PARENTING STYLES

Authoritarian
- fixed/inflexible right + wrong
  - Blind + Total obedience
  - Dictatorial + controlling
  - Rarely allow discussion
  - Punish/threaten

Results
- Moody, inhibited
- Less creative, self-reliant and mature
- Shy, lacking self-confidence and negative attitude to parents
- Rebellious

Permissive
- tolerant, non-controlling/threatening
  - Overprotective or uninvolved
  - Rarely make demands and set few limits
  - Don’t question adolescent’s decisions/desires/behaviour
  - Allow adolescents to make own decisions

Results
- Feel vulnerable
- Not mature to use freedom
- Uncertainty and unable to make decisions
- Selfish and lack of social responsibility
- Exhibit socially unacceptable behaviour eg. Drugs
- Reproach parents
- Happier than authoritarian children

Authoritative
- Clear limits + rules
- Discuss rules, views+ encourage communication
- Help adolescents understand reasoning behind acceptable/non behaviour
- Sensitive and understanding to needs/emotions
- Demanding + nurturing
- Good behaviour is demonstrated through example + discussion

Results
- Confident, responsible and independent
- State views confidently because they are sure of respect from parents
- Positive opinions of parents and their relationships
Independence

3 objectives pursued:
- Behavioural autonomy - own decisions
- Emotional autonomy – self reliant + responsible
- Moral/value autonomy – own value system

Conflict between adolescents and their parents

Generally positive relationship. View fathers as wise/reliable and mothers as understanding/sympathetic. Conflict typically over trivial matters.

Causes of conflict/stress:
- Biological changes
- Emergence of adult sexuality
- Need for independence
- Search for identity
- Parents own midlife crisis
- Parents fight for control
- Transformation of family interaction

RELATIONSHIPS WITH SIBLINGS

Not usually always good/bad. Main source of conflict is rivalry between same gender close in age. First borns typically authoritarian. Children with an elder brother are usually more aggressive. An elder sister is usually nurturing.

Causes of conflict between siblings:
- Words
- Wearing others clothing
- Teasing
- Invasion of privacy
- Possessions
- Parent’s pet
- Duties/chores
- Embarrassment in front of friends
- Name-calling
- Conflict over privileges

RELATIONSHIPS WITH OTHER RELATIVES

Grandparents provide a link between past and present and can be a source of advice when children are in conflict with parents. A positive relationships will impact how adolescents view the elderly. Grandparents can have a negative impact if they get too involved or interfere with parents or take the side of the adolescent.
RELATIONSHIPS WITH EDUCATORS + OTHER ADULTS
An educator can be an excellent role model and have a significant impact on a child’s life if the relationship is personal and communication deep. However, this relationship must be handled carefully because admiration of a teacher can lead to a crush. In addition, adolescents are very effective at undermining the authority of a teacher or being highly critical.

RELATIONSHIPS WITH THE PEER GROUP
Functions of the peer group:

- **Emancipation.** The peer group provides a bridge to gain independence for their parents, a stage where they must stand on their own two feet and a safe base to grow away from home.
- **Search for individual identity.** Adolescents must loosen ties with parents and prove themselves as individuals by demonstrating their abilities. They attain self-knowledge, insight and self-evaluation in the group.
- **Social acceptability and support.** Practice social skills, form close friendships and communicate with members of the opposite sex. The group’s acceptance is often in stark contrast with their parents’ criticism.
- **The peer group as a reference + experimentation base.** Adolescents try new things and see group’s feedback. Can also assess their values against their peers.
- **Competition.** Find out what they are capable of in comparison with others
- **Social mobility.** Interaction with those from all different walks of life and become acquainted through church/sport etc.
- **Recreation.** Almost all of their leisure time spent with peers.
- **Conformity.** The search for acceptance leads to conformity. This can be positive if the peer group represents good values, but can also be very negative. In dysfunctional families, children are more likely to crave acceptance and conformity in the wake of the vacuum left by their parents.

FRIENDS
Adolescents spend a lot of time with their friends. During early adolescent these friendships are quite superficial, becoming more intense during mid-adolescence. In late adolescence a teen’s identity has formed so they are less reliant on friends and thus have a more relaxed relationship.

HETEROSEXUAL RELATIONSHIPS
Initially these relationships are clumsy and childish, characterized by teasing and mock anger. Later on they focus on being calm and good conversationalists. Romantic relationships can not just be explained away as ‘puppy love’ and can have big effects emotionally and in the risk of teenage pregnancy and STDs.
SELF CONCEPT
: cognitive aspects of the self-schema. Who am I?

Characteristics

- Complex. Comprises physical, personal, family, social, moral
- Dynamic. It constantly changes based on negative or positive situations. It can also influence the way in which a circumstance is viewed.
- Organized. Those things that are closest to who we really are, are more difficult to change than the things that are less important. Every concept also has either a negative or positive value. If an adolescent’s appearance is of paramount importance to her, a bad hair day will have a far bigger impact on her self-concept than a low test score which is personally not as important.

According to Marsch the self concept is multi-faceted. He breaks it down into a hierarchy of lower- and higher level concepts. Physical appearance and ability are two components of lower level concepts. General self-concept is found at the highest level.

SELF ESTEEM. Self-esteem is the value that people place on the selves they perceive. Self-esteem is not complex but is formed in layers. It gives dignity to human existence. Self-esteem influences social relationships, Emotional well-being and achievement. Positive self-esteem + concept can be encouraged through warmth, concern and interest. Also, children of authoritative parents are more likely to have a high self-esteem. The quality of parent-child relationships have a big influence on this too.

Teachers can also encourage positive self-esteem through valuing and accepting all learners; making standards of evaluation clear; encouraging them to compete against themselves; model appropriate methods of self-criticism and reward.

Self-concept influenced by:
- Socio-economic status (SES)
- Physical disabilities

A positive self-regard has the following characteristics:
- Responsibility
- Honesty, integrity + congruence
- Personal growth
- Positive attitude
- Expression of feelings
- Risk-taking
- Acceptance of praise
- Trust in themselves + others

A low self-concept is characterized by:
- Being less original + showing less initiative
- Feeling worthless
- Not trying hard to overcome problems
- Not trying as hard or giving up
SELF-ACTUALIZATION
One's deliberate efforts to realize all the latent possibilities of one's self. Physical, mental, affective experience + moral conscience. Self-actualizing people are able to be overjoyed and in despair; involved in their own problems + others; realistic self-concept + accept themselves; accept their faults which do not affect their self-worth; systematic + well-conceived value system.

PERSONALITY
the dynamic organization within the individual of those psychophysical systems that determine his unique adjustment to his environment. Allport.
the stable characteristics of a person, including abilities, talents, habits, preferences, weaknesses, moral attributes and a number of important qualities that vary from one person to another. Lefrancois

Personality encompasses the whole being + is the chief domain of one's development

TEMPERAMENT
Relatively consistent, basic disposition inherent in people. Consists of 3 traits:

- Emotionality. Intensity of emotional reactions
- Activity. Tempo + vigour
- Sociability

DEVELOPMENT OF PERSONALITY + TEMPERAMENT
Must be balance between genetics + environment. Educators can facilitate personality development by:

- Being genuinely interested in adolescents
- Accept, prize + trust each person as having worth
- Be willing to personally interact with the adolescent without feeling that he is inferior
- Respect + support the adolescent as he strives to find his own identity
- Build up a positive interpersonal relationship with the adolescent in warm, caring way
- Showing empathy + understanding
- Avoid creating a hostile, stressful environment

Development of a distinct identity
Starts when a baby in relationship with mother. Who am I? It requires reviewing one's assets and liabilities and using them to reconcile the self-image with the ideal self (set of values that I want to represent)

Gender Role Identity
The peer group + adults pressurize adolescents to fit into pre-conceived ideas of what is appropriate for men and woman. Today there is greater leniency as a recent perception called the androgynous identity has emerged where you transcend your gender and pick parts of femininity or masculinity that suit you. [I disagree with this identity]
Career Identity
Two phases. 14 ï 18 (crystallization phase) broad ideas of career
18 ï 21. More specific ideas and a choice of career that becomes part of their identity

Cultural Identity
Your cultural identity is how you and your ethnic group feel about everything that is distinct to you, such as your history, symbols + traditions. At the same time, one should respect other ethnicities.

DEFENSE MECHANISMS
Human beings are constantly exposed to a degree of tension and stress. According to some this is storm versus stress, or opposing forces among the id, ego and superego; or psychosocial crises in the process of identity formation. Defense mechanisms are sub-conscious methods of protecting yourself against feelings of rejection/embarrassment/inferiority AND/OR preventing these feelings from penetrating the subconscious. They distort reality and operate unconsciously so people are not aware you are using them.

- PROJECTION. Attributing unacceptable behaviour to someone else
- Regression. Resorting to a previous stage of behaviour if they cannot cope in the current situation
- Displacement. One focuses desire of hostility on the wrong object
- Denial. Refusal to acknowledge problematic realities.
- Repression. Unacceptable impulses are pushed into the subconscious.
- Rationalization. Using excuses to justify unacceptable behaviour.

IDENTITY DIFFUSION.
Identity diffusion, sometimes called ‘identity confusion’, arises when adolescents are forced into roles they’re unhappy with, when they have too little opportunity for experimentation and when they have trouble making decisions about themselves or during a time of conflicts. When adolescents have a diffused identity they typically have trouble forming close relationships, find it difficult to plan for the future, struggle to work constructively and have the choice of acquiring a negative identity. James Marcia identified four identity statuses; two dimensions being the choice to explore and commit. The four identity statuses are:
- identity achievement ë crises leading to commitment.
- Identity moratorium ë crisis with no commitment yet
- Identity foreclosure ë commitment without crisis
- Identity diffusion ë no commitment, no crisis

An educator’s role in identity diffusion involves:
- Not prescribing roles, helping them to establish their own identity
- Helping them form a realistic self-concept
- Helping them to accept themselves
- Assisting them to acquire an appropriate sexual role, career + ethnic identity.
EMOTIONAL DEVELOPMENT

Human emotions consist of four common components

- They are responses to external and internal eliciting stimuli
- Responses result from our interpretation or cognitive appraisal of these stimuli, which gives them meaning
- Our bodies respond physiologically to our interpretation of stimuli
- Emotions include behavioural tendencies – expressive (crying) or instrumental (running away)

Emotions are important:

- Emotional health affects physical health
- Emotional health affects relationships with others
- Emotions can be sources of pleasure, love and satisfaction.

There is a strong correlation between emotions and learning. The amygdala deals with emotional responses and stores emotional messages in a long-term manner. Therefore positive emotions must be used for teaching so that learning will be long term.

Adolescents are under a tremendous amount of pressure and tension that leads to a time of heightened emotionality. This decreases as they get older until a degree of emotional maturity is reached. Educators must help adolescents come to terms with and handle their emotions by:

- Verbalizing emotions
- Displaying a sense of humour
- Providing an opportunity to cry and being supportive when it does occur
- Providing physical activities to release pent-up emotion

Hallmarks of emotional maturity

- Control emotional outbursts in front of others
- Blow off steam in a suitable place and socially acceptable way
- Evaluate a situation critically before reacting to it
- Display empathy and understanding of others
- Give without expecting in return
- Not judge/dominate others continually
- Open and sensitive to own experiences

To achieve emotional maturity adolescents must be guided towards:

- Gaining a realistic perspective on usually reactive emotional situations
- Using acceptable methods to relieve emotions

Three Broad Categories of Emotions

JOYOUS – warm and loving
INHIBITORY – fear (things, self, relationships, unknown)
- Worry + anxiety
HOSTILE – anger, aggression, jealousy
HANDLING ADOLESCENT AGGRESSION

- Never answer aggression with aggression
- Act firmly without using physical punishment
- Treat adolescents as individuals + display patience + sympathy
- Allow time for cooling off
- Acknowledge need for autonomy + freedom of choice

LAWRENCE KOHLBERG ų moral dilemmas

Studied boys aged 10 Ŵ 16, told them stories of moral dilemmas and asked how they would deal with the situation. Moral development linked to cognitive development and divided into three levels with six stages. A person can be partly in one stage and partly in another. A change in age is accompanied by a change in cognitive, social etc development. Only 20 Ŵ 25 % of adults reach post-conventional stage. If in the conventional stage a child can reason according to their own convictions then later in the post-conventional stage their reasoning and actions according to their convictions are likely to be socially acceptable.

Criticism of Kohlberg:
- Stages of morality claim to be universal is based on insufficient knowledge of other cultures
- Overemphasis justice and underemphasizes care
- Fails to link morality to spiritual and religious values
- Fails to credit the roles of emotion, socialization and parental guidance

Research has found:
- As we age from childhood to adolescence moral reasoning changes from preconventional to post conventional
- Even in adulthood, post-conventional reasoning is relatively common, though it varies in cultures
- Levels are not skipped
- A person's moral judgements do not always reflect the same level/stage within levels
- Post-conventional stage is usually found in westernized, formally educated and middle/upper class background. Kohlberg's theory has a western cultural bias

Carol Gilligan

Kohlberg's associate who found that females approach moral issues from a different perspective. She stated:
- Women emphasize sensitivity to others feelings + rights
- Men emphasize justice Ŵ preserving rules, principles + rights
- Women emphasize care of human beings instead of obedience to abstract principles

The study revealed that:
- Women rely on an interpersonal network of care orientation
- Men rely more heavily on justice orientation
Her alternative:

- At Level 1, women are more concerned with survival and self-interest. Gradually they realize the difference between what they want (selfishness) and what they should do (responsibility).
- This leads to Level 2—others are put first.
- Level 3 (many never attain it) in the universal perspective they realize that they are not powerless, but active in decision making.

How are values to be taught in school?
A teacher is not meant to indoctrinate pupils with her beliefs, but rather to stimulate them to formulate their own ideas of right and wrong through discussion, participation and thought. Value clarification provides scenarios where students have to choose how they would respond to a situation therefore showing them what values are important to them, what they would stand up for, what they would let go, etc.
CHAPTER 3

Factors that influence intelligence:

- **Heredity + environment.** The one is impossible without the other. Genetics can’t be changed so we must focus on the environment.
- **Culture.** Intelligence tests measure the skills necessary in a specific culture.
- **Gender differences.** Girls + boys are equally intelligent, but boys are gifted in maths/spatial orientation; while girls are good at verbal skills.
- **Self-concept.** A positive self-concept leads to a positive attitude and usually success in academics.
- **Language.** An essential means in performing because it is the primary vehicle of thought.
- **Motivation.** Intrinsic motivation puts children in a position to use their intelligence favourably and motivation in general can increase children's intelligence.

Enhancing Intelligence

Critical thinking + reasoning skills must be developed in order to enhance intelligence. The teacher dishes out info + the student only learns the necessary stuff for exams typically. This must change. Noteworthy programmes for the development of thinking skills are:

- **Instrumental enrichment.** Feuerstein. Equal weight to teacher + student. Mediating learning experiences. Climate of mutual respect + involvement.
- **Critical thought movement.** Richard Paul. Exposure to ideas with which they disagree to develop critical thinking. Critical thinkers check accuracy + validity of info before using them. Formal-operation thinkers use info to solve problems + reason. Formal operational thought does not guarantee critical thinking.
- **Philosophy for Children.** Mathew Lipman. Thinking about thinking. Emphasizes metacognition of his own cognitive processes + ability to control + regulate processes. Compromises methods adopted by learners to ensure effective thinking + learning.
- **Cognitive Research Trust (CoRT).** de Bono. Perceptual aspect of thought. Learners must suspend judgement while considering alternative using thinking tools. Lateral thinking NB to see the world differently. Use new angles and draw on wide variety of experience. Abbreviations for thinking procedures. P – positive or good points. M – minus points. I – interesting points.

What is creativity?

Discovery consists of looking at the same thing as everyone else and thinking something different. – Albert Szent-Györgyi

Aability to think about something in novel + unusual ways and then find unique solutions to problems. – Santrock

Convergent thought = one conventional answer

Divergent thought- application + transfer of info in new situations
Creativity + Intelligence

Main characteristics of creative individuals:
- Readiness to work hard
- Above average intelligence, but not dependent on intelligence
- Fluency regarding repetition + processing of existing knowledge
- Originality
- Flexibility, pliability, latitude of thought using a variety of approaches
- Elaboration or the ability to handle a specific problem in its finest details
- Sensitivity to the environment + to one's own feelings + emotions

Motivation ï Intrinsic/Extrinsic

Motivation is, in essence, the needs, goals and desires that spur a person to action. Motivation will always result in heightened activity and ideally, the realization of goals. Movement + purpose. There are two kinds of motivation ï intrinsic and extrinsic. Intrinsic motivation is the desire for achievement that comes from within because an individual personally enjoys and is interested in the task at hand. It is this inner drive (which originated from the self- and meta-cognition systems of the brain) that also brings satisfaction to those doing the job. They are goal-orientated, enthusiastic, enjoy studying + invest optimal effort. Extrinsic motivation is stimulated by external factors, the hope of reward, or the desire to please another person. These people do the minimum, have little curiosity, are pessimistic about success, rely on others' assistance and require the approval of others.

Erik Erikson

- Development of personality is genetic + social influence
- Development passes through changes determined by: maturation of abilities + interests, and, demands made on the individual by society
- Eight stages of life, each with a crisis that must be resolved

1. Trust vs mistrust (hope). 0 ï 1 years
2. autonomy vs shame/doubt. (will power) 1 ï 2 years
3. initiative vs guilt. (goal-directedness) 2 ï 6
4. Industry vs inferiority. (proficiency) 6 ï 12
5. Identity vs identity diffusion. (dependability) puberty to adulthood [centerpiece of theory]
6. intimacy vs isolation (love) early adulthood
7. Generativity versus stagnation (providence) 25 - 65
8. Integrity vs despair (wisdom) 60 ï 70

Moral Development

From 12 and onwards adolescents want to make their own decisions and not rely so much on others. Moral concepts become more abstract and a critical, objective and rational approach to moral values is developed. Locus of control ï external or internal. Internal ï own control of life. External ï other forces blamed

Factors influencing moral development

ROLE OF THE FAMILY
- Parental warmth + trust
- Frequency + intensity of parent-adolescent interaction
- Type of discipline. Consistency has the best effect. Authoritarian leads to children becoming hostile, insensitive + uncaring. Permissiveness leads to children without a personal value system. Authoritative leads to children who are obedient, socially outgoing + independent. Erratic leads to antisocial + deviant behaviour
- Conflict may arise because of double standards, parents having higher values + peers from other backgrounds having different values + standards
- Parental role models. Strong, positive role models can be emulated if reasoning is supported in a positive way

ROLE OF PEER GROUP
Unstructured leisure time + diminishing parental involvement can lead to peers having a powerful impact on adolescent life. Since acceptance is important, conformity occurs. They may discuss values for hours and learn to understand different values.

ROLE OF NEW MORALITY
We live in a society where right and wrong is up to you, roles are interchangeable and adolescents are confronted daily with social, religious, economic etc problems.

ROLE OF REFERENCE GROUPS
Living in a deviant society can cause you to adopt that behaviour.

ROLE OF TELEVISION
Tv has a huge affect on adolescents. It speaks on sex, violence, idealization of immaturity, materialism, hedonism + commercialism of the media. It also presents them with anti-values. Anti-personal relations, anti-co-operation, anti-democratic. Commerials and soap operas further present false information and incorrect values that in no way benefit our lives. If tv is correctly controlled by parents, it can be beneficial if programs viewed deal with art, nature or science.

ROLE OF SCHOOL
Not teaching values has a negative impact. So what should be taught? Respect, cooperation, compromise, honesty, compassion, service, justice etc.

ROLE OF THE COMMUNITY
3 development levels of morality in every culture.
1 ð amoral. Self interest and pleasure at all costs
2 ð system of social agents. Allegiance to others/approval
3 ð values + ideas. Personal principles
Exposure to pluralistic societies help adolescents develop level 3.

Characteristics of adolescent religious development

RELIGIOUS AWAKENING
Integration of religious dogma + practical life by seeking answers. Critical mindset coupled with disillusionment leads to religious doubt which is described in stages ð rejection, alternatives, continued quest + renewed faith. Their interest in religion
increases when they either becomes members of their parents religion or drives them into skepticism against previously held convictions.

RELIGIOUS REVIVAL
Most adolescents discover that they do need religion after all. This can lead to an interest in the occult, or searching which eventually leads to becoming a member of a certain religion. Becoming a member brings a certain amount of status and identity. Educators who are held in high esteem can influence children spiritually. African Religion has certain values + practices:

- Religion is a way of life, a constant initiation into new spiritual realms
- Family is the basic social unit + education is the family and community's responsibility. Respect is essential
- Belief that ancestors watch over them + gave moral values to them

THE NEED FOR RELIGION IN ADOLESCENCE
Religion brings stability to a tumultuous time of life. Religion is important to the adolescent, and this is shown by the fact that those who profess religion to be important regularly attend church and are committed to it. Their religious choice affects their behaviour, results in heightened responsibility and gives their lives meaning.

ROLE OF EDUCATORS IN MORAL DEVELOPMENT
A religion teacher must be qualified in this field. Educators must:

- Be aware of the doubts/frustrations of adolescents in religion
- Live out the qualities of friendship, respect and acceptance
- Be role models and have good interpersonal relationships with students. An open mind, appreciation of diverse beliefs and uncompromising allowance for people's own choice is necessary.

ADJUSTMENT TO SECONDARY SCHOOL
Transition from primary to high school is difficult + usually results in decreased interest in academics, more dislike for educators + less favourable attitude towards performance in school. Positive aspects are that children feel more grown up, having more subjects to choose from + more opportunities to meet new friends + spend times with them. If they are in a happy family environment, have a positive self-concept and siblings who have gone before it will make the transition easier. Orientation in the first few weeks of grade 8 helps develop team work. This results in better peer relationships, increase in emotional health + self-concept, increase in creativity. It is better if a school provides more support, less anonymity, more stability and less complexity.

Maslow's theory ̶ basic needs cannot be satisfied without work, and unless they are satisfied, higher needs cannot be addressed.

PROBLEM SOLVING
The process of identifying a problem, an obstacle or an inability to act; it involves thinking of possible solution and testing + evaluating them.
MODELS OF PROBLEM SOLVING
Torrance + Myers
1. sensing problem/challenges
2. recognizing the real problem
3. producing alternative solutions
4. evaluating ideas
5. preparing to put ideas into practice

Parnes, Noller + Biondi
1. fact finding
2. problem finding
3. idea finding
4. solution finding
5. acceptance finding

D'Zurella + Goldried
State your problem
Outline your response
List your alternatives
View the consequences
Evaluate your results

Umstot
1. Define and clarify the problem
2. search for solutions
3. Evaluate the solutions
4. Implement the decisions
5. Follow up

DECISION MAKING
A choice is drive by aspirations
Decision is a mental process or activity and involves a choice
3 stages
1. Aspirations. Striving for self-actualization (Maslow) represents the highest level that can be attained by humans. Primary needs are food, clothing, safety. Secondary are success, self-respect, status, independence + acceptance.
2. Choice. Determine which aspirations should be rated the highest so that they can make a responsible + realistic choice
3. Decision. Act of will leads to the decision. They will then take action to achieve it. The act of will is affected by the attitude. (attitude is continual mental state of readiness that is a predisposition to react consistently towards a given class of objects.

Different kinds of decision makers
Intuitive decider: it feels right
Agonising decider: I can't make up my mind
Delaying decider: I'll think about it tomorrow
Fatalistic: whatever will be, will be
Systematic: I am systematic + organized

PRINCIPLES OF DECISION MAKING
Aims + values/setting goals: objective must be determined
Information gathering: possibilities weighed
Solutions/decision structuring
Decision making/final choice: action

Then I evaluate!

CAREER CHOICE
The aim must change from choosing the right career to choosing a vocational direction.
1 I authentic self-knowledge
2 I knowledge about the career

SELF-KNOWLEDGE
Insight into one's own personality + capabilities. It leads to identity formation.
Comprises:
- Bodily knowledge. Observation of physical characteristics, perceptions + the way this will affect a career choice.
- Mental knowledge (gifts + talents). Ability to grasp a given situation. Don't choose a career beyond capabilities.
- Aptitude. Potential that enables him to attain a particular level of competence. Talents.
- Interest. What one wants to and likes to do.
- Sociality. How you feel about relationships with others. Determined by the ability to communicate, basic behaviour patterns, common sense and personal effectiveness, contributory relationships + social accomplishment.
- Higher intellect/faculties. Do my beliefs of right and wrong correspond with my chosen career choice?
- Personality. What gives you a wholly distinctive character. Types: realistic, investigative, artistic + creative, social + service rendering, entrepreneurial + conventional.

Johari Window.
Window A I the things you know about yourself that other know too
Window B I the things you know about yourself that others don't know
Window C I the things you don't know about yourself that others know
Window D I the things you don't know about yourself and others don't know either

Window A should be expanded and Windows B, C, D reduced

CAREER KNOWLEDGE
Two parts I adolescent's share + the advice of parents, educators etc. many places to get info I parents, media, interviews, literature, doing part time work
3 main considerations in choosing a career:
1. Job description
2. Working conditions
   Job opportunities
Chapter 7: Special Concerns in adolescent development

EATING DISORDERS

Obesity can be caused by: hereditary factors, metabolic disturbances, hormonal imbalances + variations in the underlying fat cells. If one parent is obese, there is a 50% chance of obesity in the child if two are, the chances are 80%. During adolescence the basal metabolism declines by about 15% making it easier to gain weight. Overeating can be attributed to:

- Parents overfeeding due to love /antagonism
- Avoid pressures of social interaction, sports or relationships
- Urge caused by an empty feeling
- Compensate for feeling of inferiority
- Punish out of sense of guilt
- Antagonism towards parents

Obese adolescents:
- Regard themselves as unattractive + less socially acceptable
- Experience lack of control + individuality
- Incapable of identifying + controlling their biological urges
- Eat because food is available, not out of hunger

ANOREXIA NERVOSA

Life threatening emotional disorder characterized by an obsession with food + weight. Drastic reduction in food intake + unhealthy loss of weight. Typical patient is bright, white, between puberty + early twenties, well-behaved and appealing. Characterized by:

- Cessation of menstrual periods
- Vomiting
- Social withdrawal
- Thick, soft hair covering the body
- Constipation + difficulty in urinating
- Social withdrawal
- Loss of appetite (later stages)
- Abnormally slow heart beat

Various viewpoints on the cause:

- Reaction to society’s obsession with slenderness
- Psychological disturbance where the adolescent stops eating to eliminate sexual maturity + menarche and stay a little girl
- An effort to gain control of their own body, especially if coming from a home where perfectionism and performance is expected
- Physical disorder as a result of a disturbance in the functioning of the hypothalamus or a deficiency of some chemical in the brain
Treatment takes years and is very difficult. It requires psychotherapy of the patient and family, and a balanced nutritional program. Also, patients must be taught about gaining their own identity, thinking, autonomy + independence. In some severe cases, force feeding is required.

Bulimia Nervosa
Binge-purge syndrome closely related to anorexia. The sufferer regularly (at least twice a week) consumes up to 5000 calories in a single sitting and then purges it by vomiting, laxatives, fasting or vigorous exercise. Sufferer maintains a normal body weight but health is severely compromised and can cause tooth decay, stomach irritation, hair loss, rupture of the oesophagus, cardiac arrhythmia or severe potassium depletion + blood alkalosis as a result of repeated binging and laxative abuse. 3 of the following criteria must be present for the disorder to be bulimia:

- Consumption of high-caloric, easily digested food in a binge
- Inconspicuous eating during a binge
- Termination of eating episodes by abdominal pain, sleep, social interruption or self-induced vomiting
- Repeated efforts to lose weight through severely restrictive diets, vomiting, laxatives
- Frequent weight fluctuations of greater than 5 kgs due to alternating binges + fasting

Theories: 1) electro-physiological disturbance in the brain 2) depressive disorder 3) psychoanalytical ľ to satisfy a hunger for love + attention not received from parents

Cognitive disturbances relating to food also develop, for eg. Not informed about nutritional requirements; unreasonable, distorted expectations about food and weight loss (some food is good and some bad); perfectionists with an exaggerated fear of failure; believe that losing weight will make people like them more; problems expressing emotions

Cognitive ľ behavioural therapeutic approaches can be used. Also individual psychotherapy, dietary and family therapy + counseling. They must be taught to recognize the signs of an imminent binging session + avert it by doing something else. Family members must be supportive. In some cases, antidepressants are prescribed.

Some symptoms of possible grade 9 dropout
- Consistent failure in school work
- Unhappy family situation
- Irregular attendance
- Low reading ability
- Disciplinary problems
- Non-participation in extracurricular activities
EMOTIONAL DISTURBANCES
Endogenous – a condition that can be linked back to a internal/biological basis
Macrolevel – stressors related to the outside world
Mesolevel – stressors related to the family/peers
Microlevel – stressors related to the self

Adolescence is a challenging phase of life as teens have to deal with acquiring an identity, gender role, career + ethnic identity. They must learn to deal with and express emotion appropriately + struggle to master a realistic, positive self-concept in the midst of a demanding and stressful society.

STRESS
Today’s adolescents are increasingly exposed to many stressors as we see the many economic, political and religious problems within our world. Stress is especially prevalent in the adolescent’s life. Too much stress causes glucocorticoids to be raised which kills neurons in the hippocampus and results in apathy, disinterest, haste and distraction.

CONSEQUENCES OF STRESS
Physical – headaches, tension headaches, cramps, tight muscles, insomnia, excessive perspiration, speech problems, nail biting, nausea
Mental – anxiety, depression, mood swings, lack of motivation, restlessness, poor eating habits, loss of memory, socially inept

Coping with stress
3 factors that make individuals for susceptible to stress:
- Combination of stressors
- Adolescents who do not have the support of parents, friends or family
- Stress coping strategy. Problem focused as opposed to emotion focused.

Positive emotions have many benefits namely improved health, more social support and better behaviour + ability to cope with problems. Problem-focused coping is more effective because it looks at the source of the problem. There are occasions where emotion focused coping is better because the situation cannot be changed, but the way it is dealt with is important.

Educators can help adolescents cope with stress by:
- Teaching them problem solving techniques
- Teaching them stress-handling techniques and exercises
- Teach them a sense of personal control
- Help them realize the importance of a healthy immune system
- Help them have a positive attitude
- Refer them to a professional if necessary

Sometimes underlying stress manifests itself in delinquent behaviour. This misconduct should be evaluated to see if there is a deeper reason for it.
DEPRESSION
Depression: serious psychological disorder marked by sadness, helplessness + hopelessness. Fairly common in adolescence.
Aggression: externalizing problems
Internalizing problems: anxiety

It is NB to distinguish between mild depression (after someone's death or during tough times) and clinical depression (deep feelings of pain and loss that leave a person unable to function effectively.

Symptoms of adolescent depression
Emotional ï sadness, happiness, anxiety, misery + inability to enjoy
Motivational ï loss of drive, loss of interest, difficult starting anything, difficult to focus on anything
Cognitive symptoms ï negative cognition about self, negative cognition about world, negative cognition about the future
Somatic symptoms ï loss of appetite, loss of energy, sleep difficulties, weight loss
Anxious Depression: loneliness, crying, fear doing something bad, feel the need to be perfect, feel worthless, nervous, feel guilty, are suspicious, worry

CAUSES OF DEPRESSION
• Psychoanalytical ï idea of losing something (real or symbolic). Loss of self-esteem + feelings of helplessness
• Biological ï hormonal changes, genetic + chemical factors in the brain
• Learned helplessness ï that individuals come to perceive themselves as having little control over their environment
• Environmental factors ï pressures of society
• Cognitive: beginning of hypothetical thought opens up new, possibly depressive ways of viewing the world.
• Holistic ï address all the above + integrates them. Emphasizes environmental factors + individual predisposition

Helping adolescents deal with depression
Biological ï antidepressant medication to counteract neuro-endocrine problems
Psychotherapy ï roots of depression
Cognitive behaviour interventions ï emphasize social skills, changing thinking and building positive self-concepts
Family therapy ï changing patterns of daily relations that may contribute

Fast and efficient treatment is essential.
SUICIDE
Increasing in adolescents. Reason: exposure to greater stress + more depression.

Factors in adolescent suicide:
- Disturbed family backgrounds – conflict, violence, rejection, economic stress, physical or emotional deprivation, absence of loss of one/more parents
- Absence of a warm parental figure or emotional/social isolation – not feeling close to any adult, difficulty communication with significant others, do not anybody to talk to
- Poor relationships, isolation and helpless
- Depression – loss of love object may lead to depression characterized by mourning, crying, withdrawal of interest and lack of motivation
- Alcohol + drug abuse – act impulsively
- Stress – bad coping may lead to the decision to end it all
- Immature personalities with poor impulse control – lack of identity + self concept
- Highly suggestible in following the examples of others – suicide epidemics
- Mental illness – hallucinations to feel urged to kill themselves
- Guilt and/or anger + hostility – eg, girl’s boyfriend is about to break up with her so she kills herself to punish him
- Interpersonal problems – act of aggression directed at loved ones, society or the self
- Need to attract sympathy, attention or manipulate others – communicate that an adolescent is hurting and in desperate need which unfortunately leads to death

Four risk factors:
- Psychiatric problem, depression or drug abuse
- History of family suicide
- Being under stress, especially in the area of achievement or sexuality
- Parental rejection, family disruption or conflict

Educators should:
- Be sensitive + observant in order to help children cope with depression and suicidal thoughts
- Enhance adolescents self-concept and be encouraging and caring
- Encourage adolescents to develop a special interest or skill
- Use proactive intervention to avoid unnecessary stress
- Help adolescents to form effective social support networks
- Acknowledge adolescents’ feelings and encourage verbal meditation

ANXIETY DISORDERS
3 anxiety disorders – separation anxiety disorder
- overanxious disorder
- avoidant disorder of childhood or adolescence

Anxiety is a complex pattern of three types of reactions to perceived threat: motor responses, physiological responses and subjective responses.
Motoric response — avoidance, trembling voice, crying, nail biting, no eye contract, rigid posture + stuttering
Psychological responses — heart rate, muscle tension, sweating, palpitations, breathlessness, nausea, headache
Subjective responses — thoughts of being scared, hurt, in danger; self-deprecatory + self-critical thoughts; thoughts of inadequacy and images of bodily injury

Separation anxiety — excessive anxiety concerning separation from major attachment figures such as parents. It includes worry that focuses on separation and a reluctance/refusal to sleep away from home. Usually has an acute onset. Often suffers also have concurrent overanxious disorder.

Overanxious disorder — unrealistic worry over future events, extreme self-consciousness, generalized anxiety not centred on anything, unrealistic worries over the appropriateness of past behaviour, perfectionism, somatic complaints, self-consciousness, tension
Avoidant — marked and persistent avoidance of unfamiliar persons, coupled with a clear desire to socialize with familiar people. Also, lack of assertiveness + self-confidence, avoidance of normal heterosexual + heterosocial activities; and impairment in social interactions. Usually goes hand in hand with overanxious disorder. It gets worse when adolescent is under stress/developmental transitions.

More adult disorders that children may be diagnosed with:
Phobic disorders — fear/avoidance of specific objects or situations
Panic disorder — sudden attacks of intense anxiety
Obsessive-compulsive disorder — urges to engage in repetitive/irrational behaviours
Post-traumatic stress disorder — anxiety linked to a catastrophic event which is relived over and over. Stimuli is avoided and persistent symptoms and increased arousal are experienced.
Chapter 8: Social Concerns

STDs
Particularly prevalent during adolescent because they are often sexually active, with more than one partner and without using protection. There are more than 25 different infections that can be transmitted sexually. Two signs and symptoms:
- Vaginal discharge, itchiness around the vagina + abdominal/vaginal pain
- Discharge from the penis, pain when passing water or the inability to do so

Chlamydia is most common. Includes:
- Infections in the cervix
- Pelvic inflammatory disease
- Painful urination/ cloudy discharge
- Infections in the rectum/urinary tract

May cause a baby being born to contract the disease. Increases risk of premature babies/stillbirth. Usually easily treated but can cause sterility if neglected

Gonorrhoea is mild pelvic pain + similar to Chlamydia. Treated with penicillin or other antibiotics. Can cause sterility, infection of the heart valves or joints, skin lesions and meningitis.

Genital herpes is chronic, recurring, often painful viral infection. Can be fatal to a baby born to a herpes sufferer. Tiny itching blisters on the penis, vulva, cervix or rectal area. Fever, headaches and pain in the pelvic area. Is also linked to cervical cancer

Syphilis is bacterial infection that usually occurs in stages.
First stage is painless chancre that heals fairly quickly and then disappears
Secondary stage is long after the chancre, the sufferer gets a rash and hair loss over the entire body
Latent phase if secondary stage is not treated, it goes into latent stage which destroys part of the body and can cause the patients death. It can cause diseases of the aorta, cardiovascular system, neurological system.
Treated with antibiotics.

Protection + treatment of STDs
Protection: Testing, avoidance of multiple partners, good hygiene, no sexual contact if infected.
Treatment: seek immediate treatment from a doctor, stop all sexual activities, inform partner(s), take medicine and finish course, go to doctor for a follow up visit, avoid becoming infected in future (abstinence!!)

AIDS
Caused by HIV virus that attacks the immune system + results in death. Virus in body = HIV +. Active virus = AIDS (six months to 7 years after becoming HIV positive)
How is HIV/AIDS spread?
- Unprotected sex — vaginal fluids + semen
- Infected blood (drug users, blood transfusion, sharing razors/toothbrushes, blood splashing on broken skin, touching infected blood with unprotected hands)
- Woman with AIDS passing it on to baby during pregnancy, after birth or during breastfeeding
- It is NOT spread via toilet seats, kissing, mosquitoes, cutlery, swimming pools, second hand clothes, tears/saliva

Symptoms + early signs of AIDS
Early symptoms — prolonged fever, loss of more than 10% body weight, night sweats, oral thrush
Later symptoms — persistently swollen glands, itching skin rash, persistent diarrhea, tuberculosis, change in mental behaviour.
There is no cure!!

AIDS in SA
- Country with the largest amount of infections
- Each year one in 40 South Africans become newly infected
- 1.2 million AIDS orphans in 2005
- 2006 estimated that 21% of educators had AIDS
- 90% of the age group 15 – 24 that were infected in 2005 were women
- 2006 one in six adults aged 15 – 49 is living with AIDS

The reality of children:
- living with one/both parents having AIDS
- having AIDS
- losing one or more parents to AIDS
- being confronted with death at a young age
- being stigmatized

Education on HIV/AIDS
Implementation in schools:
- continued life-skills and AIDS program in schools
- Age-appropriate education on AIDS as part of the curriculum
- Enabling + accepting environment

Development of sexuality involves the social system as a whole, community values, schools, peer groups, family and the individual child.

When teaching infected children, be aware:
- Neurological difficulties may arise as a result of the virus penetrating the brain
- Central nervous disorders occur frequently
- These adolescents may experience developmental delay, cognitive defects, hearing/vision impairment, seizures
- Psychological/physical devastation as a result of the disease

REASONS FOR TEENAGE PREGNANCIES
- Heightened sexuality
- Lack of information on contraception and lack of use
- Having a baby may be viewed as a sign of maturity + motherhood giving a sense of identity
- Escape from an unhappy home situation or reaction to loss of a parent
- History of being abused, raped or victims of bad parenting
- Growing up in a cultural environment where fertility is a sign of strength and men maintain that using condoms diminishes pleasure

Myths about pregnancy:
- Contraceptives make you sterile
- Plastic wrap makes an effective condom
- **You cannot get pregnant the first time or if it's your period**
- If the male withdraws in time
- If you have sex standing up

CONSEQUENCES OF TEENAGE PREGNANCY
**Psychological**
- Ambivalent/happy/depressed. Forced into a marriage with someone they have not really bonded with. Not ready to be a parent so irritable, seldom play with children, use corporal punishment, and feel overwhelmed.
- Those who choose not to get married are usually more independent and ambitious, have a better chance at finishing school and more economic and social support.

**Economic**
- Pregnant girl is likely to drop out of school, as well as her boyfriend if he has to support her. Teenage mothers might have to rely on social support if from poor communities.

ALCOHOL + SUBSTANCE ABUSE
**Alcohol**
- Alcohol abuse is the use of alcohol to a degree that it causes physical damage, impairs physical, social, intellectual or occupational functioning; or harmful behaviour to others
- Alcoholism is a long term, repeated, uncontrolled use of alcoholic beverages.
- Alcohol interferes with the mind, impairs perception, sensory-motor control + thinking speed, prevents the individual from functioning normally
- Drinking and driving is the greatest danger surrounding alcohol use. Alcohol abuse usually starts between age 14 and 15.
- Adolescents drink to make them feel relaxed, uninhibited, sexually aroused, able to escape reality + take risks, feel accepted + be rebellious

**SUBSTANCE ABUSE**
- Reasons for use: curiosity, desire for sensation, peer pressure, escape
- Six groups of drugs: depressants, narcotics, stimulants, inhalants, relaxants (euphorians) and hallucinogens. They differ in effect, cost + availability, practices used in, popularity.
DEPRESSANTS (Rohypnol, Mandrax)
- Alcohol based barbiturates + tranquilizers which make you feel relaxed
  - Rohypnol (date rape drug). Colourless, odourless + tasteless. Recently made with blue dye. Used as sleeping pill with a prescription. Added to drinks (usually of women) at parties to increase their intoxication and rape them. Causes stupor/coma/death when consumed with alcohol.
  - Mandrax (white pipe, buttons, MX, gholfsticks, lizards, press-outs, flowers) was considered to be a safe drug. Mixed with dagga to give the same high to regular users. SA country with highest number of Mandrax users. Causes severe withdrawal symptoms and in large doses leads to dependence, slowed thinking + speech, depression, insomnia, epilepsy, and in overdose  ð coma or death.

NARCOTICS (Heroin)
- Narcotics are depressants that induce tranquility + are effective painkillers. Natural ð opium. Synthetic ð methadone. Habit forming and leads to complete dependence. Signs of withdrawal are dilated pupils, perspiration, restlessness, and later nausea, vomiting, tremors.
  - Heroin (H, Smack, horse, hairy, harry, china white) white, odourless, bitter powder naturally occurring from the seed pod of various poppy plants. Mixed with other substances so its easy to overdose. Short term effects of addiction: pain, clouded mental functioning, fatal overdose, spontaneous abortion. Long term effects: physical dependence, brain damage, damage to kidneys, liver + lungs, rupture of heart living and valves. Destroys user’s personality and causes isolation. Sharing needles way of sharing AIDS. Becoming the number 1 used drug among SA youth.

STIMULANTS (Nicotine, Cocaine, Crack, Amphetamines, Crystal Meth)
- Nicotine (skyf, draw, cigarette, smokes, fags) - most commonly used and abused. Easily absorbed into the lungs, nose and mouth. More addictive than alcohol/cocaine. Children who start smoking before the age of 12 are most likely to use heroin before they are 18. Heart attacks, strokes, cancer, emphysema and chronic bronchitis are results. Also injures pregnancy by causing stillbirth, miscarriage, defects, premature births etc.
  - Cocaine (coke, snow, Charlie) ð most dangerous as it destroys the brain. Very expensive. Usually snorted, dissolved in water and injected. Powerful stimulant that results in euphoria. Highly talkative, makes happy, increases alertness + feeling of control. Regular use leads to anxiety, tremors, vomiting, respiratory collapse, heart failure (overstimulates nervous system). Leads to stillbirths and deformities in babies.
  - Crack. (Coke, snow, Charlie, flake) cheaper than ordinary cocaine. Smoked. Swifter, more pronounced and more extensive damage than ordinary cocaine.
  - Amphetamines. ìuppersî they enhance ability to perform strenuous tasks and concentrate. Commonly used by students cramming. Used in WW2 to get soldiers going. Taken orally, injected, taken via the rectum, smoked or sniffed. Causes restlessness, tremors, headaches, dry mouth and erratic (sometimes violent) behaviour. Depression, fatigue, blood pressure and respiratory failure.
  - Crystal methamphetamine (crystal meth, tik, tuk-tuk, crystal straws, combat drug, Hitler’s drug, lolly, popeyes, ice, crystals). Fine powder, large crystals or straws. Instant
rush followed by a high that lasts for a few hours. Inhibits appetite. Damages brain cells that contain serotonin and dopamine. Induces psychotic symptoms, paranoia, hallucinations. Brain shrinkage and makes users more likely to develop a chronic mental illness. Started in the Western Cape community but not the drug of choice Northern SA.

INHALANTS
Petrol, model-aeroplane glue, paint thinners etc. used by the poor to get a high. Dizziness, dullness, floating sensations. Long term use leads to kidney damage, nervous system damage, brain tissue and bone marrow. Death.

RELAXANTS (euphoritants, dagga)
> dagga (marijuana, zol, skyf, joint, weed, ganja, grass, hash) very commonly used. Leads to release from inhibitions, tensions and anxieties. Mild doses i talkative, relaxed and jovial. Heavier i intense sensory experiences. Large i impair co-ordination and induce hallucinations. Heart and lung damage, cancer, danger to unborn baby. Impairs functioning of the hippocampus and has a negative effect on social development and school performance.

HALLUCINOGENS
Psychedelics, LSD, PCP. i perceptions of things that don't exist, see things as larger or smaller than they really area, change experience of time and space. Can cause suicide because of the mistaken belief they can, for eg. fly. Pleasant to horrific paranoia.

SIGNS OF DRUG ABUSE
- Trembling hands
- Sudden loss of appetite or need to sleep
- Dilated pupils
- Reddened eyes
- Staggering or stumbling
- Poor judgement or speed, distance or time

Stronger indicators:
- Unexplained appearance of drugs, needed, syringes, bent spoons
- Needle marks on arms and legs
- Scabs, boils, sores
- Unusual quantities of various solvents eg. Nail polish remover, petrol
- Rapidly changing moods
- Vomiting + abdominal pains

Facts on alcohol/drug abuse in SA
SA is known as the drug trafficking capital of the south and the dumping grounds of the south. In CT, 45 % of high schoolers had used drugs and 32 % still did. Drug use goes hand in hand with crime and sexual promiscuity.

Harm that drug abuse causes
- Ill health, many hospital visits and earlier death
- Poison the body resulting in organ failure
- Increased risk of death due to interpersonal violence and car accidents. At least 40% of car accidents involve alcohol.
• Smoking is a health hazard and may cause lung cancer, cardiac arrest and respiratory problems
• Dangerous impurities in drugs
• Misjudgement
• Malnutrition
• Severe mental illness
• Suicide
• Secondary infection, eg. STDs, AIDS, blood poisoning

Social consequences
• Academic difficulties, truancy
• Involvement in crime and gangs
• Deterioration in psycho-social functioning

DRUGS AND THE LAW
• Medicines and Related Substances Act, Drugs and Drug Trafficking Act. First contravention (controlled drugs) heavy penalty in prison without the option of a fine
• Controlled drugs are scheduled, dependence producing substances including Mandrax and Dagga
• It is an offense to be in possession of controlled drugs which have not been prescribed by a doctor

REASONS WHY ADOLESCENTS USE DRUGS
Peer influence, family problems, media, personality attributes,

WHERE TO FIND HELP
Different procedures. Doctor, SANCA, Life Line, Youth for Christ, hospital, Department of Health, school psychologist

ROLE OF THE EDUCATOR
Making aware the dangers of drug use. Recognize the symptoms and counsel with authority. Be involved with the adolescents.

STREET CHILDREN
Younger than 18, accept the street as their home and way of life and beg/do odd jobs/prostitution as a way of life.

Categories of street children:
• Children who were rejected by parents or forced to leave home
• Children who flee from home because of continual conflict
• Children who are the product of rejection by society

Often form gangs but they are not usually delinquent because they are not politicized and are completely destitute. Earn about R20 a day.
Characteristics of street children
- between 7 and 18 years old
- black
- mostly boys
- leave home at age 13
- come from poor homes and dire living conditions. Six out of ten SA children live in poverty.
- Socially maladjusted
- Malnourished

Causes of street children
- Collapse of family system
- Poor family relationships
- Clashing values of parents/children
- Unemployment and poverty
- Overcrowding and housing shortages
- Sexual abuse and neglect
- Alcohol and drug abuse
- Orphanage
- Unreasonably strict discipline

Throw outs, run-aways, push-aways

Street children do not get an education, and it is very difficult to integrate them back into school because of their delayed cognitive development and alcohol and drug abuse.