagnosed as abnormal. However, an evaluation based on the ability to adjust to what others do and think can be misleading. The following elements must be taken into consideration when discussing normality:

1. An accurate perception of reality
2. Self-awareness
3. Self-control
4. Feelings of self-worth and acceptance
5. Ability to build good relations
6. Productivity

2.2. What is abnormality?

It is necessary to define abnormality based on statistical frequency. When individual characteristics (height, weight, intelligence, etc.) are measured, a profile which contains different values is found. Abnormal behavior is one

that is statistically observed infrequently or which deviates from the norm. However, according to this definition, a very intelligent or happy person can also be classified as abnormal. Therefore, it is necessary to consider certain factors when defining abnormal behavior. In order to define children with serious disorders, their academic performances must have been affected adversely, and they must exhibit certain characteristics significantly (Ataman, 2003). These characteristics are as follows:

2.2.1. Learning disability and educational failure

Existence of an inexplicable situation where an individual is evaluated from a mental, emotional and health perspective over a long period of time.

2.2.2. Inability to build, develop and maintain relationships with people

Failure to build relationships with peers and other adults (parents, teachers, etc.) and to maintain them.

2.2.3. Emotions, emotional reactions and behaviors which are extraordinary and inappropriate under normal circumstances.

Emotional states-reactions which draw attention and which are inappropriate under normal circumstances.

2.2.4. Being unhappy, desperate and depressed in general

2.2.5. Tendency to develop fears and physical symptoms about himself or his environment.

Even though these characteristics included in this definition contain schizophrenia as well, unless an emotional disorder is determined, they should not be used as a criterion to define "emotionally disabled" or "socially maladjusted" children. Interpretation of an emotional disorder as "serious" may lead to misunderstandings. It can also prevent children with mild emotional disorders from benefiting from special education services during their education. An emotional disorder is considered a phenomenon different from behavioral disorder which may cause children with behavior disorders to be excluded from this categorization. In addition to observations, criteria which are used to define an emotional disorder need to be supported by scientific research as well. Establishing a characteristic which is not supported by scientific findings as a general and common criterion can be misleading. When discussing the educational performance of a child with an emotional disorder, one should not consider the academic dimension alone. A child may exhibit prominent educational performance inability even if his cognitive development is not affected adversely. In other words, it is possible to observe emotional disorder without waiting for one or more of other characteristics to emerge and affect the academic development. In the definition of emotional disability or disorder, emotions and emotional reactions which are not considered appropriate in normal states and circumstances are also open to discussion. The assumption that normal emotions and emotional reactions develop under appropriate and normal conditions must be analyzed. However, describing an emotion or an emotional reaction as a "disorder" or "disability" when circumstances and states are normal does not reflect the truth. In this chaos of definition, should we attribute emotional disorder to the individual or to the environment (appropriate normal situations and conditions)? Since special education programs are usually designed for children and aim to change the child, the definitions are made not in relation to his environment but in relation to the child himself.

Another important issue is whether the concept of emotional disability or disorder can be addressed within the socially maladjusted children category. Emotional disorder can present social maladjustment as well; however, not every socially maladjusted child is emotionally disabled. When the issue is regarded from this point of view, it is necessary to know in which category children with emotional disorders must be evaluated. It is clear that it is easier to define the emotionally disabled child after defining socially maladjusted children and establishing the criteria which are used in this definition. According to Enç (1975), adjustment is the ability to establish and maintain a balanced relationship between oneself and the environment he is in. Based on this definition, a maladjusted child is one who experiences difficulties in establishing and maintaining a balanced and effective relationship between

himself and the environment he is in, and whose development was interrupted as a result and who has behavior patterns that cannot be rectified through the ordinary relations of those around him. These children are either extroverted (unsuccessful at school, restless, nervous, have tendency to throw tantrums, bite nails, bite their hands or fingers, itch harshly, sensitive to criticism, aggressive, hurtful, destructive, inarticulate, careless, disrespectful of authority, lie, steal, have hallucinations, etc.) or introverted (calm, shy, cowardly, timid, insecure, secretive, impulsive, have feelings of worthlessness, inferiority complex, day dream, etc.).

When the emotional disorder or the emotionally disable child concepts which are not included in the socially maladjusted child are differentiated, one can see that a socially maladjusted child can exhibit one or more of emotional disorders, or a child with emotional disorders is left outside the definition. In other words, it is considered normal when a child who conforms to the socially maladjusted child definition exhibits emotional disorder, but it is a matter of discussion whether a child who displays emotional disorder should be included in the socially maladjusted child definition. If a child with emotional disorder displays one or more of the criteria listed above, he should be considered socially maladjusted, but in practice he is not included in this category. There are no tools or methods to distinguish the maladjusted child from the child with emotional disorder (Ataman, 2003). This situation may deprive the children who need special education of the right to receive education according to their disability group.

Since the emotional disorder classification in special education is open to misunderstanding, is interpretive, and has a subjective dimension, it is necessary to evaluate the indicators very carefully. National Mental Health and Special Education Coalition suggested a new terminology and definition (Ataman, 2003). Accordingly, the term emotional disorder means a disability characterized by behavioral or emotional responses so different from appropriate age, cultural, or ethnic norms that they adversely affect academic performance. The academic performance (academic, social, vocational, and personal skills) of children with emotional disorders are inadequate. The responses of these children which are expected to be given under extraordinary circumstances and which are outside the temporary responses are permanent. Most of the emotional responses are related to the school, and general educational interventions prove to be insufficient. A child with emotional disorder may exhibit other disabilities as well.

There might be other groups that affect the educational performance (schizophrenia, affection, anxiety and other adjustment disorders). In response to the problem of definition in the United States, Ministry of National Education, Special Education Services Regulation defines emotional disorder as emotional adjustment difficulty. According to this definition, emotional disorder is a situation in which the health of an individual cannot be explained by intellectual and sensory factors, and the educational performance and social adjustment is adversely affected due to the emergence of one or more of qualities such as an inability to build or maintain satisfactory relationships with peers and teachers, a general pervasive mood of unhappiness or depression, a tendency to develop physical symptoms (e.g. nail biting, thumb sucking) or fears associated with personal or school problems. (MEB, 2000; Ataman, 2003). The disabilities grouped under psychological and emotional disabilities have a very wide range.

We have addressed the most common psychological and emotional disorders in this article. An individual with psychological and emotional disorder in the family affects the family life in various ways. With the inclusion of a disabled member, intense emotions are experienced. The fact that the individual has "special needs" becomes an important problem in the family in relation to his acceptance in and continuance of his life with the family. The word "emotion" usually reminds inner experiences, echoes or responses which are not very intense. In other words, they are the quality or sum of sensory facts. It is a process which emerges upon the perception of the situation one is in, which excites internal organs, and which makes itself felt in the body, behaviors and consciousness. For example, anger is an emotion. Tantrum, on the other hand, is the emotive level expression of that emotion. Emotions emerge in three layers.

1. *Physiological level:* These are physiological changes that occur within the body during the emotional experience. The perceived sensory stimulus causes great changes in the heartbeat, respiration, and the amount of secretions produced by glands.

2. *Internal experience level:* An emotion is experienced inside subjectively. It is impossible for others to know this experience.

3. *Emotional behavior:* An individual can understand his own emotions and excitements directly, but he can understand others' emotions only through their behaviors. In daily life, we try to interpret someone's emotions by looking at his revelatory behaviors. Therefore, understanding psychological and emotional disabilities, defining and minimizing the factors that cause them, taking measures based on the acquired data will offer advantages to individuals and the society. Families and educators have great responsibilities in this regard (Kurç, 1989; Zulliger, 1996; Köknel, 1990).

3. Characteristics of an Individual with Psychological and Emotional Problems

Asocial", "anti-social", "abnormal", "person with behavioral disorder" are some of the terms used to define people with psychological/emotional problems. In society, they are labeled with attributes which express a prominent emotional disorder or maladjustment situation such as outcast, unbalanced, disagreeable, rebellious, mutinous or aggressive. Individuals with psychological/emotional disorders may exhibit behaviors such as excessive anger, nervousness, restlessness, disturbance, lack of interest in school or work, failure in academic works, extreme jealousy or stealing, carelessness, shyness, cowardice, insecurity, emotionality, sensitivity. These emotions and behaviors, which can also be observed in normal individuals, are permanent in disabled people. Some or most of these behaviors are observed continuously in persons with psychological/emotional disability.

3.1. Emotional State

- The most important needs of children are being loved, liked, accepted and valued. The more they are loved and cared by their mother, teachers and other grown-ups, the better their psychological health will be.
- The child has a strong desire to be the center of attention at home, at school and among his friends. It is difficult for him to share the parent's love at home or the teacher's love at school.
- As a result of problems and stresses at home or school, the child starts to lie, cheat in exams, or take others' belongings. The child may start to suck his thumbs, bite nails, and twitch for the same reasons.
- Being successful is a strong motive in every child. When they cannot achieve a real success, they may boast imaginary ones.
- Children are affected by various emotions. Emotions such as fear, anger, jealousy, joy and love fill up a child's day one after another; their emotional states change rapidly. The subject of their fears is generally imaginary creatures such as goblins, ghosts, devils. Since children believe that these creatures exist in dark places or closets, they are afraid of the dark, the basement or the attic. They are afraid of not being loved by their parents or friends, losing their mother, running late for school or failing to complete their homework before going to school. The tales and stories they are told, the books they read, the films and plays they watch may be the origin of such fears. Developmental factors which might affect children's psychological and emotional development must be known by the parents and they should receive psychological consultants' assistance (Başaran, 1974; Yavuzer, 1994; 1995; Neyzi, 1984). Social activities in primary schools should aim to develop children's social skills (Hunkins and Maxey, 1982). To this end, special educational programs which are aimed at the emotionally disabled children are needed.

4. Perspective and History of Preparing Educational Programs for Emotionally Disabled Children

In educational sessions, special education programs must be designed which do not introduce a new fear phenomenon. It was believed that this was the psychiatrist's or the psychologist's responsibility at the Children's Counseling Centers in the United States. However, after 1961 (Meyen 1982), based on the premise that every fact that will be taken into consideration radically can be taught to emotionally disturbed children by their teachers, National Institute of Mental Health developed many experimental special education programs. From then on, the role of teachers as the "professional psychological health educator" for the disturbed students in the development

groups has increasingly been accepted in the official school programs. President John F. Kennedy stated that the problems observed during upbringing which were inter-related and which originated from various factors were based on the needs of the youth and the children. In 1963, President Kennedy prepared an experimental support aiming the use of other measurements for psychological and mental disorders and the employment of qualified personnel with groups of people who are diagnosed through these measurements. Subsequently, official educational school services assisted many disturbed children in accordance with the provisions of the law. The idea that these children "had a condition which was caused by their own psychological development" but that "there was not a single way to address these conditions" has been one of the greatest achievements of the early periods of this century. If the children at these schools spend more time, this could lead to a positive psychological development. A clinical model is suggested for emotional disturbances. This model may demonstrate the difference between the problematic behavior and adjustment problems in diagnoses such as psychosis, schizophrenia and personality disorder. When the widespread definitions of educators are taken into consideration, the observational outputs set forth by emotional disturbances can be summarized as follows:

(1) Their ability to benefit from academic studies is low due to their mental capacity, and visual and auditory problems.

(2) They are unable to build and maintain satisfactory interpersonal relationships with their peers and adults.

(3) Their responses are impulsive in social and environmental conditions.

(4) Their moods of happiness and depression vary considerably.

(5) They frequently complain about physical disorders which do not have a medical basis (Bower, 1969).

It became apparent that it was necessary to abandon the medical model with regards to children with emotional disorders, and to use new definitions. (Meyen; 1982).

Accordingly, maladjusted reaction is a situational disturbance which presents as a result of the inability to cope with certain life facts and events. Autism is one of the disturbances observed in children. Characterized by bizarre behaviors, autism is an extraordinary isolation. Symptoms usually emerge in the first two and a half years of life. Behavioral disorders have become synonymous with emotional disorders. The medical model is an approach used in relation to emotional disorders. Positive reinforcement is encouraging someone to achieve a result by rewarding a desired behavior. Psychosis; it is a medical word and defines a type of disturbed behavior. It is characterized by abnormal actions, thoughts, emotions, and lack of contact with reality. Emotionally disturbed children are a heterogeneous group. The behavior patterns (e.g. anger towards the teacher or the authority figure) can be similar (Hallahan and Kauffman: 1978). Complex problems in emotional disturbances have been long discussed. The muscular strength and condition of individuals with psychological and emotional problems are weaker than the others and their postures are distorted. This situation may result in weight increase in children and adults. Therefore, it is necessary to increase the level of activity (it is a known fact that exercises increase social attention and self-confidence and decrease depressive complaints, and are beneficial for coronary problems). Some of psychological and emotional disturbances have been discussed here.

5. Attention Deficit and Hyperactivity Disorder (ADHD)

This is a condition which starts before childhood (before seven years of age) and is characterized by hyperactivity and difficulty in achieving and maintaining concentration. In other words (1) Attention deficit (difficulty in achieving and maintaining concentration), (2) Hyperactivity (difficulty in self-control), and (3) audacity or impulsiveness in behaviors and thoughts. This situation may start in childhood and continue throughout life. It is observed more frequently in boys at school age. ADHD has adverse effects on child development, his life, his interpersonal relationships and school life. As a result, academic failure becomes inevitable.

5.1. Symptoms

When compared to their peers, hyperactive children with attention deficit disorder exhibit certain behavior patterns such as inability to sit still, hyperactivity, talkativeness, inability to listen to others, unresponsiveness to

verbal warnings during communication, difficulty in obeying rules, difficulty in performing expected behaviors, inability to adapt to group dynamics, starting a new activity before completing the previous one, losing their belongings frequently, participating in dangerous activities without thinking about consequences. Such students cannot easily adapt to school life, and their academic performance may be low. They usually experience problems in learning and social relationships. If these children are not guided, their family relations and social adjustments may suffer. They may exhibit anxiety and depression, aggressiveness, behavioral disorders, feelings of guilt and substance abuse. Children with ADHD have difficulty in adapting to the educational environment, and since they cannot focus, they cannot finish the jobs they start. A team-work is necessary to diagnose a child with ADHD (a child psychiatrist, a psychologist, and a special education expert). According to DSM-IV, three basic conditions need to exist together in order to diagnose a child with ADHD:

(1) hyper-activity, impulsiveness, and inattention,

(2) symptoms must start before 7 years of age and be considerably more prominent when compared to their peers,

(3) symptoms must be so severe that when compared to their peers, they prevent the child from performing duties and behaviors expected of them both at home and at school.

The attention deficits of children with ADHD do not go away in their youth and adulthood.

This condition frequently co-exists with insubordination disorder, conduct disorder, learning disorder, depression, dysthymia and various anxiety disorders, alcohol and substance abuse. Some of the problems individuals with ADHD have to cope with throughout their lives are as follows:

(1) identity crisis,

(2) low performance at school and at work,

(3) problems about achieving autonomy and independence,

(4) conflicts with the family and the environment,

(5) other problems (behavioral disorder, substance abuse, accident proneness, emotional responses and inability to control temperament, getting angry easily and failure to control anger, etc.).

During youth and adulthood, such behaviors result in disciplinary problems at school, loss of jobs, break-down of family relationships, loss of friends from opposite sex, and depression caused by such losses. (Aysev; 2001; TC. Başbakanlık Ö.İ.B.; 2008).Children with ADHD are classified as children with special needs, and special education programs are created at the Guidance Research Centers by taking their psychological and educational needs into consideration.

5.2. Treatment

It is difficult to diagnose ADHD in early childhood because inattention and hyperactivity can be seen in normal children as well. However, this situation may be temporary in normal children. On the other hand, children with hyperactivity disorder cannot perform activities that require attention like the others do, and they experience difficulties in playful activities. Diagnostic difficulty can be experienced with girls as well. Girls with ADHD (dislike for school, avoiding going to school, depression, anxiety, cognitive retardation, etc.) exhibit less hyperactivity and display less behavioral disorders, which results in a difficulty in early diagnosis. During evaluation, the story of the child is taken (interview with the family, pre-natal and post-natal child development, parent's attitudes, parent-child relationship, mother's pregnancy period, etc.). Meanwhile the severity of the condition is determined by talking with the child in a manner that he understands. The personality and mental characteristics of the child are determined through some tests (Bayer Draw-A-Person Test, sentence completion test, child behavior problems – CBCL, Conners teacher grading scale, Bender-Gestalt motor perception scale, Ankara Developmental Screening Inventory, Stanford-Binet, WISC-R, child depression scale, situational-continuous anxiety scale, learning difficulty tests, etc.). In addition, the Screening and evaluation scale in DSM-IV is used and differential diagnosis characteristics are observed. The family is informed about the situation, and a treatment and education plan is prepared. Neuropsychological principals are employed during these evaluations. Most of these

studies are conducted with a view to evaluate the brain functions of the child and his interactions with the environment. These assessments aim at understanding the functionality of the child's activities at home, at school, outside school as a special individual, and to collect information about his mental state. In evaluating attention, number range, continuous performance tests are used; in evaluating verbal memory, California learning test is used; in evaluating visual and spatial perception, Benton's Judgment of Line Orientation Test, Benton face recognition test, design with cubes are used; in evaluating executive functions, controlled word association – FAS test and category naming, Wisconsin card matching test, Stroop test, push / do not push test, late recognition test are used. During treatment, parent and teacher training and support programs are developed. General or specific learning disorders may be observed in children with ADHD. Therefore, in one-to-one trainings, the teachers and the parents need to be informed about the nature and treatment of the disorder. As a result, these children need to be diagnosed, segregated and placed. (Enç; 1975; Hunkins et al.; 1982; American Psychiatric Association; 1994; Aysev; 2001; Ataman; 2003).

5.3. Education

The education of children with ADHD must be carried out within the special education field by applying certain methodologies. The primary criteria for such education must be as follows:

- The ADHD diagnosis must be put by a group of experts consisting of medical, psychological and educational specialists (child-teenager psychology clinics, etc.).
- Educational orientation decisions must be made by the Guidance Research Center (RAM) educational diagnosis, monitoring and evaluation team.
- The decisions made must be submitted to "provincial special education services board" and a "placement decision" must be made.
- The placement decision of this board the must be notified to the school and the special education needs of the child must be determined and notified as well.

Following these formal procedures, special education programs might be prepared that would improve the child's performance at school and his adjustment. These programs usually include the education of the teachers, parents and peers of the child. Medication might be recommended by a specialist doctor if necessary. Structured special education programs contain concentrations skills, social skills and skills aimed at personal development. "Individualized Educational Programs" which are prepared for such students provide guidance in line with the needs of the student within the teacher–student–family context. When children with ADHD are not aided, the probability of experiencing emotional and social problems (e.g. committing crimes, substance abuse, problems in interpersonal relations, etc.) increases with age.

6. Autism

Defined as a restricted communication and social development, autism is a congenital impairment. It is a developmental disorder which significantly affects the child's normal development from babyhood and early childhood. Autism is a Greek word ("aut" and "ism") and is characterized by excessive daydreaming and introversion. In other words, the autistic locks him up in an isolated world. In autism, speech is delayed or does not develop at all, areas of interest are restricted; the child is more interested in inanimate objects than people; he is not interested in games or does not want to play with his peers; or he exhibits repetitive behaviors. These characteristics facilitate the diagnosis; however, discussions about the reasons, treatment, and educational methods are still continuing. Although it has certain characteristics similar to the childhood schizophrenia, autism, which is a severe form of emotional insulation, can be seen in certain schizophrenias other than the simple type (Geçtan; 1978). Childhood autism was first labeled as "early infantile autism" by Leo Kanner. (Wolff, 1986; Ataman, 2003). The main characteristics of autism are as follows:

1. Eextreme aloneness (failure to build relationships with the environment and individuals),

2. Ppreservation of sameness (no change in their behaviors and environments),
3. Not talking (talking does not serve communication).

Autistics, who live in their inner world, do not interact with people and their environment in a usual way. In other words, this is a universal characteristic of autism. Language is not a means of communication for autistics. They usually do not talk at all. Sometimes they talk excessively. They repeat the words they are told or the words that they accumulate. They have an obsession with a monotonous life, as a result of which they have restricted their behaviors. However, when an external situation breaks this monotony, they demonstrate anger, or experience panic attacks. Autistics admire objects and their ability to act accordingly. Kanner has emphasized that autistics' perception abilities are superior in certain areas (1954). Autism is not considered a mental disorder. In early infantile autism, the child is unsuccessful in building relationships with his environment. The delay and disorder of speech is in the form of echolalia. Behaviors are based on impulses. There are repetitive gestures such as jumping, grabbing and letting go of small objects. The degree of autism may range from mild to severe. There are some autistics who play with their friends, learn how to read and write, acquire social skills appropriate for his age despite their autistic characteristics. They either avoid eye contact or stare directly into one's eyes. These universal characteristic are appropriate to the environments the autistics are in. These are observed in the behaviors in the past repetitively. Repetitive actions of the past conflict with the repetitive actions of the present. This conflicting situation forms the basis of obsessive approach which is seen in certain behaviors. Monotonous situation is only observed in obsessive behaviors.

If a parent does not answer an autistic child's repetitive question or says that he knows the answer because he has given it before, the child may throw tantrums. If the autistic child's behavior is not adjusted to new conditions and is the repetition of the old, his request is understandable. If the child sits at the dinner table and waits silently, this is an indication that he wants to eat. There are certain elements which cause autism and which appear during childhood. Although some autistic children have brain damage, not all of them have a neurological disorder. Environmental stress around autistic children profoundly affects their behaviors. Parents' attitudes also play a major role in autism. However, autism in childhood does not cause schizophrenia in adulthood; similarly, it would be wrong to assume that schizophrenic adults were autistic in their childhood. It is believed that the attitudes of the mother cause schizophrenia in children. This idea has an important place in explaining adult psychosis and infantile autism. The findings regarding the emergence of autism are contradictory. (Neyzi, 1984; Wolff, 1986). The reasons underlying autism can be classified into organic, neurological and biological factors. Genetics, brain functions, immune system factors, birth traumas, childhood stress, separation and unexpected life changes are some of these factors. Although inattentive mother attitude is considered one of these reasons, it does not explain the condition completely. Organic reasons are accepted to be effective in general. The frontal lobe of the brain (the forehead area) controls the individual's behaviors in new situations and environments. It is believed that the differences in the frontal lobes of autistic children are the underlying reason for the repetitive behaviors. Whether the cerebellum in autistic individuals is smaller than normal people, or whether certain parts of the brain stem are smaller or non-existent in autistic individuals, and whether these are related to a HOXA1 gene is being studied. (Ataman, 2003). Abnormal behaviors observed in autistic children are as follows:

(1) Behaviors which lead to insufficient social interaction (indifference, inability to make eye contact, indifference to being called by one's name, tuning out, not playing with one's peers, aloneness, failure to understand others' feelings and thoughts, etc.).

(2) Behaviors which lead to game and communication inability (retardation in speech and language development, not using speech as a means or objective of communication, failure to use or understand body language, failure to create imaginary games and role-play, etc.).

(3) Compulsory behaviors (holding, carrying, turning, watching, smelling solid objects, repetitive behaviors like clapping, rocking, running, turning, being interested in only very limited subjects, insisting on doing things in a certain way, overreacting to changes in or disruption of order, insisting on details, resisting to change, etc.), and

(4) other symptoms (over-sensitivity in one or all of senses (i.e. sight, hearing, touch, taste, smell), insensitivity towards pain, unresponsiveness to wounds, hyperactivity or immobility, insensitivity to dangers, etc.).

Some or most of these symptoms can be observed in autistic children. DSM – IV categorizes autism in the pervasive developmental disorders group, along with mental retardation and specific developmental disorder. The most important characteristic of autism is the delay and difficulty in the acquisition of cognitive, language, social and motor skills. Language and speech skills show differences in autistic children. Those who do not speak at all and who do not use any language or not communicate through signs and facial expressions constitute 50% of the whole autistic population. The other 50% can communicate at varying degrees. However, echolalia is the common characteristic of those that has verbal skills. Echolalia is a behavior in which the child repeats a word he hears immediately or afterwards. Using memorized words and others' repetitive words during communication and not using their own creative sentences are the greatest obstacles before adapting to new situations. For example, if the mother of the child had said "Be careful! You'll spill your meal!" when the child wanted to eat something, he will repeat these phrases whenever he wants to eat. He is unable to express his desire to eat with his own words or sentences. It may not be possible to understand echolalia expressions all the time. When the child says "Close the door", it is difficult to understand which desire this statement refers to. If this sentence is used when the mother left the child alone in his room, then he is expressing the same desire. The child expresses his desire to stay alone with this repetitive sentence. This situation is explained through undeveloped sense of self in autistic children and is accepted to be the underlying reason for "insufficient mental flexibility". They cannot adjust their tone of voice during speech; they talk monotonously; they cannot understand the meaning of the emotional tone of a speech. It was found that autistic children who use language are unable to detect synonyms, metaphors, nuances of meaning. For example they cannot understand the metaphor in "it is raining cats and dogs", which complicates communication for them. The child cannot understand what he hears. The main problems while using the language emerge not in relation to its syntax but to its semantics. Non-verbal communication skills are also underdeveloped. The language is a mere expression of their desires. They are not interested in the language's power of influencing the environment. The subjects they are interested in are limited (birthdays, animals, foods, etc.). Autistic individuals experience problems in building relationships between themselves, their environments and their behaviors and cannot answer open-ended questions such as "what, why, how, when". For example, an autistic who is exhausted from heat and who sits in the bathroom is unable to explain his behavior.

6.1. Social Skills

They cannot understand gestures, mimics, body language and non-verbal messages. They cannot make eye-contact. The autistics who can imitate can acquire social, linguistic and cognitive skills. Their relations with toys are restricted (rocking, turning, being interested only in a single part, etc.) and typical. They frequently play alone and their games consist of repetitive actions.

6.2. Cognitive Skills

Autistic individuals are unable to attend to all features of stimuli. Since they can focus only on one of many features of an object, they may confuse that object with similar ones. If he has not perceived an apple as a whole with its form, smell, taste and color and concentrated on only its yellow color, then he can confuse it with other yellow fruits, such as a pear. Since they concentrate on only one or some of the stimuli, their responses become less and limited as the number of stimuli in the environment increases. If he only focuses on the tone of voice or mimics, he will never grab the meaning of the words or what is wanted of him. In terms of organization of information, since the autistic child only attends to a single aspect of the information, his overall understanding is limited, as a result of which he cannot remember the information as a whole or reorganize it in a way which would allow him to use it again. This characteristic adversely affects the autistic child's ability to develop concepts and interact with his environment. Since autistic children repeat words, they may memorize them. But they find it difficult to remember them without certain clues. In summary, early infantile autism is a developmental disorder in social interaction and verbal or non-verbal communication. The most distinguishing characteristics are repetitive behavior patterns,

medium mental disorder, and excessive resistance towards environmental changes and daily routines. Among pervasive developmental disorders are Rett Syndrome, Asperger Syndrome, PDDNOS (Pervasive Developmental Disorder Not Otherwise Specified), childhood disintegrative disorders (Gleitman, 1992; Ataman, 2003; Pehlivantürk, 2004;).

6.3. Treatments

Various methods have been developed to reduce the symptoms of autism. Pharmacological method (medication) is the most prevalent one. Psychotherapies are also very common. Holding therapy is frequently used. This technique had some positive effects on certain autistic children. It plays an important role in eliminating the disorder or defect in the relationship between the mother and the child. Sensory integration therapy is a model which is carried out on a one-to-one basis with the autistic child and is widely used. Facilitated communication model is used with children with severe communication disorders in order to enable them to communicate at home and school. Even though medical, psychological and pharmacological treatments provide certain improvements in autistic children, they are not sufficient for eliminating autism entirely. There is a consensus that education is the most valid method for meeting the fundamental needs of the autistic child. The disruptive effect of autistic children's behaviors on their learning skills and their fragmented processing of information adversely affect their education. Therefore, it is difficult to evaluate how much an autistic has or has not learned something.

Their educational programs must be designed by considering that autistic children think and express themselves in pictures rather than words, and that they find it difficult to understand long sentences and long verbal expressions. It is important that the educational programs start at an early age. They need to be designed by taking the autistic children's characteristics and needs into consideration. They should also aim at educating them in a school environment with their peers and offering them socialization opportunities. The most important point is that teachers need to know the characteristics of the autistic children very well and not misjudge them as under-motivated, unsuccessful students. Their programs should emphasize social and communication skills. They should be child-centered. They should be based on the imitative behaviors of autistic children. They should incorporate their tendency to observe and imitate the behaviors of their peers, and thus contribute to their acquisition of social skills. Education should be more visual and pictures must be used to this end. Instead of long verbal expressions, written instructions must be used, which help them to learn better. For autistic children who cannot write, short instructions must be used. To this end, they should be encouraged to write, read, draw and paint pictures. Instead of a learning environment which is full of rich stimuli, autistic children need an environment which has fewer stimuli. Learning environments which have numerous equipment and other materials make it very difficult for the autistic children to understand.

In primary schools, autistic children should continue their education in blended classrooms according to a program. In this regard, the autistic child's teachers and peers need to be educated about autism. The behaviors of autistic children may take the teacher and the students by surprise and make their social acceptance more difficult. Autistic children may lack socialization and learning skills due to communication problems. The program should emphasize the acquisition of social skills. Activities which will enable the autistic children to interact with their peers must be planned and implemented. Peer education helps the autistic child to learn easily and to socialize, and allows them to evaluate and reward successful behaviors. Employment of their peers in the program as peer tutors is vital for the autistics socialization and acquisition of communication skills. Teachers need to obtain the support of speech therapists, special education experts and psychologist with regards to in-class and out-of-school social environment behaviors and communication problems. In order to integrate autistic children in the society and make them less dependent, they need to share the same educational environments with their peers. In this regard, they need education programs tailored to their needs. Autism is a psychological problem in children. I would like to discuss other common developmental disorders shortly.

6.4. Rett Syndrome

Although a normal development is observed in the child, his head circumference does not grow enough between five months and four years of age. In addition, loss of manual skills, and repetitive stereotyped hand movements, such as wringing, are observed. Social skills and language development are disrupted at two or three years of age.

6.5. Childhood Disintegrative Disorder

These children display a normal development between the ages of two and four; however, their social, communication, speech and adjustment skill regress severely later.

6.6. Asperger Syndrome

These children have normal intelligence and display a normal development. However, they experience great difficulties in their social interactions and relations. Although their language development is normal, their social communication skills (facial expressions, mimics, gestures, intuitive knowledge, etc.) are insufficient.

7. Sexual Ambiguities and Sexual Identity Problems

Sexual identity is the perception and acceptance of oneself and his/her body within a certain gender (female or male). His/her emotions and behaviors are shaped accordingly. A man perceives and accepts himself as a man with his body and his self; as a result, his instincts, sensations, emotions, behaviors and attitudes are directed towards the opposite sex. This shows that his male sexual identity developed wholly and normally. When sexual identity is developing and gender-specific roles are being acquired, internal and external stimuli develop together. In other words, an individual becomes aware of his or her body starting from childhood and learns the gender-specific behaviors from his/her parents. According to the social learning theory, he will start to learn gender-appropriate behavior patterns from his parents or other parental figures by imitating their behaviors or imitating them. Psychological development and growth is a result of genetics, various behavioral patterns coming from the environment, and the direction of the individual by himself**.** (Pikunas and Albrecht, 1961). During this development process, as the child's identity develops, these imitated behaviors turn into new behavior models which integrate with his identity. Even though the person goes through an identity crisis during puberty, he/she continues to develop his/her sexual roles and identities. In order for an appropriate sexual identity to develop, an appropriate biological development is necessary. However, being a girl or a boy biologically, having normal sexual organs, and proper operation of sexual glands are not sufficient for a healthy sexual identity. Environmental conditions, parental attitudes and features of one's upbringing play an important role in the acquisition of the sexual identity and maturation. Sexual identity crisis may be inevitable for a boy who is raised like a girl. Homosexual attitudes and behaviors can be observed also. Psychological problems which are caused by dissatisfaction with one's sexual identity can make it difficult for an individual to adjust to his/her identity and gender. For a healthy sexual development, the child must identify with the parent of his/her gender and take his or her as a model. Lack of sexual health knowledge (excessive attitudes towards sexual subjects within the family, accusations, controls, not allowing privacy, misinformation, provocative or stimulating behaviors, feelings of guilt or transgression, getting caught red handed, sexual fears, shyness, exaggerated sexual behaviors, sexual perversion, etc.) may result in an unhealthy sexual identity development. (Geçtan; 1978; 1989; 1997; Offer and Subshin; 1984; Uğurel, 1984).

7.1. Sexual ambiguity at birth

In certain situations, the child's sex may be ambiguous at birth. In other words, there might be androgyny, save for certain organ anomalies. In this case, the parents need to take necessary precautions and determine the gender of the child at early age. At puberty, the determination of the gender of the child may cause severe psychological and

emotional problems. Children whose sexual identity is ambiguous are born with genitalia which are not fully developed. Here the family environment is the most important factor in the determination of the sexual identity of the child. In such a case, it is necessary to seek professional medical, psychological and academic assistance. If the parents act quickly, the child's sex will be determined earlier and gender changing problems which might arise in the future will be eliminated at the outset.

8. Anxiety Disorders

Anxiety is an arbitrary and abnormal state of excessive fear which presents with physical symptoms. In anxiety disorder, the individual feels restless and unhappy; he fears that "bad things" may happen any time. However, there is no concrete danger or threat that can substantiate this belief. Fear is a normal emotion which helps the individual to defend himself against possible threats. Therefore, it has a very important function in life. Behaviors which are accompanied by fear and anxiety can be seen in every aspect of life. The situational anxiety of a student who takes a test; continuous anxiety situations which are felt when a target behavior is not achieved and which are accompanied by feelings of personal inadequacy; excitements, nervousness can be considered in this group. Temporary or permanent (acute/chronic) sources of anxiety affect the psychological health of the person adversely. Situations which turn into anxiety disorder require intense reactions. In this case, the individual expresses the anxiety responses of a normal person very frequently and in an exaggerated manner. Their responses not only make life harder for the individual but affect his psychology adversely as well. When anxiety is at a normal level, it protects the individual, motivates him to take precautions, warns him against dangers, and forces him to take action. When it is excessive, it causes "anxiety disorder". In anxiety disorder, the severity and frequency of the situation or the event which causes the anxiety is not proportionate to the intensity of the fear the individual feels. In other words, the intensity of the event which is experienced and the intensity of the fear are very different. The physical symptoms of an anxiety disorder (palpitation, chest pain, tightness, light-headedness, aches and pains, shiver, vertigo, tiredness, fatigue, numbness, blurred vision, shaking, difficulty of swallowing, abdomen pain, nausea, diarrhea, frequent urination, feeling the need to urinate, menstrual problems, perspiration, dry mouth, hot flashes, cold hands, difficulty in breathing, hyperventilation etc.) and the feeling of fear are very exaggerated. A series of disorders whose common characteristic is anxiety has been termed "anxiety disorders". These are separation anxiety, panic disorder, phobias, obsessive-compulsive disorders, post-trauma stress disorder.

8.1. Separation anxiety disorder

This is a type of anxiety an individual experiences as a result of separation from a person to whom the child is attached (e.g. mother or a person who substitutes a mother). The excessive anxiety responses (the fear that the attached person may be hurt, continuous concern regarding the disaster which caused the separation, having frequent separation nightmares, excessive discomfort and physical symptoms, etc.) adversely affect the child's daily life (e.g. not going to school, insomnia, disruption of eating habits, etc.). Separation anxiety can be seen in all children and it may decrease in time. However, in case of an anxiety disorder, these symptoms need to continue at least for two weeks. This is an important diagnostic factor. Separation anxiety is a normal type of anxiety which is observed since infancy. It is a result of the sudden break-up of the positive loving relationship between the baby and the mother (or a mother figure that overtook his upbringing). However, even though this reaction is normal during the development of the child, the separation anxiety the child feels in an attachment process which does not develop normally becomes chronic instead of decreasing in time.

8.2. Neurotic anxiety

This is a condition which develops as result of the perception of dangers originating from instincts. This is a fear concerning the result when the ego fails to prevent the instinctive release response. Defense mechanisms of the ego keep the impulses under control against the conflicts with the society and the situations which cause anxiety. If there

is a disorder in this mechanism, the psychic energy may turn into a primary anxiety observed in the infancy. In order to protect itself from instinctive dangers, the ego may resort to maladaptive defense mechanisms. As a result, neurotic symptoms appear. When subconscious instinctive impulses are brought into consciousness through psychoanalysis, irrational and maladaptive anxiety turns into rational and adaptive reality anxiety. Neurotic anxiety may present itself in three different ways.

8.2.1. Free-floating Anxiety

This is a general state of anxiety which is ready to be connected to a situation which might arise at any time. The individual is always in fear and depressive. Freud describes this situation as "anxiety neurosis".

8.2.2. Phobic anxiety

This anxiety is an intense fear of a certain object or a situation. The intensity of the reaction is disproportionate to the situation which is deemed dangerous. The fears which emerge during adulthood (fear of dark, animals, thunder, height, etc.) usually start in childhood and continue throughout adulthood.

8.2.3. Anxiety attack (panic)

There is no connection between the situation which causes the fear and the reaction given. It may present with independent or specific symptoms in the form of attacks. The state of anxiety is not believable. The neurotic anxiety starts to identify with the reality anxiety as much as the instinctive desires of the individual connected with the external dangers. As a result, the individual starts to fear from his instincts. As long as instinctive discharges are not punished, the individual does not need not to fear. Anxiety which appears as a result of a disorder of the operation of the ego causes a disconnection in the relationship of the individual with the external word (Geçtan, 1978; Feldman, 1996).

8.3. Panic Attack

Panic attacks are periods of intense fear and apprehension that present with physical symptoms. During these attacks, fear of death, of going insane and losing control are experienced intensely. Because of the physical symptoms that accompany them (vertigo, feeling faint, feeling of being out of breath, numbness, prickling, etc.), the individual believes that he will die of heart attack or respiratory insufficiency. As a result, the physical symptoms (palpitation, chest pain) are seen as sings of an impending death. The individual tries to escape from this situation but fails to do so. Fainting may occur during attacks caused by hyperventilation. Difficulty in concentration, speaking, remembering are also observed. Attacks may be frequent (2 or 3 times a day) or seldom (2 or 3 times a year). Attacks reach their peak approximately in 10 minutes. Sometimes they start to clear up suddenly or slowly (within 20-30 minutes). Sometimes these attacks last more than an hour. However, in order to diagnose someone with panic attack, this situation must last at least a month. In addition to medical treatment, behaviorist and cognitive psychotherapies can be used as well. Relaxation and breathing methods and systematic desensitization techniques can be useful.

8.4. Phobias

Excessive fear of or avoidance from things (e.g. situations, activities, objects, etc.) which normally do not cause fear or anxiety. If the child has "white fur" phobia, he will react with an intense anxiety and try to escape when he encounters white a fur (his mother's white fur, a white bearded man, white toy bear, a cloth with white furs, etc.) or sees one in a picture or a film.

8.5. School phobia

Excessive fear of going to school observed in children. When the school time comes, the child cannot go to school because of panic and severe anxiety, or he may experience such feelings at school. This condition presents with various behaviors (crying, yelling, sleeping, finding excuses, getting sick, begging, being over-excited, stomachache, nausea, etc.). After the school time, these symptoms disappear automatically. A feared element at school (a threat, a person, a bad friendship, peer pressure, failure, discipline, etc.) may be the reason of this fear. Another reason might be the child's fear of separation from the mother or his caretaker (separation anxiety). In certain situations (loss of parents, sickness of the child or his parents, death, etc.), the child might have not gone to school for a long time and might have become accustomed to this. It is highly possible to see school phobia under these circumstances. After staying at home for a long time, the fear of adapting to school may cause the child to refuse to go to school. The school phobia should not be confused with temporary separation anxiety which appears when a child first starts to school and is separated from his mother. School phobia is when a child cannot learn the skills which would enable him to eliminate the psychological obstructions before going to school and adapting to school environment and when these symptoms aggravate in time. It is normal when a parent accompanies the child at the school garden or even in the classroom for a few weeks when the school is opened. This helps him to get used to school and adapt to it. In case of a phobia, however, the condition aggravates in time instead of decreasing and becomes permanent.

8.6. Specific Phobia

A prominent and nonsensical fear of an object, situation or fact. The individual fears that the object of fear will harm him in some way. For example, he may avoid travelling in a car for fear that he might die in an accident. When the individual encounters feared object, he feels severe panic and exhibits escape behavior. When it is not possible to escape the situation, the individual feels excessive distress and his life is affected adversely. The fundamental characteristic of a specific phobia is the individual's inability to endure to this troublesome situation. The person is aware of the absurdity of the situation; however, the proximity of the feared object, the intensity of the fear, and the existence of the possibility of escaping determine whether they affect the social and professional life of the individual or not. When they do, people exaggerate the fear so that it becomes possible to diagnose the person with it. There are many types of specific phobias: (1) Situational type: It is frequently seen in childhood and late puberty (e.g. using means of mass transportation, bridges, tunnels, planes, elevators, cars, etc.) (2) Natural environment type: Fear of natural conditions and phenomena which start at childhood (e.g. storm, water, flood, height, etc.) (3) blood-wound-injection type: fear of medical interventions (e.g. blood, injection, wound, medical operations, etc.) This is frequently observed in patients. It may cause fainting, avoidance and deterioration of health. (4) Animal type: Fear of animals or insects which start during childhood. (5) Other type: The individual fears situations, events and objects (feeling out of breath, drowning, vomiting, getting sick, loud sounds, legendary characters, etc.) which he believes that can hurt him. This sort of phobia can appear as a result of an experience of the individual which poses a danger. For example, if a person who is interested in hunting and who lives a life or death situation with a wild animal is later saved, he may not want to experience such a situation again and give up hunting. Another person who hears this story may develop the same specific phobia as well. Specific phobias which are observed in women can vary from culture to culture. Phobias are generally psychological disorders and must be treated. Psychological treatment continues until the feared object or situation no longer elicits the emotion. When necessary (during depression and panic attacks) medication may be prescribed.

8.7. Social Phobia

It is the fear of being assessed negatively by others (as someone weak, crazy, problematic, passive, etc.). As a result, the individual avoids social activities at all times. The activities that cannot be avoided are difficult to endure. Even though the person is aware of the irrationality of his fear, he cannot help it. Sometimes this stress can turn into

a panic attack. The fear (shaky hands, palpitation, quavering, panic, flushing, excitement, etc.) individuals feel in situations which require communication with the public (e.g. public speaking, reading, writing, eating, drinking, meetings, joint activities, etc.) results in lowered self-esteem, failure to defend oneself, inferiority complex and failures at social roles, statuses, duties and responsibilities. Social phobia which starts at early an age and which is observed from time to time in adulthood may have been caused by a social trauma the individual experienced. A stressful event which humiliates the individual can result in such a phobia. Such a phobia needs to be treated. As with the other types of phobias, its treatment may require psychological support and medication.

8.8. Obsessive-compulsive disorder (OCD)

Feelings, thoughts, impulses, imaginations which fill the consciousness of an individual involuntarily and which disturb him are called obsessions. Mental actions and behaviors which are repeated to reduce the anxiety caused by the obsessions are called compulsion. Obsessions and compulsions force the individual to lose time. Even though the person is aware of the fact that obsessions are exaggerated, meaningless and irrational, this awareness appears at different levels. For example, he may be aware that repetitive washing of hands (i.e. the obsession that he might get sick because of the microbes in dirty hands) is an irrational thought. However, he might be undecided about his irrational thoughts in certain situations. He might make rational explanations when these thoughts turn into actions. He might want to neutralize these disturbing and irrational thoughts via other thoughts and actions. But this causes a compulsion to develop. The most common compulsions are washing, cleaning, counting, controlling, and ordering. The obsessive and compulsive situation prevents a person from concentrating on something. As a result, he fails at cognitive actions. In this disorder, the person may exhibit certain symptoms like sleep irregularity, hypochondria, alcohol consumption, substance abuse, feelings of guilt. OCD may be mild during puberty and young adulthood. A sudden onset of OCD may be caused by a traumatic event, or it might be learned. In addition, genetics and biological elements also play a role in OCD. Medical and psychological treatments must be used to rehabilitate this disorder (Çağlar, 1981; Feldman, 1996; Palladino, 1998; TC.Başbakanlık Ö.İ. Bşk., 2008).

8.9. Post-trauma stress disorder (PTSD)

These are symptoms which develop in the face of situations that threaten the individual's life and integration of his body (e.g. fire, accidents, conflicts, rape, earthquake, etc.). Persons who experience or witness such a frightening and painful events feel helplessness, fear, horror which they cannot cope with successfully. This disorder appears in proportion to the severity of the incident and its closeness to the individual. The possibility of the disorder increases in relation to the severity, duration and closeness of the trauma to the person. Not being supported by the family or society, personality disorders or disorders which manifest clinical symptoms may cause PTSD. The types of reactions observed in PTSD are as follows:

(1) Reliving the incident again and again; the individual may experience attacks when he remembers the event or has dreams about it which last a few seconds or hours. When the individual experiences a similar event, or remembers a part or aspect of it, he may experience intense emotions and give physiological reactions.

(2) A general unresponsiveness; The individual avoids stimuli which cause the trauma (e.g. talking about the trauma, activities or persons related with the trauma, the location and conditions of the trauma). The inner impulses decrease. He avoids human relations, loses interest in friendship, sexuality, love, etc. He feels that he has no future.

(3) Over-stimulation; The person is more stressed and depressed in comparison to his previous state. The person exhibits inability to perform routine activities (difficulty in falling asleep, insomnia, irrigation, tantrums, distraction, inefficiency, anxiety, etc.) and weakness.

If the person survived the event which causes the PTSD, he may have feelings of guilt towards those who could not (Feldman, 1996). Since he avoids all kinds of stimuli which may remind the traumatic event, he may have problems in social life, family relations and business life. He may feel shame, sadness, anger, worthless and have low self-esteem. They may be socially isolated, and changes may be observed in their personalities and attitudes.

During supportive therapies, the person should not be allowed to deny the event. He should be encouraged to accept the trauma and express his feelings, to make plans for the future with the support of his family and friends.

9. Schizophrenia

This is a cognitive disorder which affects the individual's ability to understand and conceive the reality, to control his emotions, to judge and to communicate. The fundamental characteristic of schizophrenia is that it is a disorder of the thoughts, perceptions and emotions of the individual. The person may have hallucinations: he may hear voices or have thoughts that command, insult or threaten him or make comments about him; he may act according to those commands and visions which he has when he is awake, etc. He may see imaginary objects that others do not see or hear sounds that others do not hear. He may be unable to adapt to social rules, exhibit aimlessness, strange attitudes, behaviors, and facial expressions and gestures. In a schizophrenic patient, self-care skills (e.g. showering, combing the hair, shaving, cutting nails, brushing teeth, etc.) are insufficient and performed carelessly. He is inattentive about dressing and hygiene. His dressing style is extraordinary and disregards time, space, season or situation. He may have facial expressions which accompany feelings of indifference to the environment, anxiety, anger or sadness, or he may have a totally dull facial expression. His speech may be hesitating, disconnected, very detailed, wandering, irrational, and unintelligible. He might be isolated from the society, and tend to stay alone, or he might be dependent on his relatives. Nonsense and pointless behaviors (e.g. staying still for a long time, staring at a point, staying in the same position for a long time, etc.) may be observed. He may have irrational behaviors based on the fear that others will harm him or his relatives (e.g. that he is being watched or will be poisoned). He may believe that he has supernatural powers that will overcome evil, that he has gifts, that he is the chosen one, etc.. Schizophrenics believe that communication means such as the press, radio and TV communicate with them (e.g. that they read their minds, that their thoughts are stolen, that they are sent messages via them, that they broadcast messages for them, etc.).

They may also believe that the borders between their bodies and the external world vanish (out of body experiences, changing of some organs, disappearance of some organs, etc.). Presence of a few symptoms may not be sufficient for schizophrenia diagnosis. Symptoms may be discontinuous or severe. Support of a psychiatrist must be sought for treatment. Although there is no single factor that causes schizophrenia, it is believed that genetic, biological, environmental, psychological and social factors are involved. Even though genetic factors cause a predisposition, it is not true that children of schizophrenics will have the same condition. There might be some experiences that trigger schizophrenia (getting beaten up a lot, being forced to work uninterruptedly, excessive suffering, blind love, death, separation, etc.). They both need pharmacological treatment and psychological support. Schizophrenic individuals may be isolated from the society, but some of them manage to continue their social relationships and their professional activities. They may have feelings of guilt because of their behaviors which they believe was wrong. They may also have feelings of shame because they believe that their behaviors are misunderstood by their environment. Both psychological and social approaches and medical methods should be employed during the treatment of schizophrenia. Any confusion in the thought and belief of the individual may cause depression. This may cause the individual to become introverted (e.g. avoiding human relations, not trusting anyone, minimizing human relations, maladjustment, loss of skills and abilities, failure to work, unemployment, etc.). Through rehabilitation, this incapacity may be eliminated, and the person might gain more experience. It is necessary to regulate the person's relations with the environment. Schizophrenic reactions are categorized into three groups:

1. Simple schizophrenia,

2. Hebephrenic schizophrenia and regression, and

3. Paranoid schizophrenia.

Emotional insulation and solitude is a method for minimizing one's emotional reaction area and protecting oneself against getting hurt. Emotional insulation may present itself as (1) a precaution against the influence of others on the individual's internal and external needs, or (2) an intellectualization mechanism of the individual. In the former category, the individual tends towards neurotic hoarding (i.e. collecting, accumulating things or money, etc.) in order to be independent. He saves things meticulously against events which might happen in the future. The latter category, on the other hand, is the endeavor to avoid from emotional responses which he will give to painful events through intellectualization. Such an emotional insulation mechanism is frequently used in certain schizophrenia types. Simple schizophrenia is characterized by closing oneself to the external world which causes anxiety, tendency to daydream, develops slowly and progressively. It presents with disinterest to the environment after puberty, a decrease in relations and school performance. He does not make any effort regarding working or taking any responsibility. His face becomes expressionless, meaningless and dull due to increasing poverty of ideas. Due to the deterioration in his abstract thinking abilities, he speaks very little and finishes his words quickly. Advanced dissolution and deterioration is not observed in his psychological functions save for infrequent attacks of violence. Although there might be intellectual and emotional closure, such delusions are very rare. Autism, which is a severe form of emotional insulation, may be observed in some schizophrenics. In catatony, which is a form of schizophrenia that develops more dramatically, autism may be observed more severely than in simple schizophrenia.

When one of the introversion and expression periods dominate the other, a phenomenon called catatonic stupor is observed in which the individual loses all of its autistic activities and where he preserves the same posture for hours or days, just like a statute. His looks are empty, and his face is expressionless. In this state, the bodily needs of the individual (e.g. eating, clothing, excretion, etc.) must be met. Since volition is totally lost, the person does not move. There are two reactions in catatonic stupor. (1) The individual is prone to suggestion and performs directives given to him automatically. He repeats the actions and words of the person opposite him without understanding them. He preserves the position of the arms and legs which are given to them. This is called wax elasticity (flexibitas cerea). (2) The individual resists to external stimuli. He does not do what he is told, does not speak, and resists to any attempt to change the position of his body. Catatonic stupor may sometimes turn into catatonic stimulation (walking briskly, disconnected talking, shouting, sexual activities in a crowd, violence, maiming, killing, suicide. In Hebephrenic schizophrenia, ego has disintegrated very quickly and severely. This type of schizophrenia which presents with attitudes different from other people starts at childhood. It is characterized by not participating in games, propensity to daydream, interest in religion and philosophy, emotional obtusion, and childish reactions (e.g. laughing for no reason, irrational answers to questions, repeating similar words, disconnected talking, nonsensical gestures, "mannerisms", talking to oneself, laughing and subsequent crying for no reason, interest in excrement and urine, complete lack of feelings of shame, exhibitionism, tantrums, violence, and delusions) With delusions (e.g. religious, sexual, disease, being watched, self-provoking sounds, etc.), the individual is trying to escape the difficulties of the adult life through regression. (An example: A Hebephrenic schizophrenic is with his doctor. Doctor: "Tell me how you feel" Patient: "London's bell rings for a long time, long, dot. Hah-ha! (uncontrolled laughter); Doctor: "Do you know where you are now?" Patient: "I am a Queen" (loud laughter), look at my magic, I will turn you until eternity…" etc.).

Paranoid schizophrenia develops after passing through certain stages. Difficulties in human relations and skepticism are the most significant symptoms. The delusions of "being mentioned" come along with suspicion. The individual tries to express the difference which he feels inside and which he cannot explain through the clues which he assumes that come from the environment. He believes a word which he heard was about him. He thinks that his inadequacies are talked about by others. He may have delusions of irrational beliefs about being chased (e.g. believing that he is being followed or watched), labeling delusions (e.g. believing that a wrong telephone call is sign that he is being checked upon) and delusions of grandiose (believing that he is a world famous scientist or an explorer). In this type of schizophrenia, the delusions of grandiose (e.g. "I am Napoleon, I am God, etc.) are in the form of receiving orders from historical figures, from space, or from God. Sirhan B. Sirhan, who assassinated Senator Robert F. Kennedy was diagnosed as paranoid schizophrenic (Haber and Runyon,1978). A section of a psychotherapy session will demonstrate this disorder better (Doctor: "What is your name?" Patient:" Who are you?" Doctor: "I am the doctor, who are you?" Patient: "I cannot tell you who I am." Doctor: "Why can't you tell it?"

Patient: "You would not believe me." "Doctor: "What are you doing here?" Patient: "I am here to stop the Russians." Doctor: "What will you do to stop the Russians?" Patient: "I'm organizing." Doctor: "Who are you organizing?" Patient: "Everyone … I'm going to use my own Atom Bomb." Doctor: "Then you are a very important person!" Patient: "Indeed. Without any doubt." Doctor: "What is your name?" Patient: "You know me as Franklin D. Roosevelt." Doctor: "Didn't he die?" Patient: "I'm sure he did. But I am alive." Doctor: "But you said you were Franklin D. Roosevelt?" Patient: "I am his spirit. Roosevelt, God and I … It all formed outside this, and look how I compete with healthy people!.... Who are you?" Doctor: "I am a doctor here." Patient: "You do not look like a doctor. You look like a Russian to me." Doctor: "How can you tell that one of your agents is a Russian?" Patient: "I can read it in his eyes. You can see all of my signs from eyes. I look into your eyes and I get all my signs from them." Doctor: "Do you receive any sound from a Russian?" Patient: "No. I look directly into the eyes. I bought a mirror to look into my own eyes. I can tell it with colors, in the form of a road." Doctor: "Did you have any problems with people before coming here?" Patient: "Well. Only with Russians. They were trying to besiege me. When they were running from fire, they tried to throw a bomb at me." Doctor: "How can you tell that it was a bomb?" Patient: "I knew it. I was aware of it." (Haber and Runyon,1978; Geçtan, 1978; Gleitman, 1992; Feldman, 1996).

10. Dementia

This is a progressive disorder which causes the individual to lose cognitive and social skills to the extent that he cannot perform his routine tasks. Inadequacies and disorders are observed in certain cognitive functions (e.g. reading, writing, speaking, remembering, recording something in the memory, thinking, reasoning, concept of time and space, understanding what is being read, performing routine tasks, etc.). Progressive dementia may render the person incapable of performing his daily tasks (e.g. eating and drinking, showering, going to the toilet, etc.). The slowing down of cognitive faculties as a result of normal aging process is different from dementia (failure to perform daily tasks without help although there is no physical disorder). Older people, women, the undereducated, and people with continuous conditions (e.g. high blood pressure, diabetes, heart disease, etc.) are more susceptible to dementia. Genetics is another important risk factor. People who suffer head trauma are at more risk. Although dementia is characterized by forgetfulness, not every forgetfulness can be diagnosed dementia. Dementia can be mild, medium or severe. In mild dementia (i.e. difficulty in remembering recent events, facts or conversations, confusing times and locations, inability to think reasonably, indecisiveness, inability to understand what is being read, inability to perform tasks regularly, disinterest in one's routine works, difficulty in continuing social relations, etc.); medium dementia (prominent forgetfulness, dangers in living alone, insufficiency of self-care skills, negligence in household and family responsibilities, untidiness and neglect and carelessness in clothing, getting lost outside the house, confusing locations, abnormal behaviors, inability to remember names and numbers, confusing information about friends and relatives, etc.); severe dementia (the severity of symptoms increases, inability to perform daily tasks, to recognize friends and relatives, to find one's home, talking nonsense, enuresis and encopresis, requiring continuous care, etc.). As this severe condition progresses, the individual becomes totally bed-ridden and dependent on as caretaker. It becomes highly possible to lose the patient of an illness or dementia.

11. Substance Addiction

This is the abuse of addictive substances (alcohol, drugs and narcotics) in a manner which disrupts the adjustment of the individual and the emergence of physiological and psychological symptoms within a year. In physical addiction, the tolerance (increasing the dose of the substance to feel its effects and to tolerate this high dosage) and withdrawal syndrome (sudden cessation of the substance, and emergence of physical symptoms within the tolerance and withdrawal cycle) are the fundamental characteristics of physical addiction. Psychological addiction, on the other hand, is the desire to use the substance even though the individual is aware of its harms. The person may have an attack if he feels an irrepressible desire to find the discontinued substance in order for him to feel better and to function in the society. There are certain factors which facilitate substance addiction: (1) Characteristics of the

substance; narcotics generally lead to relaxation and euphoria; the individual who tries them a few times may want to use them again and in greater quantities. As a result, the substance can cause addiction in a short time. Substance addiction can become a habit more easily in individuals who have social and emotional problems. (2) Individual characteristics and personality; individuals who want to use the substance which gives them the feeling that they are free from adjustment problems, from real life and the troubles which come with it have usually the following characteristics: psychological and emotional instability, maladjustment, addictive personality, weakness in the face of conflicts and obstructions, aggressiveness and impulsive behaviors, emotional immaturity, childish personality, tendency towards sexual problems and perversion, people who conflict with the society and who are misfits, individuals who have difficulty in abiding by social, legal, conventional and moral rules, individuals who frequently conflict with laws. (3) Today, substance addiction can be seen in every society, country and individuals of all ages. Environmental factors are very important both in the family and external environments when individuals feel weak physiologically or psychologically (psychological and emotional problems of individuals, diseases, lack of communication, unsatisfied emotions, stress and pressure, difficult and conflicting living conditions, too rigid or too flexible cultural values in a society, attitudes of the parents, influence of the peers or friends, solitude, dependency/independency conflict, pretension, getting deceived or convinced, search for adventure, trying new things, inability to cope with one's problems, etc.) (Palladino,1997; Feldman, 1996).

12. Mood Disorders

Emotional fluctuations of a normal individual (unhappiness, despair, sadness, grief, boredom, pessimism, etc.) do not hinder the normal flow of his life. In mood disorders, emotional disorders make it very difficult to continue with one's life. The most prevalent form of mood disorders is depression.

12.1. Depression

Depression can be multifaceted (physiological, emotional, cognitive and behavioral). Its main characteristic is a depressed mood. The person in depression generally has negative emotions (e.g. he is unhappy, sad, cheerless, pessimistic, hopeless, alone, etc.) and thoughts. His interest in himself and his environment is diminished. He cries for no obvious reason or experiences intense emotions (guilt, restlessness, tension, anger, suspicion, anxiety, worry, bad temper, etc.). In certain situations, he experiences apathy (e.g. inability to cry, to affiliate, to feel anger, etc.). He may be in a negative or positive mood (e.g. lively, joyful, happy) based on the intensity of these emotions. Symptoms of depression are as follows:

12.1.1. Emotional

The most common emotion is deep and painful sadness. They do not enjoy life because they lose interest in it. Life has lost its meaning in a depressed person.

12.1.2. Physical

Physical changes observed in the individuals bodily functions (not eating, overeating, excessive loss of weight or becoming overweight, gastrointestinal problems, insomnia, inability to fall asleep, disruption of sleep, waking up too early or too late, weakness, fatigue, headaches, backaches, other painful situations, lack of sexual drive, avoiding social contact, hypochondria, etc.) reinforce the belief that he has a physical condition.

12.1.3. Behavioral

Behavioral his actions (e.g. speech, walking, working) slow down. Since their energy level is down, they get tired very easily. Daily routines are difficult for them; as a result they either do not do them or spend plenty of time and energy to complete them. On the other hand, some people may exhibit psychomotor agitation and restlessness due to increased speed. Since hyperactivity creates stress, the person may have anxiety attacks. They cannot relax and sit still; as a result, they are always in negative and mixed feelings.

12.1.4. Cognitive

Negative thoughts (suicide, guilt, despair, unhappiness, desperation, forgetfulness, difficulty in concentration, indecisiveness, etc.) cause the person to see himself, his environment and his future in a negative light. The changes in his thoughts (feelings of guilt because he does not perform his responsibilities, thinking that he is a burden on others, exaggerating the negative aspect of things, believing that nothing will change for better in the future, etc.) result in deeper negative emotions.

Factors that cause depression are as follows: (1) Biological factors. Genetic anomalies affect the hormone balance of the brain and cause depression. It is believed that hormones play a major role in depression. There are findings which indicate that women are more prone to depression before and during menstruation, after giving birth, and during menopause. Depression may be observed based on seasonal changes. The shortening of days during autumn and spring may also trigger depression. (2) Psychological-social factors; The person may be depressed because of the difficulty he experiences when coping with the problems in his social environment (family problems, economic problems, conflicts and frustrations in business life, non-satisfaction with work, loss of a loved person, unemployment, loss of property, becoming sick, being offended, humiliation, rejection, disappointments and failures which cause feelings of worthlessness, lack of social and psychological support, etc.). Depression is first initiated by a vital event. The subsequent attacks follow this event. Physical and psychological predisposition also aggravates this condition. Personality traits have a defining role in depression. People with certain personality traits (e.g. taking too much responsibility, selfishness, scrupulousness, insecurity, being easily blamed, too kind to everyone, trying to make everyone happy, benevolent, sensitive, strong sense of responsibility, attachment to close ones, commitment and indulgence, having high expectations of oneself and others, perfectionist, honorable, people who repress anger, affected easily, become sad frequently, curious, inquisitive; vital events, repressions, being offended, unrealized expectations, frustrations, inability to say no to others, having a giving personality, feeling downtrodden, being beaten, resigned, having lost one's source of satisfaction and adjustment, etc.) and people who have experienced certain important event become depressed more easily.

Relationship between depression and mourning*:* Mourning people may exhibit symptoms of depression; however, if this period is extended, the person may lapse into depression. The mourning person is in psychological and physical pain because of the loss of a loved person or object. As a result, he severs his ties with the outside world and focuses on the lost person or thing, and satisfies his feelings of having the lost person. This situation continues for a while, and then the person goes back to his former life. In a depressed person, the loss may be imaginary. The reality in mourning may not be present in depression. The depressed person may be living the losses which originate from the attitudes of his parents in his childhood on an imaginary level. The difference between the loss in the thoughts and the real loss differentiates mourning from depression. Relationship of depression with changes of life: Life events which occur between the ages of 40 and 60 (illness, retirement, children leaving the house, delayed marital satisfaction, conflicts, bodily changes, getting old, end of fertility, reduction in hormones, dissatisfaction in professional life, etc.) make people depressed. Situations and emotions like trying to satisfy inexperienced feelings, the fact that the lost time will not allow one to realize the desired goals, the impending death, etc. may cause depressive feelings. If the individual feels intense sadness in the face of this reality, he may succumb to depression. (3) Cognitive factors; the person may have a negative view of himself. He always sees the down side of things and disregards the positive aspects. This causes sadness, anxiety and boredom. They are unable to see their habit of making a negative judgment about everything. The chain of unhappy events in their childhood reveals themselves in every negative life event. Believing that he is not a loved person in his marriage or in his business life, or that the future is dark and that life means nothing, he may be depressed. The negative perception and thinking style must be turned into a positive one. Even the severe depression is a treatable condition. Psychological support and pharmaceuticals are used to treat patient. (TC.Başbakanlık Ö.İ.Bşk., 2008; Geçtan, 1978; Haber and Runyon, 1978).

References

Amerikan Psikiyatri Derneği, (1994). *DSM IV* (translated by F. Köroğlu), Ankara: Hekimler Yayın Birliği.

Ankara Valiliği (2010). *Özürlü Hakları*. Ankara: Taşkın Matbaacılık.

Ataman, A. (2003). *Özel Eğitime Giriş*. Ankara: Gündüz Eğitim and Yayıncılık.

Aysev, S.A. (2001). *Dikkat Eksikliği Hiperaktivite Bozukluğu ve Özgül Öğrenme Güçlüğü*. Ankara: A.Ü.Basımevi.

Başaran, İ.E. (1974). *Modern Eğitim Psikolojik Temelleri*, 4. Basım, Ankara: Gül Yayınevi,

Çağlar, D. (1981). *Uyumsuz Çocuklar ve Eğitimi*. II.Baskı. Ankara:A.Ü.Basımevi.

Enç, M., D. Çağlar, Y. Özsoy. (1975). *Özel Eğitime Giriş*. Ankara: A.Ü.Yayınları No.49. Kalite Matbaası.

Feldman, R.S. (1996). *Understanding Psychology* IV.Baskı. New York:McGraw-Hill, Inc.

Geçtan, E. (1978). *Çağdaş İnsanda Normal Dışı Davranışlar*. Ankara: A.Ü.Yayınları Na.69.

Geçtan, E, (1997). *İnsan Olmak*, İstanbul: Remzi Kitabevi , 18. Basım, Mayıs

Geçtan, E, (1989). *Çağdaş Yaşam ve Normaldışı Davranışlar*, İstanbul:Remzi Kitabevi, 7. Basım,

Gleitman, H. (1992). *Basic Psychology*. III.Baskı. New Yok: W.W.Norton and Company.

Haber, A. ve R.P.Runyon. (1978). *Fundamental of Psychology*. II.Baskı. USA:Addison- Wesley Publishing Company, Inc.

Hallahan, D. P. ve J.M. Kaufman (1978). *Exceptional Children: Introduction to Special Education.* Englewood Cliffs, N.J: Prentice-Hall.

Hunkins, F.P. ve J. Jeter, P.Maxey. (1982). *Social Studies in the Elementary Schools. Columbus*, Ohio: Charles E. Merrill Publishing Co.

Köknel, Ö. (1990) *Korkular Takıntılar Saplantılar*, İstanbul: Altın Kitaplar Yayınevi - Basımevi, 1. Basım

Kanner, L., (1954). *Erken Bebeklik Otizminin Hangi Dereceye Kadar Yapısal Uyumsuzluklardan Kaynaklandığı Söylenebilir*?.Research Publications of Association for Research into Nervous and Mental Diseases,

Kurç, G. (1989). *Bazı Kişisel, Sosyo-Ekonomik Ve Kültürel Değişkenlerin Lise Öğrencilerinin Uyum Alanları ve Uyum Yönlerine Etkisi*, Unpublished Doctorate Dissertattion, Ankara: Hacettepe Üniversitesi

Meyen, E. (1982). *Exceptional Children in Today's School*. Denver, Colorado: Love Publishing Company.

Neyzi, O. ve ark., (1984) *Çocuk Sağlığı ve Hastalıkları*, Cilt 3, İstanbul: Bayda Basım-Yayın-Dağıtım A.Ş,

Offer, D. Ve M. Sabshin. (1984). *Normality and the Life Cycle*. New York: Basic Boks, Inc., Publishers.

Palladino, J.J. (1998). *The Annual Editions Series*. USA: McGraw-Hill Companies.

Pehlivantürk, B. (2004). Otistik Bozukluğu Olan Çocuklarda Bağlanma. *Türk Psikiyatri Dergisi, 15*(1):56-63.

Pikunas, J. ve E.J .Albrecht. (1961). *Psychology of Human Development*. New York: McGraw-Hill Book Company, Inc.

TC. Başbakanlık, Özürlüler İdaresi Başkanlığı. (2008). *Ruhsal ve Duygusal Özürlüler*. Ankara: Mattek Matbaacılık.

Uğurel, R. (1984). *Gençlik Psikolojisi*, İstanbul: İstanbul Üniversitesi Edebiyat Fakültesi Yayınları- No: 2677, Acar Matbaacılık Tesisleri, 2. Baskı,

Wolff, S. (1986). *Problem Çocuklar ve Tedavi*. Çev:A.Oral ve S.Kara. İstanbul:Say Kitap Pazarlama ve Dağıtım.

Yavuzer, H, (1994). *Çocuk ve Suç*, İstanbul: Remzi Kitabevi, 7. Basım,

Yavuzer, H, (1995). *Ana-Baba ve Çocuk*, İstanbul: Remzi Kitabevi, 8.Basım,

Zulliger, H. (1996). *Çocukta Ruhsal Bozukluklar ve Tedavisi* Çev: Kamuran Şipal (2. Basım), Cem Yayınevi.