SURESH
GYAN VIHAR
UNIVERSITY
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# Master of Arts
# (Psychology)

# School Counselling

## Semester-I


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**SURESH GYAN VIHAR UNIVERSITY**
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## School Counseling

### Learning out comes

### Students will be able to understand:

**Unit-1**

- Define and understand the objectives of school counseling in an educational setting.
- Identify and analyze the various factors that influence school counseling practices.
- Recognize and apply the principles that guide ethical and effective school counseling.

**Unit-2**

- Define and understand the role of counselors in middle or junior high schools, considering the unique challenges of this transitional period.
- Define and understand the role of counselors in secondary schools, recognizing the specific challenges and responsibilities in the secondary education system.

**Unit-3**

- Understand and describe the format of examinations for children and families, considering a comprehensive approach.
- Identify and describe tests of cognition used in psychological assessments for children.

**Unit-4**

- Define and understand academic problems in children, recognizing challenges in learning and education.
- Define and understand learning disabilities, recognizing specific difficulties related to information processing.

**Unit -5**

- students will be equipped with a diverse set of skills in employing psychological therapies and counseling techniques tailored for children.
- They will understand the principles and applications of play therapy, behavior modification, family therapy, and group therapy.

# SCHOOL COUNSELLING
# SYLLABUS

**UNIT I**
**COUNSELLING IN SCHOOLS**
Introduction to School Counselling, Factors Influencing School Counselling, Principles of School Counselling, Role and Functions of School Counsellor

**UNIT II**
**COUNSELLING IN EDUCATIONAL SETTINGS**
Introduction, Counselling in Elementary School, Role of Elementary School Counsellor, Characteristics of Elementary School Students, The Middle or Junior High School Counsellor,The Secondary School Counsellor, Role of a Counsellor in a Trauma Laden Situation in School

**UNIT III**
**ASSESSMENT IN CLINICAL PSYCHOLOGY**
Introduction, Examination of the Child: Format of the Examination of the Child and Family,Psychological Assessment of the Child, Tests of Cognition, Tests of Personality and Temperament, Psychological Assessment from a Clinician Perspective, Uses of Psychological Assessment

**UNIT IV**
**Counselling CHILDREN**
Introduction, Specific Problems and Disorders in Children, Academic Problems, Learning Disability, Attention Deficit Hyperactivity Disorder (ADHD/ADD), Autism Spectrum Disorders, Externalizing Problems, Internalizing Problems, Developmental Problems and Specific Developmental Delays, Language Disorders, Child Psychopathology

**UNIT V**
**PSYCHOTHERAPY WITH CHILDREN**
Introduction, Psychological Therapies or Counselling for Children, Techniques of Therapy, Play Therapy, Behaviour Modification, Family Therapy, Group Therapy

UNIT I

# COUNSELLING IN SCHOOLS

**STRUCTURE**

1.1 Learning Objective
1.2 Introduction to School Counselling
1.3 Factors Influencing School Counselling
1.4 Principles of School Counselling
1.5 Role and Functions of School Counsellor
1.6 Chapter Summary
1.7 Review Questions
1.8 Multiple Choice Questions

## 1.1 LEARNING OBJECTIVE

**After completing this unit, you will be able to:**

- Delineate the factors influencing school Counselling.
- Describe the Principles of school Counselling.
- Elucidate the Role and functions of the school counsellor.

## 1.2 INTRODUCTION TO SCHOOL COUNSELLING

Guidance and counselling programmes have become the need of the hour. Each and every educational institution should have a well-established guidance and counselling programme to cater to the needs of our students and youth. In this unit we are focusing upon the developing, planning and organisation of Guidance and Counselling services under a comprehensive School Guidance Programme. Developing a school guidance programme needs proper understanding of the requirements of the planning, the resource persons, management of resources, different types of guidance services etc. In this unit we will be dealing with counselling in schools. We start with giving an introduction to school counselling and the factors that would influence school counselling. Then we deal with the principles of school counselling and delineate the role and functions of a school counsellor. Then we discuss counselling in different part of the school in that at elementary level, middle level, secondary level in school.

## 1.3 FACTORS INFLUENCING SCHOOL COUNSELLING

The primary objective of every guidance and counselling programme is to adjust the perceptions and ambitions of the target (the client) to match the expectations of the deliverer (the counsellor or guidance professional). Guidance and counselling are normalisation mechanisms, designed to eradicate non-standard / undesirable / anomalous behaviours and attitudes from the recipient group. The School Counselling Program is comprehensive in scope, developmental in nature, proactive in design, and differentiated in order to address individual and societal needs.

The role of the school counsellor is multidimensional. School counsellors ascribe to the ASCA Code of Ethics and participate in on-going professional development. School counsellors incorporate leadership, advocacy, counselling, consultation, coordination, collaboration and teaming, and the use of data to ensure students' success in the domains of academic, career, and personal/social development. School counsellors are shared stakeholders working in collaboration and partnership with students, families, educators, and community members in a variety of settings at a building, district and community level.

School counsellors, in collaboration with stakeholders, are invested in helping students make the transition from school to school, school to work, or school to higher education or career and technical training. All students benefit from an interdisciplinary delivery system, which includes a school guidance curriculum, individual student planning, responsive services, and system support. The ongoing use of a variety of data sets,

including process, perception and results data, is integral to ensure that every student receives the benefits of the School Counselling Program.

The data is used to identify and address individual student needs and issues, examine current practices, and determine the best ways to make systemic changes in order to seek continuous improvement. The School Counselling Program delineates a framework of specific, measurable outcomes in the three domains of academic, career and personal/ social development. These outcomes must align with each student's developmental needs and must answer the question, "How are students different as a result of the School Counselling Program?" The School Counselling Program fosters an environment that encourages students to develop self-awareness, as well as understanding, tolerance and acceptance of others' diverse qualities, backgrounds, beliefs and aptitudes. The School Counselling Program enables our students to become productive members of the global community.

The School Counselling Program, using a variety of tools, assists all students in identifying and cultivating their intellectual strengths and personal attributes as they explore their higher education and/or career options. The School Counselling Program will help students develop the skills of critical thinking, problem solving, decision making, self-reflection and effective communication. The School Counselling Program promotes life-long learning for all students.

**Guidance**

Guidance is the act of making decisions for another person to help students and clients get somewhere or help them to have a better future by showing them how to do it themselves. Counselling is the act of steering another's thoughts till they come up with the correct answer or behaviour themselves. Neither is fool proof. Guidance is different than counselling because guidance is mainly meant for simple and uncomplicated issues as for instance if a person wants to improve himself or herself on certain areas of behaviour etc. or the availability of various careers in a particular area or subject.

In counselling however, it is mainly for major issues like how to deal with a trauma and its consequences, how to deal with Post Traumatic Stress Disorder, how to deal with the shock sustained in witnessing a murder of one's own close friend or relative. An issue of such a magnitude that the person is unable to sleep for days on end, cries incessantly, depressed and extremely anxious, then this needs counselling. A divorce, a separation from the spouse, break up of a family due to sudden natural calamity etc. may require counselling rather than guidance. Counselling and guidance programs in schools are an educational development of the 20th century. School counselling increases student's ability to concentrate, study, and ultimately learn. It decreases classroom disturbances. Counselling services support teachers in the classroom in order to enable teachers to provide quality instruction designed to assist students in achieving high standards. School counsellors are trained to recognise "early warning signs" in at-risk youth. School counsellors work with principals, teachers, and other staff to develop and implement school safety, and to prevent school violence. Students who have counselling programs

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reported being more positive, and having greater feeling of belonging and safety in their schools.

**Role of school counsellors**

In the United States, the school counselling profession began as a vocational guidance movement at the beginning of the 20th century. In 1907, Jesse B. Davis became the principal of a high school and encouraged the school English teachers to use compositions and lessons to relate career interests, develop character, and avoid behavioural problems. From that grew systematic guidance programs, which later evolved into comprehensive school counselling programs that address three basic domains: academic development, career development, and personal/social development.

In North Carolina, one has to complete an approved master's degree in school counselling program in a regionally accredited college or university in order to be a licensed school counsellor. Within these counsellor education programs, several standards are studied such as the professional identity of school counselling, cultural diversity, human growth and development, and career development. Also required are the core components for helping relationships, group and individual work, assessment, research and program evaluation, knowledge and requirements for school counsellors, contextual dimensions of school counselling, foundations of school counselling and an internship under a highly qualified school counsellor. School counsellors are expected to apply their professional training in schools in order to support student academic success.

Through comprehensive school counselling programs of developmental, preventive, remedial, and responsive services, school counsellors address academic development, career development, and personal/social development of students. This job description is a guide for the implementation of such comprehensive school counselling programs in the public schools of North Carolina. Professional school counsellors, formerly referred to as "guidance counsellors," are professional educators who have a master's degree or higher in school counselling (or the substantial equivalent), and are certified or licensed by the state in which they work. Professional school counsellors possess the qualifications and skills necessary to address the full array of student's academic, personal, social, and career development needs.

Professional school counsellors advocate for and care for students, and are important members of the educational team. They consult and collaborate with teachers, administrators and families to help all students be successful academically, vocationally and personally. The role and function of school counsellors may be based on how they spend their time. Individual counselling, guidance activities, consultation and group counselling are major activities as measured by time commitments. It is noted that for senior high counsellors, paper work, scheduling and administrative tasks are seen as significant time robbers that deter counsellors from allotting more time for individual and group counselling. The variety in school settings will also account for some differences in the way's counsellors may carry out their roles. However, some common influences determine the role and function of counsellors regardless of the setting. These influences are:

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a. **Professional constants or determinants:** These indicate what is appropriate and not appropriate to the counsellor's role. These include guidelines and policy statements of professional organisations, licensing or certification limitations, accreditation guidelines and requirements, and the expectancies of professional training programs.

b. **Personal factors**: These factors involve the interest of the counsellor such as what he or she likes to do, what the counsellor gets encouraged to do and is rewarded for doing by the school, community or his peers, what the counsellor has resources to do, what the counsellor perceives as the appropriate role and function for a given setting and finally how life in general is going for the counsellor. The counsellor's attitudes, values and experiences both on and off the job can influence how he or she views the job.

## 1.4 PRINCIPLES OF SCHOOL COUNSELLING

Principles of Guidance:

1. Parents and teachers have guidance responsibilities.
2. Take time to solve problems and make decisions.
3. Let the counselee develop his own insights.
4. Problems arise from situations.
5. Guidance is a lifelong process.
6. Guidance service should be extended to all, not simply to the maladjusted.
7. Guidance workers should rigorously observe a code of ethics.
8. Guidance places emphasis on the dignity, worth and individuality of the child as a means of promoting the democratic way of life.
9. Guidance is concerned with the choices and decisions to be made by the student.
10. Guidance is primarily concerned with prevention rather than cure.
11. Guidance is concerned with the "whole" students not with the intellectual life alone.
12. Guidance is a continuous process throughout the school life of each student.

School counselling is based on some principles which suggest how counselling programs can make their contributions more effectively:

- School counselling and guidance programs are designed to serve the developmental and adjustment needs of all youth.
- The school counselling program should be concerned with the total development of the student it serves.
- This program also recognises that individual development is a continuous, ongoing process and so school counselling programs must themselves be developmental.
- People guidance is viewed as a process that is continuous throughout the child's formal education.
- Trained professional counselling personnel are essential for ensuring professional competencies, leadership and direction.

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- Certain basic activities are essential to program effectiveness and these must be specifically planned and developed if they are to be effective.
- The school counselling program must reflect the uniqueness of the population it serves and the environment in which it seeks to render this service.
- The school counselling program should base its uniqueness on a regular, systematic assessment of the student clientele's needs and the characteristics of the program's environmental setting.
- Teacher understanding and support of the school counselling program is Counselling in Schools significant to the success of such programs.
- The school counselling program is accountable. It recognises the need to provide objective evidence of accomplishments and the value of those accomplishments.
- The school counsellor is a team member. The counsellor shares a concern and programs for youths with psychologists, social workers, teachers, administrators and other educational professionals and staff.
- The school counselling program must recognise the right and capability of the individual to make decisions and plans.
- The school counselling program must respect the worth and dignity of every individual.
- The school counselling program must recognise the uniqueness of the individual and the individual's right to that uniqueness.
- The school counsellor should be a role model of positive human relations of unbiased, equal treatment.

**CHECK YOUR PROGRESS**

1. **Explain the significance of school counselling.**
2. **What are the factors which influence school counselling?**
3. **Elucidate the principles of school counselling.**
4. **Who are school counsellors?**
5. **Why are the guidance programmes conducted?**

## 1.5 ROLE AND FUNCTIONS OF SCHOOL COUNSELLOR

The school counsellor conducts various activities for the elementary, secondary and higher secondary students. They are:

- Individual Counselling
- Organising and conducting counselling groups
- Classroom and other group guidance activities
- Standardised test administration and interpretation
- Non-standardised assessment (i.e. case studies, observation, information gathering interviews, questionnaires)

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- Needs assessment (to determine the priority needs of the target population)
- Consultation activities
- Providing career guidance and information
- Providing educational guidance and information (including scholarships, college placement, student scheduling)
- Prevention planning and implementation activities
- Developmental activities
- Administrative activities

## 1.6 CHAPTER SUMMARY

School counselling increases student's ability to concentrate, study, and ultimately learn. It decreases classroom disturbances. Counselling services support teachers in the classroom in order to enable teachers to provide quality instruction designed to assist students in achieving high standards. School counsellors are trained to recognise "early warning signs" in at-risk youth. School counsellors work with principals, teachers, and other staff to develop and implement school safety, and to prevent school violence. Students who have counselling programs reported being more positive, and having greater feeling of belonging and safety in their schools. Professional school counsellors, formerly referred to as "guidance counsellors," are professional educators who have a master's degree or higher degree in school counselling (or the substantial equivalent), and are certified or licensed by the state in which they work. Professional school counsellors possess the qualifications and skills necessary to address the full array of student's academic, personal, social, and career development needs. Professional school counsellors advocate for and care for students, and are important members of the educational team. They consult and collaborate with teachers, administrators and families to help all students be successful academically, vocationally and personally. The factors which influence school counselling are professional constants or determinants and personal factors. Professional determinants include guidelines and policy statements of professional organisations, licensing or certification limitations, accreditation guidelines and requirements, and the expectancies of professional training programs. Personal factors involve the interest of the counsellor, the encouragement that he gets from the school, community or his peers and resources of the counsellor. The counsellor's attitudes, values and experiences both on and off the job also influence how he or she views the job.

## 1.4 REVIEW QUESTIONS

### SHORT ANSWER TYPE QUESTIONS

1. **Differentiate between guidance and counselling.**
2. **List some areas where school counselling help students.**
3. **What are the personal factors that influence school counselling?**
4. **Why is school counselling important?**

NOTES

5. **List the activities conducted for elementary, secondary and higher secondary students by school counsellors.**

## LONG ANSWER TYPE QUESTIONS

1. **Explain the principles of school counselling.**
2. **Discuss the role and functions of the school counsellor.**
3. **Discuss the positive impact of school counselling on students.**
4. **How does school counselling help teachers in delivering quality education?**
5. **List all the principles of guidance.**

## 1.8 1.8 MULTIPLE CHOICE QUESTIONS

1. **_____________ is the act of making decisions for another person to help students and clients get somewhere or help them to have a better future by showing them how to do it themselves.**
   a. Guidance
   b. Counselling
   c. Orientation
   d. Presentation

2. **_______________ is the act of steering another's thoughts till they come up with the correct answer or behaviour themselves.**
   a. Guidance
   b. Counselling
   c. Orientation
   d. Presentation

3. **________________ increases student's ability to concentrate, study, and ultimately learn.**
   a. Classroom Presentations
   b. Case studies
   c. Orientations
   d. School counselling

4. **________________ indicate what is appropriate and not appropriate to the counsellor's role.**
   a. Professional constants
   b. Determinants
   c. Both a and b
   d. Personal factors

5. **_________________ increases student's ability to concentrate, study, and ultimately learn.**
   a. Classroom Presentations
   b. Case studies
   c. Orientations
   d. School counselling

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6. **____________________ promotes life-long learning for all students.**
   a. School Counselling Program
   b. Personal factors
   c. Classroom Presentations
   d. Case studies
7. **____________________ are trained to recognise "early warning signs" in at-risk youth.**
   a. School counsellors
   b. School teachers
   c. School administration
   d. None of these
8. **________________ is concerned with the choices and decisions to be made by the student.**
   a. Counselling
   b. Orientation
   c. Presentation
   d. Guidance
9. **The school ________________ conducts various activities for the elementary, secondary and higher secondary students.**
   a. Administration
   b. Principle
   c. Teacher
   d. Counsellor
10. **_______________ support teachers in the classroom in order to enable teachers to provide quality instruction designed to assist students in achieving high standards.**
   a. Counselling
   b. Guidance
   c. Case studies
   d. Orientations

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# UNIT II

# COUNSELLING IN EDUCATIONAL SETTINGS

**STRUCTURE**

2.1 Learning Objective
2.2 Introduction
2.3 Counselling in Elementary School
2.4 Role of Elementary School Counsellor
2.5 Characteristics of Elementary School Students
2.6 The Middle or Junior High School Counsellor
2.7 The Secondary School Counsellor
2.8 Role of a Counsellor in a Trauma Laden Situation in School
2.9 Chapter Summary
2.10 Review Questions
2.11 Multiple Choice Questions

NOTES

## 2.1 LEARNING OBJECTIVE

**After completing this unit, you will be able to:**

- Describe the Characteristics of the elementary student.
- Explain the functions of a counsellor in the middle/ junior high school.
- Analyse the role of a counsellor in a trauma laden situation in schools.
- Describe the role of a counsellor in the secondary school counsellor.

## 2.2 INTRODUCTION

In this unit we will be dealing with counselling in schools. We begin by providing an overview of school counselling and the variables that may affect it. After that, we discuss the fundamentals of school counselling and outline the responsibilities of a school counsellor. Then we talk about counselling in many parts of the school, including elementary, middle, and secondary levels as well as in a school that has experienced trauma due to certain violent acts.

## 2.3 COUNSELLING IN ELEMENTARY SCHOOL

Elementary schools are a powerful socialising force in a human development. Every individual carry important imprint for their elementary school experiences throughout their lives. In this setting, the young pupil is expected not only to acquire knowledge but also to learn to meet the school's behaviour and social expectancies. Failure to learn generates behavioural problems, inappropriate behaviours and social skills handicap learning. As a basis for guidance in the elementary school, two needs have to be considered – those basic needs which continuously demand satisfaction and those developmental needs which must be met during different life stages. According to Maslow's theory, as the teacher and counsellor view the elementary pupil and the ability to become self – actualised and develop potential, the teacher or counsellor must be concerned with the degree to which the pupil's lower – order needs are being met. The developmental needs of human kind have been presented by Havighurst as "developmental tasks" in his life stage theory. Counsellors and teachers in the elementary school should focus on the following developmental tasks for middle childhood:

- Learning physical skills necessary for ordinary games.
- Learning to get along with age mates.
- Developing fundamental skills in reading, writing and calculating.
- Learning appropriate gender – specific roles.
- Developing concepts necessary for everyday living.
- Developing conscience, morality and a scale of values

Maslow and Havighurst focus both the personal and the cultural nature of the needs of children as they grow and develop. There is also an implied developmental task for educational programs – the task of providing learning experiences appropriate to the needs, both basic and developmental of the elementary school child.

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## 2.4 ROLE OF ELEMENTARY SCHOOL COUNSELLOR

Counsellors and other elementary school specialists must work closely and effectively with classroom teachers. Their major focus should be on guidance activities which are usually classroom oriented. This naturally leads to an emphasis on consultation and coordination. In addition to counselling, consulting and coordination functions, the elementary school counsellor has responsibilities for people's orientation, assessment and career and other development needs as well as significant attention to the prevention of undesirable habits and behaviours.

**Counsellor**

He should be available to meet individually or in groups with children referred by teachers or parents or identified by the other helping professionals in need of counselling. Counsellors can anticipate individual pupils coming to the counselling offices for assistance, advice or support. Current social issues like substance abuse, child abuse, divorce and discrimination are a frequent basis for individual counselling in the elementary school.

**Consultant**

The counsellor may confer directly with teachers, parents, administrators and other helping professionals to help the student in school setting. He also helps others to assist the student – client in dealing more effectively with developmental or adjustment needs.

**Coordinator**

Elementary school counsellors have a responsibility for the coordination of the various guidance activities in the schools. Coordinating these with ongoing classroom and school activities is also desirable.

**Agent for Orientation**

As a human development facilitator, the elementary school counsellor recognises the importance of the child's orientation to the goals and environment of the elementary school. The counsellor may plan group activities and consult with teachers to help children learn and practice the relationship skills necessary in the school settings.

**Agent of Assessment**

The school counsellor while assessing the students should also understand the impact of culture, environment of the school and other environmental influences on people's behaviour.

**Agent of Prevention**

In the elementary school, there are early warning signs of future problems for young children like learning difficulties, general moodiness and actingout behaviours (fights, quarrels, disruptions, restlessness, impulsiveness and obstinacy). There is research evidence that children who cannot adjust during their elementary school years are at high risk for a variety of later problems. Further, substance abuse, violence among peers, vandalism has increased among elementary school pupils raising concern for preventive efforts.

## 2.5 CHARACTERISTICS OF ELEMENTARY SCHOOL STUDENTS

While planning for counselling programmes for the elementary school children, the counsellor should focus on the following characteristics of the student:

- The elementary school student is experiencing continuous growth, development and change.
- The elementary school student is relatively limited in the ability to verbalise. Counselling in Schools
- The reasoning powers of the elementary school pupil are not fully developed.
- The ability of the elementary school pupil to concentrate over long periods of time is limited.
- The elementary school pupil displays feeling more or less openly.

Any successful programme in the elementary school that focuses on the student must have not only the approval but also significant involvement of the faculty. It must be teacher centered. Close and frequent contact with parents must be anticipated in primary years. The counselling process in elementary school must be activity oriented. As the elementary school years are noted as developmental years, the elementary school guidance program must respond accordingly with a developmental rather than a remedial emphasis

### CHECK YOUR PROGRESS

1. **Explain the significance of counselling in elementary school.**
2. **What are the characteristics of elementary student?**
3. **What's the difference between a coordinator and consultant?**
4. **List the need of guidance in elementary school.**
5. **What are the developmental tasks as presented by Havighurst?**

## 2.6 THE MIDDLE OR JUNIOR HIGH SCHOOL COUNSELLOR

The middle/ junior high school focuses on providing the orientation and transitional needs and the educational and social–developmental needs of their populations. The counsellor's working in a middle or junior high school will be involved in the following roles:

- **Student Orientation:** The counsellor would orient the students and their parents to the programs, policies, facilities and counselling activities at this school level and later, their pre-entry orientation to the high school they will attend.
- **Appraisal or Assessment Activities:** Apart from school record and standardised test data, counsellors involved in the use of observation and other techniques to identify emerging traits of individual students during this critical development period.
- **Counselling:** At this school level, both individual and group counselling would be used by the counsellors. It is observed that in middle or junior high school, group counselling is used more frequently than individual counselling.

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- **Consultation:** Another role of counsellor is to provide consultation to faculty, parents and also to school administrators regarding the developmental and adjustment needs of individual students.
- **Student Development:** At this middle school level, school counsellor's, faculty and other helping professionals should focus on student development. This refers to understanding the developmental characteristics of this age group and their attending developmental tasks and planning programs that are appropriately responsive.

## 2.7 THE SECONDARY SCHOOL COUNSELLOR

The roles and functions of the secondary school counsellor are in no way different from those of counsellor's in the elementary and middle high schools. The only difference is in how counsellor's in the secondary school discharge their role and function and in various emphases appropriate to secondary school testing. For instance, the emphasis at the secondary school level shifts slightly from the preventive to the remedial in dealing with many common counselling concerns. Many of these issues are serious life problems such as addiction to drugs and alcohol, sexual concerns and interpersonal relationship adjustments. Further, there is less client emphasis on preparing for decisions and more emphasis on making decisions. These include immediate or impending career decisions or further education decisions, decisions relevant to relationships with the opposite sex and perhaps marriage and decisions involved in developing personal value systems. One of the thrust areas of secondary school counselling is guidance programs. The goals of guidance programmes are:

- To help students with their academic achievement in high school.
- To help students plan and prepare for postsecondary schooling.
- To help students with personal growth and development.
- To help students plan and prepare for their work roles after high school.

The secondary school counsellor should focus on the following characteristics of adolescents while providing counselling:

- It is a period of continuous physical growth and arousal of sexual impulses.
- It is a period of movement toward maturity with focus on independence, responsibility and self–discipline.
- Many adolescents exaggerate their ability to solve the problems of the world and those that are personal for them. Many become critical of adult solutions to social problems, life styles and values and deny that adults can evaluate life of the adolescents.

## 2.8 ROLE OF A COUNSELLOR IN A TRAUMA LADEN SITUATION IN SCHOOL

**THE THERAPEUTIC INTERVENTION**

**Phase1 of Intervention:** Initial Contact with the School

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This first contact with the school will highlight the fact that when entering a system such as a school, one must let oneself be guided by the needs of the clients as they emerge and be flexible enough to respond to them as they arise. One can almost speak of an element of "therapeutic flexibility" which is necessary when working with a large system. If one's initial plans are too rigid and too prescriptive, they may not be adequate to address the wide range of needs of the clients and may eventually be rejected. Knox and Roberts (2005) also argue for the fact that each school incident is unique and one cannot possibly anticipate all the effects that the traumatic event is going to have on the school.

**Phase 2 of Intervention:** Group Debriefing with Children

The day after the meeting with the school teachers the team went to the school in groups of must address the classes of the children who had actually witnessed the shocking or traumatic incident. As group debriefing is an accepted manner of trauma work (Udwin, 1993) this would be the most effective manner to reach all the children who had directly witnessed the event.

**The intervention should aim at the following:**

- Allowing the children to express their feelings regarding the traumatic incident in a non-threatening context.
- Allowing them to regain some sense of control over their environment.
- Normalising the experience as a group by allowing them to see that their classmates had experienced similar feelings of fear and anxiety.

Allowing the children to develop an increased sense of security, competence and mastery following a traumatic event is regarded as desirable goal of trauma work with children. Also, one could use a developmentally appropriate technique such as drawings which would allow the children to express their feelings around the traumatic event in a non-threatening manner. Children quite often cannot express verbally what they felt or feel, but can express through drawing and painting.

Each child should be given the opportunity to draw a picture of what had happened and given a chance to talk about his/her picture to the rest of the class. Team members should provide each child with a lot of positive reinforcement throughout the process. After this each child may be asked to draw a picture describing what he or she would do if he/she were given the responsibility as director of the school to make the school safer for the children. Such an exercise would provide the children with a sense of empowerment, as they would feel involved in the decision-making about safety in schools. The teachers can also be assisted during this process and the team can give them a lot of positive reinforcement for the very quick way in which they had reacted in order to protect the children. The teachers may in fact be also much shaken after the incident, as they might have feared for their own as well as the children's safety.

**Phase 3 of Intervention:** Individual Assessment of Children

The next step is to ask teachers to identify children in the other classes whom they felt were experiencing particularly negative feelings around the traumatic incident. This offer may also be made to the children who had been the target of the group intervention as

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certain children might need further therapeutic inputs. Following the incident, a number of children also refused to come to school and parents had contacted us for advice as to how address the problem.

**Phase 4 of Intervention:** Group Intervention with Teachers

The next part of the intervention is to address the needs of the teachers at the school. As mentioned earlier the teachers seemed to have experienced a serious crisis surrounding their roles as caregivers. Moreover, they may also experience their place of work as no longer safe. Hence group sessions could be held with teachers led by two co-therapists. The value of group therapy is widely recorded in the literature, for example Yalom (1995) was considered important for teachers to share their own feelings with one another and ultimately to normalise their own experiences of the event. The groups should be so organised that each teacher or a member of the group should be able to open up and discuss issues related to the traumatic incident. The level of emotional intensity will of course differ from group to group.

**Phase 5 of Intervention:** Exiting the School System

The next step is to exit from the system. This process is quite difficult for many persons. A number of the therapists may feel that felt that they could not leave the clients or children without further therapeutic interventions. The above case of traumatic incident in a school describe two important aspects, Counselling in Schools which are given below:

There is a very strong needs in schools to have adequate therapeutic support preferably with a therapist who is well versed in the principles of counselling.

The therapist or a counsellor must be sensitive to a large number of factors in that situation where a traumatic event had taken place. Some of the questions to be resolved here include the following:

- How does a therapist enter a school system after a traumatic event in a manner that is respectful and does not create further trauma?
- What is the role of the therapist in a school context following a traumatic event?
- How does a therapist include the families in this therapeutic process?
- What are the implications of a traumatic event for the relationship between school and parents?

## 2.9 CHAPTER SUMMARY

Counselling at school improves students' capacity for focus, study, and ultimately learning. It lessens disruptions in the classroom. Counselling services aid teachers in the classroom so they can deliver high-quality instruction to help pupils meet challenging standards. School counsellors are taught to spot "early warning indicators" in children who are at risk. School counsellors collaborate with administrators, teachers, and other staff to plan for school safety, execute it, and stop school violence. Students who participate in counselling services reported being happier and feeling more at home and safe at school. Elementary schools are a powerful socialising force in a human development. Every individual carry important imprint for their elementary school experiences throughout

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their lives. In this setting, the young pupil is expected not only to acquire knowledge but also to learn to meet the school's behaviour and social expectancies. Failure to learn generates behavioural problems, inappropriate behaviours and social skills handicap learning. Elementary school counselling should focus on two needs - those basic needs which continuously demand satisfaction and those developmental needs which must be met during different life stages. The counsellor's working in a middle or junior high school will be involved in the following roles such as that of student orientation, appraisal or assessment activities, counselling, consultation and student development. The roles and functions of the secondary school counsellor are in no way different from those of counsellor's in the elementary and middle high schools. The only difference is in how counsellor's in the secondary school discharge their role and function and in various emphases appropriate to secondary school testing. For instance, the emphasis at the secondary school level shifts slightly from the preventive to the remedial in dealing with many common counselling concerns. Many of these issues are serious life problems such as addiction to drugs and alcohol, sexual concerns and interpersonal relationship adjustments. Further, there is less client emphasis on preparing for decisions and more emphasis on making decisions. These include immediate or impending career decisions or further education decisions, decisions relevant to relationships with the opposite sex and perhaps marriage and decisions involved in developing personal value systems. One of the thrust areas of secondary school counselling is guidance programs.

## 2.10 REVIEW QUESTIONS

### SHORT ANSWER TYPE QUESTIONS

1. **Explain the significance of counselling in elementary school.**
2. **Explain the role of junior high school counsellor.**
3. **Explain the role of secondary school counsellor.**
4. **What are the characteristics that a counsellor should focus on while counselling secondary school students?**
5. **List the developmental tasks that a counsellor should focus on while counselling middle school students.**

### LONG ANSWER TYPE QUESTIONS

1. **Explain the difference between the roles of junior high school and secondary school counsellor.**
2. **What's the role of a counsellor in a trauma laden situation in school?**
3. **What's the main focus of middle or junior high school counsellor?**
4. **What are the goals of guidance programmes?**
5. **What are the characteristics that a counsellor should focus on while counselling elementary school students?**

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## 2.11 MULTIPLE CHOICE QUESTIONS

**1. ______________ is a period of continuous physical growth and arousal of sexual impulses.**

a. Toddlerhood
b. Adolescence
c. Infancy
d. None of these

**2 The 'developmental tasks' in life stage theory was presented by ______________.**

a. Havighurst
b. Carl Jung
c. Charles Darwin
d. Jean Piaget

**3. The elementary school student is relatively limited in the ability to______________.**

a. Development
b. Growth
c. Verbalise
d. None of these

**4. ________________ at school improves students' capacity for focus, study, and ultimately learning.**

a. Bunking
b. Growth
c. Independence
d. Counselling

**5. ________________is a period of movement toward maturity with focus on independence, responsibility and self-discipline.**

a. Elementary school
b. Secondary School
c. Junior high school
d. None of these

**6. _________________ services aid teachers in the classroom so they can deliver high-quality instruction to help pupils meet challenging standards.**

a. Counselling
b. Developmental
c. Growth
d. None of these

**7. Children quite often cannot express verbally what they felt or feel, but can express through ___________ and_________.**

a. Drawing, Painting
b. Sleeping, Dancing

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c. Fighting, Shouting
d. Smoking, Drinking

**8. ______________________ are a powerful socialising force in a human development.**

a. Secondary Schools
b. Junior high schools
c. Elementary schools
d. None of the above

**9. Failure to ____________ generates behavioural problems, inappropriate behaviours and social skills handicap learning**

a. Learn
b. Draw
c. Paint
d. Dance

**10. What is the third phase of therapeutic intervention?**

a. Group Debriefing with Children
b. Group Intervention with Teachers
c. Exiting the School System
d. Individual Assessment of Children

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UNIT III

# ASSESSMENT IN CLINICAL PSYCHOLOGY

**STRUCTURE**


3.1 Learning Objective
3.2 Introduction
3.3 Examination of the Child: Format of the Examination of the Child and Family
3.4 Psychological Assessment of the Child
3.5 Tests of Cognition
3.6 Tests of Personality and Temperament
3.7 Psychological Assessment from a Clinician Perspective
3.8 Uses of Psychological Assessment
3.9 Chapter Summary
3.10 Review Questions
3.11 Multiple Choice Questions

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## 3.1 LEARNING OBJECTIVE

**After completing this unit, you will be able to:**

- Learn about the psychological assessment of the child.
- Understand the importance of tests such as test of cognition, test of personality, etc.
- Know about the psychological assessment from a clinical perspective.
- Learn about the uses of psychological assessment.

## 3.2 INTRODUCTION

Psychological assessment implies the observation of a sample of an individual's behaviour or evaluation of his/her capacities in a wide variety of domains. It is invariably an important and significant component of a comprehensive psychiatric evaluation which is obtained through standardized techniques which are analysed, scored and interpreted leading to quantitative and/or qualitative description of some aspects of behaviour or mental function. In children and adolescents, the most important areas for assessment include intellectual ability, visuomotor coordination, adaptive behaviour, screening assessment for psychopathology. The Unit focuses on these aspects. Psychological assessment is invariably an important and significant component of a comprehensive psychiatric evaluation. It is administered when there are problems with diagnoses, understanding the psychological correlates of a psychiatric or behavioural problem as well as for better management. There are several clinical questions that are addressed to the clinical psychologist who is part of the multidisciplinary team treating children and adolescents for a better understanding of their problems and for making appropriate treatment decisions.

Psychological assessment is generally directed at the specific question that is posed to the psychologist–it could be wide ranging and include assessment of child's developmental level, intellectual ability; providing assistance in diagnosis and differential diagnosis in cases with evidence of anxiety, depression or psychosis and understanding psychological conflicts, particularly in situations where a child is not articulate enough in the interview setting; decision on the type and technique of psychotherapy suitable for the child; and to predict the course and outcome of therapy. Psychological testing can be most helpful when a clear and specific question is referred to the psychologist. Access to the clinical history of a case is essential for the psychologist in order to interpret the test findings. Many a times after going over the clinical history of a case, the psychologist can help formulate the question for referral. Psychometry, which is also method for measuring mental capacities and processes is a more narrowly defined term that deals primarily with issues of technical and methodological outputs of measurement, such as reliability, validity and standardization whereas psychological testing or assessment is a broader term that deals with clinical questions.

Psychological assessment is the appropriate understanding of the psychological attributes or characteristics of an individual or group of individuals using objective techniques of measurement. Psychological tests are measuring devices that are used to assess a sample

of behaviour objectively, consistently and systematically. Industrial and organisational psychology is the field of psychology that applies psychological principles to work related issues. There are a variety of assessment techniques. They range from unstructured interview to structured psychological test. The main goal of these techniques is to predict job performance. Each technique has its own relative strengths and weaknesses in this regard. This unit presents the purposes of psychological tests and the manner in which the psychological tests are classified. The various dimensions that are being tapped by psychological tests are then taken up and finally the advantages and disadvantages of psychological tests are discussed.

## 3.3 EXAMINATION OF THE CHILD: FORMAT OF THE EXAMINATION OF THE CHILD AND FAMILY

A psychological test is a way of measuring behaviour and other characteristics to gain information about how an individual is functioning in some way. It is a systematic way of measuring a variety of mental abilities, behaviours, and neurological abilities. Psychological tests are created, researched, and standardized on large numbers of people to determine how different people will perform on each assessment. Tests vary by both the age of the individual and the information that is being assessed. Children are referred for a psychological assessment for many reasons. They may have attention or behaviour problems at home or in school, be subjected to bullying, be depressed or anxious, or have a learning disorder. Often when kids are struggling in school or seem to be behind their peers developmentally, a counsellor or teacher will suggest the child undergo a psychological assessment. The findings from this type of evaluation will let us know where the child excels and which areas he or she might need to address (for example: an undiagnosed learning disability). Dr. Ryan Seidman, the Clinical Director at our Children's Center notes that, "Having your child evaluated can promote improvement in academic and emotional functioning."

**Who Performs a Psychological Assessment?**

Psychological assessments are done by highly trained child psychologists who are specialists in their fields. These mental health professionals evaluate the child's strengths and weaknesses, then work with parents and teachers to come up with an approach that will help the child progress.

**How is a Child Psychology Test Done?**

These assessments aren't like "actual" tests can be and they aren't something the child can study for. In fact, it is best if the child is relaxed during the evaluation, so the assessment isn't a "pass or fail" test.

During a psychological assessment, the psychologist will:

- Talk with the child (and later with their parents) to learn more about their behaviours and emotional skills. They will also look at the child's neurological functioning in areas such as spatial processing. In some cases, they may also talk to the child's teachers or others who know the child well.

- Observe the child during the evaluation. Depending on the reason for the assessment, the child psychologist may also visit the child at home or at school to further gauge their interactions with others.
- Have the child complete a standardized test. These tests have been taken by many different people and will allow the psychologist to compare your child's results with those of others in order to evaluate a range of abilities. The psychologists want to know how the child functions in areas such as movement (dexterity) or behaviour and in subjects like reading, writing and math.
- May review school records, medical records, or test interview or the child's parents or teachers in order to learn more about the child.
- Psychological testing isn't a quick assessment. The evaluation will likely take several hours to complete and often involves more than one session to be certain the psychologist has all the details about a child. By putting this information together, the child psychologist comes to an understanding of where a child needs assistance and can develop strategies to help them reach their full potential.

**The Results of a Psychological Assessment**

When the testing is complete, the child psychologist will go over the results with the child's parents. Keep in mind that the outcomes do not reveal everything about a child's potential, abilities or skills. Rather, the evaluation is used as a way to learn about their "present functioning level" emotionally, in their school and home environments, how they learn, and their strengths and weaknesses. The child psychologist will discuss areas in which the child does well and offer suggestions to help them improve in areas that need to be addressed. If the child is diagnosed with a learning disability, or a behavioural or emotional issue, recommendations will be made for ways to help the child manage that specific concern or problem. By evaluating and understanding where the child has issues, child psychologists can provide positive coping strategies, reduce the child's stress and enrich their competence and well-being.

## 3.4 PSYCHOLOGICAL ASSESSMENT OF THE CHILD

A psychological assessment is a structured series of interviews, standardized tests, and questionnaires designed to evaluate strengths and weaknesses in several areas. These tests may identify, for example, learning styles and social-emotional patterns of functioning. Some parents seek a psychological assessment out of concerns about how well their child or teen is functioning. Other parents are advised to get an assessment by one or more professionals—an educator, a mental health professional, or paediatrician—who notice something amiss. The evaluation ensures that everyone in a child's world is working toward the same goals.

**What does a psychological assessment address?**

A psychological assessment should consider the "whole child, including family, school, and the community," says Cardona-Wolenski. Assessments are always individualized, based on the needs of the child, address the concerns that led to the referral. A psychological assessment may look at:

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- **Intelligence:** These tests look for developmental delays, intellectual gifts and/or disabilities, language and communication skills, nonverbal reasoning skills, and speed at absorbing and processing new information.
- **Achievement:** By measuring mastery of reading, mathematics, and writing, psychological and educational tests can identify academic strengths and pinpoint such learning disabilities as dyslexia. For children with special needs, the psychological assessment can help develop a Special Education Individualized Educational Plan (IEP) at a Planning and Placement Team meeting (PPT).
- **Memory and attention:** Neuropsychological testing is often used to identify attention deficit hyperactivity disorder (ADHD). This set of tests can also measure memory skills, reasoning abilities, and executive functioning, like planning and organizational skills.
- **Behavioural, emotional and social development:** Social-emotional and personality evaluation tools examine depression, anxiety, or social deficits that may contribute to difficulties at home or school. If there are mental health concerns, the assessment provides direction for behavioural management strategies to be used at home or school. It can also provide therapists with information for treatment planning, including whether or not medication is appropriate.

**What should parents of children undergoing psychological assessment expect?**

Before the first appointment, parents complete the first step of a psychological assessment, filling out questionnaires regarding the child's developmental, medical, social, and academic history. This information, along with results of earlier evaluations and reports from school, is the beginning of the psychological assessment plan. The next phase consists of interviews with both the parents and the child. Parents provide information about the child's strengths and weaknesses and discuss areas of particular concern. The child then has several testing sessions, which examine cognitive, educational, and social-emotional functioning. Once the written report is completed, the evaluator meets with parents to review the results and discuss the proposed recommendations.

## TYPES OF PSYCHOLOGICAL TESTS

There are many different kinds of psychological tests depending upon the need. Some tests involve one on one interactions between the psychologist and the client, some involve rating scales and questionnaires that are completed by the child's caregiver, some are detailed interviews about a child's symptoms, and some are completed by the psychologist after observing the client's behaviour. Some of the psychological tests are as follows:

- Intelligence tests (both verbal and nonverbal)
- Achievement tests
- Kindergarten readiness tests
- Developmental tests
- Memory tests

- Aptitude test(for specific skills, such as social perception skills)
- Personality test
- Neuropsychological tests
- Direct observation test
- Psychological disorder test etc.
- **Intelligence tests** measure various aspects of mental functioning. This includes tests for reasoning, planning, decision making, and making judgments. They sometimes have a child copying designs with blocks, completing patterns, and doing mental math exercises. Some intelligence tests are completely nonverbal, meaning no language is required in administering or understanding the assessment.
- **Achievement tests** assess how a child is currently doing in a variety of academic areas. These tests can help psychologists understand whether a child is on grade level in various areas. These tests are typically used for children once they are involved in formal schooling (kindergarten and older).
- **Aptitude tests** help psychologists understand the learning ability of a child. For example, how fast the child can learn a specific skill set.
- **Developmental tests** are typically used for younger children to help determine whether they are meeting developmental milestones in various areas, including receptive and expressive communication, cognitive development, and motor development.
- **Personality tests** help screen the child for any psychological problems.
- **Observational tests** typically use a semi-structured situation, where the psychologist or other trained professional is looking for specific behaviours or actions. These types of tests are often used with autism, to determine the presence or absence of symptoms of autism. There are many different psychological assessments, and part of the evaluation involves the psychologist choosing the assessments which will provide the information needed to get the information that will be most beneficial to answer the testing questions.

Testing has traditionally involved one on one in-person appointments; however, research and technology have steadily been moving towards virtual methods of psychological evaluation. Rating scales and some psychological tests can be directly emailed to clients to complete. The use of video conferencing has rapidly moved the field of remote assessment, and more and more organizations, including many school districts and universities, are accepting remote and virtual assessments as valid and necessary during this time.

The benefits of online testing include the ability to meet for appointments from the safety and security of one's own home. Those in rural areas are able to reduce long travel times, and appointments can be broken up, especially those involving young children who would struggle with long periods of testing. Testing can be difficult for those who do not have solid internet connections at home, and disruptions in technology can be problematic.

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While every effort is made to ensure the safety and security of online sessions, there are always possibilities of internet security concerns. Psychological evaluations incorporate the results of various psychological tests to gain information about an individual and provide information about the individual's strengths and weaknesses, along with specific recommendations to address the relative weaknesses.Common questions about psychological assessment.

**How much time does a psychological evaluation take?**

This really depends on the question being asked, and the information needed to address that question. Typically, assessments involve between 2 and 4 video appointments and some questionnaires which are completed in addition to that time. It can be a time taking process; however, to get an accurate understanding of a child's functioning, it is important to address various things that may affect the child. Once all the information has been collected, the psychologist writes up all of the information in a written report and shares the information with the client, advising them on recommendations and providing any referrals for additional services.

**Do I need to prepare for a psychological testing appointment?**

No, the purpose of psychological tests is to see where a child or adult is at this point in time. If you are struggling with reading or memory, those types will likely be difficult for you; however, it is important for the psychologist to see and understand this in order to provide appropriate diagnoses and recommendations for you. Sometimes parents can become frustrated when their child does not perform particular tasks on testing day, but the psychologist would prefer to see how a child typically acts rather than their optimal functioning.

### CHECK YOUR PROGRESS

1. **List the different types of psychological tests.**
2. **Define psychological assessment.**
3. **Who Performs a Psychological Assessment?**
4. **How is a Child Psychology Test Done?**
5. **How much time does a psychological evaluation take?**

## 3.5 TESTS OF COGNITION

Cognitive assessments or intelligence tests (IQ tests) are used to determine a child's learning capability by identifying their cognitive strengths and weaknesses. When interpreted in combination with comprehensive background information and parent and teacher interviews, the results of cognitive tests can assist with the development of individualised intervention and learning plans for children. Cognitive assessments with children assist in the examination of:

- Intellectual giftedness: A cognitive assessment will help to determine whether a child can access gifted and talented programs or special classes, including admission to selective schools, acceleration or opportunity classes, and GERRIC

(UNSW). It can also guide teachers in the provision of extension activities in the classroom setting.

- Learning difficulties or disabilities: A cognitive assessment in conjunction with an educational assessment can assist in identifying the presence of a learning difficulty or disorder and help teachers make appropriate accommodations for students in the classroom. This information can be used to manage and minimise negative experiences at schools such as poor academic results, school avoidance and low self-esteem.
- Intellectual difficulties or disabilities: An assessment will assist in identifying children with an intellectual disability, which is characterised by an IQ test score at least 2 standard deviations below the mean (this often equates to an IQ score of 70). Following an assessment, children and parents will have a better understanding of how an intellectual disability impacts the child's ability to learn.
- It will also provide information to develop effective plans or accommodations in the classroom that are tailored to meet a child's specific needs. Results can also assist in making applications to access government or school disability funding, special needs teachers or special provisions (e.g. scribe) in formal school examinations.

**ASSESSMENT PROCESS**

Cognitive assessments for children require the administration of standardised psychometric tools by experienced and accredited psychologists. These tools can assess various areas of cognitive capacity, including:

- **Verbal Comprehension:** the ability to use a range of vocabulary to understand and express general knowledge and explain concepts
- **Visual Spatial:** the ability to evaluate visual details and understand visual spatial relationships
- **Fluid Reasoning:** the ability to use conceptual information from visual details and apply that knowledge
- **Working Memory:** the ability to learn, manipulate and retain information to complete new tasks
- **Processing Speed:** the ability to quickly process and make judgements about visual information.

**ASSESSMENT TOOLS**

There are various cognitive assessment tools that are used for various purposes and age groups. We commonly use the following cognitive assessment tools:

- Wechsler Intelligence Scales for Children - for children aged 6 to 16 years
- Stanford-Binet - for children aged 2 to 7 years
- Wechsler Preschool and Primary Scale of Intelligence -for children aged 2 years and 6 months to 7 years and 7 months.

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## 3.6 TESTS OF PERSONALITY AND TEMPERAMENT

**Personality Test**

Various tests have been developed for testing personality. For instance, CPQ (Childrens Personality Questionnaire) which can be described as:

- Developed by Rutherford Burchard Porter & Raymond B. Cattell (1956)
- It can be used to measure their personal, social, and academic development and aspects of their personality that mediates performance in school and social adjustment both inside and outside the classroom.
- The test measures 14 dimensions of personality in children. The 14 dimensions of personality that are being measured were identified by, R.B. Cattell, who noted that they were objectively determined source traits
- There are four forms of the CPQ test available (A, B, C, and D). There are 140 items in each form carrying 10 items per factor per form. Each form is broken down into two parts. Thus, form A is made up of Part A1 and A2, each consisting of 70 items. Similar divisions are made for forms B, C and D.
- Each item (except the factor B, intelligence, items) has a forced-choice, "yes" or "no" answer.
- The items were constructed to be as "neutral" as possible with regard to social desirability.
- It is designed to require only a normal reading vocabulary of an average child of eight.
- The test is administered without a time limit and for younger children, the testing time can be into two parts for a given form, however, one test session should not exceed 50 minutes.

**What this Test Measures:**

| LOW SCORE DESCRIPTION | FACTOR | HIGH SCORE DESCRIPTION |
|---|---|---|
| RESERVED<br>Datached, Critical, Cool, Aloof (Sizothymia) | A | WARMHEARTED<br>Outgoing, Easygoing, Participating |
| DULL<br>Crystallized, Power measure (low intelligence) | B | BRIGHT<br>Crystallized, Power measure (High Intelligence) |
| AFFECTED BU FEELINGS<br>Emotionally less stable, Easily upset (lower ego strength) | C | EMOTIONALLY STABLE<br>Calm, Matue, Faces reality (higher ego strength) |
| PHLEGMATIC<br>Undemonstrative, deliberate, Inactive (phlegmatic temperament) | D | EXCITABLE<br>Impatient, Demanding, Overactive (excitability) |

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| | | |
|---|---|---|
| OBEDIENT<br>Mild, Accommodating, Easily Led (submissive) | E | DOMINANT<br>Assertive, Competitive, Aggressive, Stubborn (dominance) |
| SOBER<br>Prudent, Serious (desurgency) | F | ENTHUSIASTIC<br>Happy-go-lucky, heedless (surgency) |
| EXPEDIENT<br>Disregards rules (Weaker superego strength) | G | CONSCIENTIOUS<br>Persevering, Staid, Rule-bound (stronger superego strength) |
| SHY<br>Treat sensitive, Timid (Threctia) | H | VENTURESOME<br>Socially Bold, Uninhibited (parmia) |
| THUGH-MINDED<br>Self-reliant, Realistic (Harria) | I | TENDER-MINDED<br>Internally Restrained (premsia) |
| ZESTFUL<br>Likes group action, Vigorous (eppia) | J | CIRCUMSPECT INDIVIDUALISM<br>Reflective, Internally restrained (Coasthenia) |
| FORTHRIGHT<br>Natural, Artless, Sentimental (artless) | N | SHREWD<br>Calculating, Artful (Shrewdness) |
| SELF-ASSURED<br>Confident, Secure, Complacement (untroubled adequacy) | O | GOLF-PRONE<br>Apprehensive, Worrying, troubled, Insecure (guilt proneness) |
| UNDICIPLINEDSELF CONFLICT<br>Careless of social rules, Follows own urges (low self-sentiment integration) | Q3 | CONTROLLED<br>Socially precise, Following self-image, Compulsive (high self-concept control) |
| RELAXED<br>Tranquil, Composed, Unfrustrated (low energetic tension) | Q4 | TENSE<br>Frustrated, Driven, Fretful (high energetic tension) |

**PSYCHOMETRIC PROPERTIES**

**Reliability**

- Test-retest reliability after a one-week interval for each of the 14 factors on the various test forms ranges from .28-.87.
- The Kuder-Richardson Formula 21 shows internal consistencies ranging from .32-.86 with clustering in the .70s.

**Validity**

Construct validity has been established and its validity indicates both the goodness of two hypothesized structure of personality and adequacy of the measures of each construct.

**Scoring of The Test**

- Separate stencils are available for scoring the answer sheet
- Two stencils are required to obtain the 14 raw scores from each of the test forms.

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- Separate norms table are provided for boys and girls.

**Norms**

There are 3 methods of converting raw scores into standard scores.

- S stens (standard deviation stens)
- N stens (normalized stens)
- Percentile Ranks

**APPLICATIONS AND USES OF THE TEST**

- To gain a greater understanding of those children whose educational progress is clearly being affected by personality problems.
- To screen out for individual attention and guide those children who need help with emotional conflicts and behaviour disorders. Due to this earlier recognition, many behaviour difficulties can be avoided or handled before they become defensive habits and other complications resistive to treatment.
- To aid the student in making decisions about future educational and vocational goals.
- Future school achievement and creativity can be more exactly predicted and understood when appropriately weighted personality measures are used.
- To encourage the keeping of meaningful developmental records for children. Clinical practice and work with delinquents and children courts all require a diagnostic instrument which operates with these basic personality concepts.
- To measure the progressive development of character and personality. If the schools keep test and criterion records of levels on emotional maturity, self-control, anxiety level, the capacity to concentrate, social learning, and other such traits, these qualities may eventually receive as much intelligent attention as is now directed to academic grades.
- It can be conveniently applied either as an individual test, in the clinic or a group test in the classroom.
- In general, it useful in evaluating, understanding, and predicting personal adjustment, social development, and academic performance.

**CRITICAL ANALYSIS**

The CPQ includes all of the more adequately research demonstrated dimensions of personality from the general personality sphere and thus has wide applicability in both clinical and educational settings. It provides us with more broad and specific measures of personality in terms of an individual's characteristics.

However, the standardization sample has not been described in sufficient detail for objective evaluation, and that the handbook is also unclear as to when the data was collected. There is very little data to guide the interpretation of test score profiles. Also, the scoring and administration can be very tedious considering the items and time for separate test sessions.

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A re-examination of the validity of the Children's Personality Questionnaire must be done according to its reviewers since its factors were not found to correlate significantly with those it is supposed to measure. Thus, the test also needs a lot of revision and modification as the results of new research provide even more valid estimates and better psychological understanding of higher-order personality structure in young children.

## 3.7 PSYCHOLOGICAL ASSESSMENT FROM A CLINICIAN PERSPECTIVE

In order for a mental health professional to be able to effectively treat a client and know that the selected treatment actually worked (or is working), he/she first must engage in the clinical assessment of the client. Clinical assessment refers to collecting information and drawing conclusions through the use of observation, psychological tests, neurological tests, and interviews to determine what the person's problem is and what symptoms he/she is presenting with. This collection of information involves learning about the client's skills, abilities, personality characteristics, cognitive and emotional functioning, social context (e.g., environmental stressors), and cultural factors particular to them such as their language or ethnicity. Clinical assessment is not just conducted at the beginning of the process of seeking help but all throughout the process. Why is that?

Consider this. First, we need to determine if a treatment is even needed. By having a clear accounting of the person's symptoms and how they affect daily functioning we can determine to what extent the individual is adversely affected. Assuming treatment is needed, our second reason to engage in clinical assessment is to determine what treatment will work best. As you will see later in this chapter, there are numerous approaches to treatment. These include Behaviour Therapy, Cognitive Therapy, Cognitive-Behavioural Therapy (CBT), Humanistic-Experiential Therapies, Psychodynamic Therapies, Couples and Family Therapy, and biological treatments (e.g., psychopharmacology). Of course, for any mental disorder, some of the aforementioned therapies will have greater efficacy than others. Even if several can work well, it does not mean a particular therapy will work well for that specific client. Assessment can help the clinician figure this out.

Finally, we need to know if the treatment worked. This will involve measuring symptoms and behaviour before any treatment is used and then measuring symptoms and behaviour while the treatment is in place. We will even want to measure symptoms and behaviour after the treatment ends to make sure symptoms do not return. Knowing what the person's baselines are for different aspects of psychological functioning will help us to see when improvement occurs. In recap, obtaining the baselines happens in the beginning, implementing the treatment plan happens more so in the middle, and then making sure the treatment produces the desired outcome occurs at the end. It should be clear from this discussion that clinical assessment is an ongoing process.

**Key Concepts in Assessment:**

Important to the assessment process are three critical concepts – reliability, validity, and standardization. Actually, these three are important to science in general. First, we want assessment to be reliable or consistent. Outside of clinical assessment, when our car has an issue and we take it to the mechanic, we want to make sure that what one mechanic says is wrong with our car is the same as what another says or even two others.

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If not, the measurement tools they use to assess cars are flawed. The same is true of a patient who is experiencing a mental disorder. If one mental health professional says the person has major depressive disorder and another says the issue is borderline personality disorder, then there is an issue with the assessment tool being used. Ensuring that two different raters (e.g., mechanics, mental health professionals) are consistent in their assessments is called interrater reliability. Another type of reliability occurs when a person takes a test one day, and then the same test on another day.

We would expect the person's answers to be consistent with one another, which is called test-retest reliability. An example is if the person takes the Minnesota Multiphasic Personality Inventory (MMPI) on Tuesday and then the same test on Friday, then unless something miraculous or tragic happened over the two days in between tests, the scores on the MMPI should be nearly identical to one another. In other words, the two scores (test and retest) should be correlated with one another. If the test is reliable, the correlation should be very high (remember, a correlation goes from -1.00 to +1.00 and positive means as one score goes up, so does the other, so the correlation for the two tests should be high on the positive side).

In addition to reliability, we want to make sure the test measures what it says it measures. This is called validity. Let's say a new test is developed to measure symptoms of depression. It is compared against an existing, and proven test, such as the Beck Depression Inventory (BDI). If the new test measures depression, then the scores on it should be highly correlated with the ones obtained by the BDI. This is called concurrent or descriptive validity. We might even ask if an assessment tool looks valid. If we answer yes, then it has face validity, though it should be noted that this is not based on any statistical or evidence-based method of assessing validity. An example would be a personality test that asks about how people behave in certain situations. It, therefore, seems to measure personality or we have an overall feeling that it measures what we expect it to measure.

A tool should also be able to accurately predict what will happen in the future, called predictive validity. Let's say we want to tell if a high school student will do well in college. We might create a national exam to test needed skills and call it something like the Scholastic Aptitude Test (SAT). We would have high school students take it by their senior year and then wait until they are in college for a few years and see how they are doing. If they did well on the SAT, we would expect that at that point, they should be doing well in college. If so, then the SAT accurately predicts college success. The same would be true of a test such as the Graduate Record Exam (GRE) and its ability to predict graduate school performance.

Finally, we want to make sure that the experience one patient has when taking a test or being assessed is the same as another patient taking the test the same day or on a different day, and with either the same tester or another tester. This is accomplished with the use of clearly laid out rules, norms, and/or procedures, and is called standardization. Equally important is that mental health professionals interpret the results of the testing in the same way or otherwise it will be unclear what the meaning of a specific score is.

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## METHODS OF ASSESSMENT

So how do we assess patients in our care? We will discuss psychological tests, neurological tests, the clinical interview, behavioural assessment, and a few others in this section.

### The Clinical Interview

A clinical interview is a face-to-face encounter between a mental health professional and a patient in which the former observes the latter and gathers data about the person's behaviour, attitudes, current situation, personality, and life history. The interview may be unstructured in which open-ended questions are asked, structured in which a specific set of questions according to an interview schedule are asked, or semi-structured, in which there is a pre-set list of questions but clinicians are able to follow up on specific issues that catch their attention.

A mental status examination is used to organize the information collected during the interview and to systematically evaluate the client through a series of observations and questions assessing appearance and behaviour (e.g., grooming and body language), thought processes and content (e.g., disorganized speech or thought and false beliefs), mood and affect (e.g., hopelessness or elation), intellectual functioning (e.g., speech and memory), and awareness of surroundings (e.g., does the client know where he/she is, when it is, and who he/she is?). The exam covers areas not normally part of the interview and allows the mental health professional to determine which areas need to be examined further. The limitation of the interview is that it lacks reliability, especially in the case of the unstructured interview.

### Psychological Tests and Inventories

Psychological tests are used to assess the client's personality, social skills, cognitive abilities, emotions, behavioural responses, or interests and can be administered either individually or to groups. Projective tests consist of simple ambiguous stimuli that can elicit an unlimited number of responses. They include the Rorschach test or inkblot test and the Thematic Apperception Test which requires the individual to write a complete story about each of 20 cards shown to them and give details about what led up to the scene depicted, what the characters are thinking, what they are doing, and what the outcome will be. From these responses, the clinician gains perspective on the patient's worries, needs, emotions, conflicts. Another projective test is the sentence completion test and asks individuals to finish an incomplete sentence. Examples include 'My mother' …. or 'I hope.'

Personality inventories ask clients to state whether each item in a long list of statements applies to them, and could ask about feelings, behaviours, or beliefs. Examples include the MMPI or Minnesota Multiphasic Personality Inventory and the NEO-PI-R which is a concise measure of the five major domains of personality – Neuroticism, Extroversion, Openness, Agreeableness, and Conscientiousness. Six facets define each of the five domains and the measure assess emotional, interpersonal, experimental, attitudinal, and motivational styles (Costa & McCrae, 1992). These inventories have the advantage of being easy to administer by either a professional or the individual taking it, are standardized, objectively scored, and are completed either on the computer or through paper and pencil.

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That said, personality cannot be directly assessed and so you can never completely know the individual on the basis of these inventories.

**Neurological Tests**

Neurological tests are also used to diagnose cognitive impairments caused by brain damage due to tumors, infections, or head injury; or changes in brain activity. Positron Emission Tomography or PET is used to study the brain's functioning and begins by injecting the patient with a radionuclide which collects in the brain. Patients then lie on a scanning table while a ring-shaped machine is positioned over their head. Images are produced that yield information about the functioning of the brain.

Magnetic Resonance Imaging or MRI produces 3D images of the brain or other body structures using magnetic fields and computers. They are used to detect structural abnormalities such as brain and spinal cord tumors or nervous system disorders such as multiple sclerosis. Finally, computed tomography or the CT scan involves taking X-rays of the brain at different angles that are then combined. They are used to detect structural abnormalities such as brain tumors and brain damage caused by head injuries.

**Physical Examination**

Many mental health professionals recommend the patient see their family physician for a physical examination which is much like a check-up. Why is that? Some organic conditions, such as hyperthyroidism or hormonal irregularities, manifest behavioural symptoms that are similar to mental disorders and so ruling such conditions out can save costly therapy or surgery.

**Behavioural Assessment**

Within the realm of behaviour modification and applied behaviour analysis, is behavioural assessment which is simply the measurement of a target behaviour. The target behaviour is whatever behaviour we want to change and it can be in excess (needing to be reduced), or in a deficit state (needing to be increased). During behavioural assessment we assess the ABCs of behaviour:

- Antecedents are the environmental events or stimuli that trigger a behaviour
- Behaviours are what the person does, says, thinks/feels; and
- Consequences are the outcome of a behaviour that either encourages it to be made again in the future or discourages its future occurrence.
- Though we might try to change another person's behaviour using behaviour modification, we can also change our own behaviour using self-monitoring which refers to measuring and recording one's own ABCs. In the context of psychopathology, behaviour modification can be useful in treating phobias, reducing habit disorders, and ridding the person of maladaptive cognitions.

A limitation of this method is that the process of observing and/or recording a behaviour can cause the behaviour to change, called reactivity. Have you ever noticed someone staring at you while you sat and ate your lunch? If you have, what did you do? Did you change your behaviour? Did you become self-conscious? Likely yes and this is an example

of reactivity. Another issue is that the behaviour that is made in one situation may not be made in other situations, such as your significant other only acting out at their favorite team's football game and not at home. This form of validity is called cross-sectional validity.

**Intelligence Tests**

Intelligence testing is occasionally used to determine the client's level of cognitive functioning. Intelligence testing consists of a series of tasks asking the patient to use both verbal and nonverbal skills. An example is the Stanford-Binet Intelligence test which is used to assess fluid reasoning, knowledge, quantitative reasoning, visual-spatial processing and working memory. These tests are rather time-consuming and require specialized training to administer. As such, they are typically only used in cases where there is a suspected cognitive disorder or intellectual disability. Intelligence tests have been criticized for not predicting future behaviours such as achievement and reflecting social or cultural factors/biases and not actual intelligence.

## 3.8 USES OF PSYCHOLOGICAL ASSESSMENT

Some may seek evaluations to help understand a patient's emotional and/or personality functioning, especially because the testing helps learn about the individual in a more comprehensive way in a shorter amount of time (instead of over several therapy sessions). Results from these measures can help with recommendations for mental health treatment, such as with use of medications and/or for therapy (such as which strategies can be most helpful to teach the patient).

Findings can also help guide other referrals, such as to other specialists (such as a psychiatrist or a neurologist). Depending on the age of the patient, these measures may include questionnaires that are only completed by the patient themselves (this is particularly the case among adult patients). When assessing a child, parents often complete questionnaires that ask about what they observe (behaviourally and emotionally) in their child. When the patient is an adolescent, it is more common that a combination of emotional and personality questionnaires is included that involve the adolescent responding to self-report measures and the parent(s) or primary caregiver(s) responding to their own measures involving observations of the child.

Parent or caregiver responses are particularly helpful (and often necessary) when assessing children and adolescents, as most children and many adolescents lack enough insight or awareness into their difficulties, and often parents are the ones to observe problems or concerns first. These evaluations are conducted in clinical settings such as outpatient practices and sometimes inpatient hospitals in which obtaining such information is necessary to guide a clinician's diagnostic impressions and treatment recommendations.

Another type of psychological assessment is a neuropsychological evaluation that helps measure more detailed aspects of cognitive functioning, such as executive functioning abilities (i.e., one's ability to plan, organize, and inhibit cognitive, emotional, and behavioural responses), attention, learning, memory, and even motor coordination and/

or strength. Individuals who specialize in these types of assessments are required to have completed more thorough post-doctoral training.

Often times, referrals may come from physicians or therapists who are concerned about a patient's functioning in these areas, whether it be related to a neurological condition (such as a seizure disorder, a head injury, or dementia) or to a psychiatric disorder (in which it is common for mood states or anxiety to negatively affect one's cognitive functioning). Neuropsychological assessments are most often conducted in medical-based settings. Yet, they can also be conducted when a more comprehensive evaluation is sought after (such as in psychiatric residential settings). When this is the case, a neuropsychological assessment battery can capture one's functioning more globally with measures of intelligence, academic achievement, neurocognitive abilities, and personality and emotional functioning.

A final consideration for any kind of psychological assessment is this: while testing is often sought after to diagnose a condition or to understand one's possible difficulties in any area of functioning, it is also important to learn what someone's strengths are. Everyone has strengths and weaknesses relative to their own abilities; it is helpful to inform individuals from testing of what their strengths are and how to use these to compensate for any documented weaknesses they may have. Information helps empower people to develop and grow, and results obtained from psychological assessment can help people be more informed as to how to proceed with utilizing their cognitive and/or emotional strengths to help improve their mental health overall.

Psychological testing results can represent the integral missing piece of a complex and fascinating puzzle. Each client comes in with their own multi-faceted experiences, difficulties, strengths, worldview, and perspective. They want to improve their lives, and feel frustrated and confused by their internal struggles. Psychological testing can provide the missing piece of the puzzle as it gathers invaluable information in helping clients achieve their life worth living goals.

Comprehensive psychological testing gives a breadth of information in a fairly short duration of time regarding numerous facets of a person's life, including their overall cognitive ability, personal behaviours, traits, and personality functioning. The data obtained through psych testing give both the client and the clinician insight into the client's world through their unique perspective.

Mental health, in general, is not a one-size-fits-all paradigm, and when treatment is tailored to each individual it usually results in a better outcome. The more that is known regarding an individual's functioning in the assessment phase of therapy, (e.g., interpersonal, intrapersonal, emotional, behavioural, and cognitive) the more we as a team can provide tailored and effective treatment for each unique individual. Data gathered through psychological testing can aid in identifying specific challenges, areas of need, clarifying diagnoses, and illuminates strengths to be incorporated, all of which can lead to more effective points of intervention and treatment planning, to help clients thrive even in the face of adversity.

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**Psychological Testing provides:**

- Developmental abilities of clients
- Increased accuracy of diagnoses
- Rich information about current levels of functioning
- An understanding of the problematic behaviours
- Highlights areas in need of additional support
- Client strengths to be incorporated into treatment
- More targeted goals for treatment planning

## 3.9 CHAPTER SUMMARY

Psychological assessment has been an integral part of clinical psychology since its inception and continues to the present day to provide practitioners with valuable information to guide their evaluation and treatment of persons who seek their help. At times, failure, to appreciate the benefits of preceding treatment with thorough assessment has led to insufficient teaching and learning of psychodiagnostics methods by clinical psychologists, as has the regrettable and short-sighted devaluing of diagnostic procedures by health insurance providers. However, the future application of psychodiagnostics methods in clinical psychology appears to rest safely in the hands of practitioners and researchers who know from their experience and data how useful assessment can be in facilitating good clinical decisions. Psychological assessment is the appropriate understanding of the psychological attributes or characteristics of an individual or group of individuals using standardised techniques of measurement having sufficient characteristics of reliability and validity. There are a variety of assessment techniques. They range from unstructured interview to structured psychological test. The main goal of these techniques is to predict job performance. There may be variety of psychological tests in which they are constructed and administered or in terms of behaviour they measure, viz., individual or group tests, speed or power tests, paper-and-pencil tests or performance tests, computer assisted tests are examples of the former, and cognitive ability, motor ability, aptitude, interest and personality tests are the examples of the latter. Personality characteristics are measured by self-report inventories and projective techniques. Psychological tests are by far the best selection devices. There are however certain limitation of psychological testing, viz., uncritical use, unfair rejection of applicants, faking of test responses, conformity and poor test administration.

## 3.10 REVIEW QUESTIONS

### SHORT ANSWER TYPE QUESTIONS

1. **What does a psychological assessment address?**
2. **What does psychological testing provide?**
3. **What do you understand by behavioural assessment?**
4. **Discuss the various psychometric properties.**

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5. **List the various cognitive assessment tools that are used for various purposes.**

## LONG ANSWER TYPE QUESTIONS

1. **What should parents of children undergoing psychological assessment expect?**
2. **What are the uses of psychological assessment?**
3. **Discuss the assessment process of tests of cognition.**
4. **What are the different methods of psychological assessment?**
5. **Discuss the application of test of personality and temperament.**

## 3.11 MULTIPLE CHOICE QUESTIONS

1. **What is the full form MRI?**
   a. Magnetic Resonance Imaging
   b. Magnetic Resonance Inventory
   c. Multiphasic Resonance Imaging
   d. None of these
2. **What is the full form of PET?**
   a. Personality Emission Tomography
   b. Positron Emission Tomography
   c. Positron Emission Technology
   d. None of these
3. **_________________ help screen the child for any psychological problems.**
   a. Aptitude tests
   b. Developmental tests
   c. Personality tests
   d. Observational tests
4. **_________________ are used to determine a child's learning capability by identifying their cognitive strengths and weaknesses.**
   a. Cognitive assessments
   b. Intelligence tests
   c. Both a and b
   d. Personality tests
5. **What is the full form of BDI?**
   a. Beck Depression Inventory
   b. Beck Depression Invention
   c. Beck Developmental Inventory
   d. None of these
6. **_________________ assess how a child is currently doing in a variety of academic areas.**
   a. Achievement tests
   b. Developmental tests

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c. Personality tests
d. Observational tests

**7. ________________ measure various aspects of mental functioning.**

a. Developmental tests
b. Personality tests
c. Observational tests
d. Intelligence tests

**8. What is the full form of MMPI?**

a. Minnesota Magnetic Personality Inventory
b. Minnesota Multiphasic Personality Inventory
c. Minnesota Multiphasic Personality Imaging
d. None of these

**9. _____________ the ability to quickly process and make judgements about visual information.**

a. Processing Speed
b. Visual Spatial
c. Fluid Reasoning
d. Working Memory

**10. _____________ the ability to evaluate visual details and understand visual spatial relationships**

a. Processing Speed
b. Fluid Reasoning
c. Visual Spatial
d. Working Memory

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UNIT IV

# COUNSELLING CHILDREN

**STRUCTURE**


4.1 Learning Objective
4.2 Introduction
4.3 Specific Problems and Disorders in Children
4.4 Academic Problems
4.5 Learning Disability (LD)
4.6 Attention Deficit Hyperactivity Disorder (ADHD/ADD)
4.7 Autism Spectrum Disorders
4.8 Externalizing Problems
4.9 Internalizing Problems
4.10 Developmental Problems and Specific Developmental Delays
4.11 Language Disorders
4.12 Child Psychopathology
4.13 Chapter Summary
4.14 Review Questions
4.15 Multiple Choice Questions

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## 4.1 LEARNING OBJECTIVE

**After completing this unit, you will be able to:**

- Understand about specific problems and disorders in children.
- Know about learning disability.
- Learn about attention deficit hyperactivity disorder.
- Learn about externalizing and internalizing problems.
- Understand about developmental problems and specific developmental delays.
- Learn about child psychology.

## 4.2 INTRODUCTION

Child's development, its meaning, study, research, and child counselling are some of the interesting and exciting areas in today's world. Researches about development have also been stimulated by the social pressure to better the life of children. While studying child development and counselling, certain questions arise in mind. In what way are children's home, school, and neighbourhood experience the same today as they were in generation past and in what way are, they different? What perception children have of the world in general and how is it different today? What is the role of heredity and environment on the development of children?

The above are some of the important and central questions in regard to child development and counselling. In order to look into and to study child development / and how to counsel children, the following three domains are to be considered, viz., (i)Physical development (ii) Cognitive development and (iii) Environment and social development. Let us deal with each of these in detail.

1. **Physical Development**
   This comprises of changes in body size, proportion, and appearance, functioning of body system, brain development, perception, motor capacity and psychical health. Special professional help is provided if there is any delay in any of the areas of physical development or any development which is not in accordance with the normal developmental schedule.

2. **Cognitive Development**
   This refers to a wide variety of thought processes and intellectual abilities, including attention, memory, academics and every day knowledge, creativity, imagination, problem solving etc. With the increase in age, the capabilities and capacities in regard to all the above areas also increase. However, there are children who do not show any increase but conspicuous stagnation or decrease in a few or many of these areas and these disturbances obviously affect the growth and development of children. In such cases, professional consultation may be needed so as to help these children overcome such problems. Such problems may arise due to social factors or environmental factors or in certain cases it could be due to hereditary factors too. The root cause of the problem is generally identified by the counsellor, and counselling is carried on depending on the causative factors so identified.

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3. **Environmental and Social Development**

   It is the development of the emotional communication, self-understanding, ability to manage one's feelings, knowledge about other people, interpersonal skills, friendship, moral reasoning and behaviour, which all develop as children start growing up from stage to stage. According to Erikson's psycho social theory of development, the various stages of development are classified on the basis of social and social and emotional development. For instance, in the 1st year of life the social and emotional development is indicated in the trust v/s mistrust in the child. In the second stage the social and emotional development is indicated in the development of initiative versus guilt, in the third stage, it is characterised by industry versus inferiority and so on and at the final adult stage it is the ego integrity versus despair.

   At each stage of development, the problem and the conflicts that arise are resolved and the individual moves on to the next stage of development and so on. If at any of the stages of development the problems and conflicts are not resolved, the individual may develop all kinds of complexes, inferiority feelings, insecurities, low self-esteem, becomes unsocial, lacks decision making power etc. In all such cases counselling will be required to both understand the causes and treat the same and bring the individual back to normal level. In this unit we will be dealing with all these factors and also many of the childhood disorders which need counselling.

## 4.3 SPECIFIC PROBLEMS AND DISORDERS IN CHILDREN

According to the recent estimates, 17% to 22 % of the children under age of 18 years meet the diagnostic criteria for one or more mental disorders. Of these ,11 to 14 million children, that is at least half of them may be severely handicapped by this order, and half may have trouble coping with the demands of community, family and school. Some behavioural disorders in childhood have long term effect. Maladaptive behaviour in childhood results from normal variations in rates of development. Early childhood experiences which are negative can also lead to inadequacy and inferiority in adulthood. Children who are unable to master academic work when their classmates are able to, it would indicate that these children are having some serious problem in learning.

So, the counsellor must keep in mind that if these childhood problems are not solved then there are chances that these children when grow up as adults may suffer from low self-esteem, depression, anxiety, inferiority complex, etc. and may also develop some or the other personality disorder in later years of life. Many of the untreated children are likely to progress into severely mentally ill adults. According to Jensen (1990) the factors include prenatal psycho pathology, family discord, divorce, low social economic status, child abuse, temperamental characteristics and stressful experiences. Egland et al (1993) stated that abused children have very high rate of psychological problems and these children require counselling as through counselling many of these problems could be sorted out and thus when they grow old and become adults, they will have balanced personality and will be helpful for themselves, family and society.

This chapter will focus on developmental problems of children and how these Counselling Children problems can be handled through various measures /counselling. The most

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commonly known developmental problem faced by the children is LD (Learning Disability), attention deficit hyperactivity disorder (ADHD), Anxiety Disorder (AD), Disorders such as Enuresis, Encopresis, Sleep Walking, Tics, Autism, etc.

## 4.4 ACADEMIC PROBLEMS

Gender issues, rising inequity, and immigration concerns are challenging that school counsellors face with their students. In 2017, the American School Counsellors Association Assistant Director Eric Sparks identified what he considers the top challenges faced by school counsellors. Many of the challenges are hot-button issues that reflect the major societal change with effects that go way beyond the hallowed halls of the chool. Other challenges posed by Sparks are more unique to school communities.

**College Readiness And Vocational Guidance:**
Sparks called this "planning." One of the biggest jobs a school counsellor has is helping a child plan for his or her future, whether that means continuing on to higher education, joining the military or entering the workforce. Ideally, a school counsellor would be involved with this process since the student entered school, providing guidance and study skills and intervening during times of poor or declining school performance. Some school counsellors even accompany students on college visits and walk them through the application process.

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- **Stress**
  "There's a lot of pressure on students these days to perform well, whether that be academically or through activities and sports," Sparks points out, "and we're more aware as a society about these kinds of issues. In the past, that might have been dismissed. But today, we have a lot more awareness of things like stress, depression, anxiety, and bipolar diagnoses. So, school counsellors need to know how to connect students with resources that can help them."School counsellors are not tasked with diagnosing mental illnesses. Some are specially certified to test for and diagnose learning disabilities.
- **Bullying**
  Bullying has always been a problem in schools—just watch any teen movie from any era. But one of the factors that have put bullying in so many headlines lately is the ubiquitous nature of social media. Yes, the rivalry between the Jets and the Sharks spilt out of the halls of the high school and into the streets, but these days a student's tormentors can follow him home and continue to bully him in his bedroom via social media.Some school counsellors monitor social media to varying degrees. As a preventative measure, counsellors are also involved with media education and lessons about how to use social media responsibly.

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- **Trauma and Crisis**
  A study from the National Child Traumatic Stress Network found that one in every four children attending school has been exposed to a traumatic event outside of school that can affect learning and/or behaviour. Individuals can experience trauma at home or in the family that affects their academics, social lives, and emotional development. Often students are not forthcoming when they are suffering from trauma. School counsellors help to identify students in crisis and what kind of support and resources they need.

  When a natural disaster, school emergency and/or death of a student or faculty member occurs, an entire community of students and faculty may experience trauma together. Typically, when a school experiences trauma, a team of crisis counsellors leads the community through recovery. The school counsellor plays an important role in leading the team.

## 4.5 LEARNING DISABILITY (LD)

LD is a kind of disorder where inadequate development may be manifested in language, speech, math, or in motor skill area. This may or may not be due to physiological or neurological defect. Most common subtype of learning disability is Dyslexia which is collectively known as reading writing difficulty or vice versa. In LD the children find difficulty in recognising and reading comprehension, often he/ she is found markedly deficient in spelling as well as in reading. The learning disability children are generally identified during the early years of childhood, because of the apparent disparity between their expected academic achievement level and their actual academic performance in one or more subjects such as Maths, English, Hindi etc. These children have an average IQ and do not have emotional problems nor do they seem to be lacking in motivation or cooperation.

### CASUAL FACTORS OF LEARNING DISABILITY

These disorders are a result of some sort of disability, immaturity, or deficiency limited to certain brain functions supportively mediating, as for example dyslexia is associated with failure of brain to develop in normally asymmetrical manner with respect to the right and left hemisphere. The portion of left hemisphere where language functioning is normally mediated, it is under developed in many such cases. Some researchers have also indicated that learning disorder also develops because of genetic transmission. Learning disorder may be due to certain basic psychological processes within the individual. It may also be because of extrinsic factors like sensory impairment, emotional disturbances, cultural differences and lack of educational opportunities etc.

### NATURE AND CHARACTERISTIC OF LEARNING DISORDER

The counsellor must remember the following points before diagnosing learning disorder in children Learning disabled children essentially suffer from serious learning problems for number of reasons. The problems and disorder are usually manifested by significant difficulties in the acquisition and use of languages (reading, writing, speaking etc), reasoning of social skills, etc. They may show symptoms of hyper activity, impulsivity and most of them show symptoms of anxiety. Learning disorder in children is not apparent in the physical appearance. Learning disorder can occur with normal intelligence. Learning

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disorder children show significant educational discrepancy i.e. avoid gap between their learning potential and actual educational achievement and they lack in mastering the academic part.

**TECHNIQUES FOR HELPING LEARNING DISABILITY**

There are several specialised counselling techniques and approaches that have been involved by the counsellor's while working with the learning-disabled children. Brief introductions of some of them are as follows:

a. **Behaviour modification approach:** In this approach the counsellor makes attempts to modify the behaviour of LD children. By reconstructing and reorganising the environmental conditions, providing opportunities for modification and change in behaviour, using proper reinforcement they help the LD children acquire desirable learning behaviour. The other counselling techniques which a counsellor uses for treating learning disorder includes token economy, positive reinforcement, timeout procedures and other behaviour modification techniques.

b. **Psycho analytic approach:** In this approach attempts are made to analyse the behaviour of the disabled child after establishing very good rapport with then child, and find out the root cause of learning disorder. Accordingly, a remedial program is planned and administered to the child to overcome the problem.

c. **Individualised instructional approach:** This technique of counselling advocates the use of small groups or even individuals for helping them to rectify their learning deficiencies. Peer tutoring has proved to be a successful technique for providing individual assistance to the affected children. The child feels quite safe and secure, and in this atmosphere with the help of the peer, the child is able to come up to a satisfactory learning level.

d. **Self-instructional approach:** In this approach the counsellor helps the children by making them realise the concept of self-learning and self-improvement measures. For this purpose, remedial programs are presented in the form of program learning text, computer assisted instructions etc. One can also include self-learning questionnaire and instructional module specially prepared for this purpose and put to use by the counsellor with the help of the teacher. For better output these programs should be guided by the counsellor.

e. **Multisensory approach:** In this type of counselling the counsellor help the LD children to use their multiple senses e.g. visual, touch, auditory etc depending upon the nature of subject material and its learning objective e.g. to provide wholesome languages experiences, a multisensory approach VAKT i.e. Visual Auditory Kinesthetic and Tactile has been devised. While counselling, the counsellor must remember to use step by step method, where the children are first acquainted with the letters of words and then slowly with the word. Once the word is mastered the learner is asked to make use of it in a sentence, then into a story writing, after that they are finally provided reading practices.

f. **Technological approach:** In this approach the counsellor can make use of advanced technology for providing remedial instructional program.

In this type of remedial instruction visual and auditory presentation are made by which the children can watch useful and interesting social and academic presentation on the video disc. At the same time, they listen to the narration with useful instructions.

**Audio tape recorder:** Reading, speaking and conversation skills can be better developed within the child with the help of the tape recorder. The counsellor is able to rectify many of languages learning difficulty, specially related to the pronunciation and way of speaking.

**Computer Assisted Instructions (CAI):** Severe LD cases find it difficult to follow Counselling Children classroom teaching and text book. For them, hypertext technology and hyper media technology are used and provision for using computer and computer technology is given. Additional help to the LD children, particularly in severe cases the counsellor can provide the certifications of LD and help them use computer while appearing in examination. In this way the advanced technology can be utilised for providing useful remedial measures to the learning-disabled problems.

### CHECK YOUR PROGRESS

1. **Describe some of the important childhood disorders.**
2. **What is learning disability?**
3. **What causes learning disability?**
4. **What kind of counselling will help in LD?**
5. **What is self-instructional approach?**

## 4.6 ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD/ADD)

This is another common problem seen in the childhood, as 5% to 7 % of the school age children suffer from the (ADHD) Goldman et al. (ADHD ) often referred to as hyperactivity is characterised by difficulties that interfere with effective task oriented behaviour in the children particularly – impulsivity, excessive, motor activity, and difficulties in sustaining attention. The prevalence of ADHD is much among the boys than of the girls (6 to 9 times more). ADHD occurs with the greatest frequency before the age of eight or nine.

### SYMPTOMS OF ADHD

The counsellor must see the following symptoms in the client before deciding that the child suffers from ADHD.

ADHD hyperactive children show excessive or exaggerated muscular activity; such as aimless or haphazard running or fidgeting.

- Difficulty in sustaining attention.
- Highly distractible and fail to follow instructions.
- Do not respond to the demands placed on them. Impulsive behaviour.
- Low frustration tolerance.
- Sometimes low IQ (below average) but not always at times they are socially intrusive.
- Have great difficulty in getting along with their parents because they do not obey rules.
- Do not appear to be anxious.
- Commonly shows specific learning disabilities as they are poor in academics.

- Pose behavioural problems in elementary grades/classes.

**CASUAL FACTORS IN ADHD**

At present the causes for ADHD are not known but probable causes of ADHD may be environment, biological, genetic or social. Many psychologists consider the biological factor, as the genetic inheritance to be the cause of developing ADHD. Hyper activity in children may be produced by dietary factors such as food colorings, food addictive, food adulteration, preservatives etc.

Due to such foods, hyperactivity Counselling Children increases because of the extra energy consumed by the children in form of chocolate candy, fast food etc. The psychological causes of hyper activity are based on the temperament and learning factors in addition to family pathogens, prenatal problems leading to hyperactivity in children.

**TECHNIQUES FOR HELPING THE ADHD CHILDREN**

Most common treatment is the use of drug that stimulates the central nervous system. In ADHD, the counselling techniques used are more or less the same as the ones used in learning disability. In ADHD these counselling techniques are used along with medications. Psycho social approaches of counselling may also be used. The medication is seen effective only when it is combined with behaviour modification, parental training etc. and has been found to be more effective in changing the social behaviour of ADHD (Pelham 1993).

Counselling the parent of child and involving them in the treatment plan and behavioural aspect of the treatment are extremely important. It is the duty of the counsellor that after diagnosing the problem correct information about the disorder should be given to parents /caretaker which should include its neutral course, positive cases, prognosis with and without treatment. They should also be given practical suggestions for the daily management of their child e.g. parents must learn the importance of avoiding stressful situation known to cause difficulty and excessive fatigue. During the parental counselling the parents can be taught the general principle of structuring the child's environment to include regular routine and proper limits set on on the child behaviour.

According to the need, and if the counsellor feels that family counselling is required then the same should be taken up with the family members. Such family counselling may help because family therapy is an umbrella where whole family is the unit by which ADHD child in the family can be treated. In addition, the counsellor must focus on the behaviour therapies / counselling which includes social modeling and imitation, social management, social support, self-instructions, self-praise and behaviour contract. Apart from this if required integrative counselling technique can be used by the counsellor. More over medication and yoga has been demonstrated to be extremely effective in treating ADHD.

## 4.7 AUTISM SPECTRUM DISORDERS

Autism is a PDD (Pervasive Development Disorder). These disorders are considered to be the result of some structural differences in the brain that are usually evident at birth or become apparent as the child begins to develop. Autism is a development disorder which involves wide range of problematic behaviour. This includes defecting language,

perception, motor development not related to reality and social situations. Sometime intellectual ability is also hindered as there is impairment on memory as well.

**CAUSES OF AUTISM SPECTRUM DISORDER**

Scientists are not certain about what causes ASD, but it is likely that both genetics and environment play a role. Researchers have identified a number of genes associated with the disorder. Studies of people with ASD have found irregularities in several regions of the brain. Other studies suggest that people with ASD have Counselling Children abnormal levels of serotonin or other neurotransmitters in the brain. These abnormalities suggest that ASD could result from the disruption of normal brain development early in foetal development caused by defects in genes that control brain growth and that regulate how brain cells communicate with each other, possibly due to the influence of environmental factors on gene function.

Twin and family studies strongly suggest that some people have a genetic predisposition to autism. Identical twin studies show that if one twin is affected, there is up to a 90 percent chance the other twin will be affected. There are a number of studies in progress to determine the specific genetic factors associated with the development of ASD. In families with one child with ASD, the risk of having a second child with the disorder is approximately 5 percent, or one in 20. This is greater than the risk for the general population. Researchers are looking for clues about which genes contribute to this increased susceptibility.

**TECHNIQUES FOR HELPING CHILDREN WITH ASD**

The counsellor can provide following method of counselling:

- Help the client in mastering the fundamentals of social behaviour
- Development of some language skills
- Behavioural counselling
- Parental counselling
- Training children to do their own work
- Engaging the child in various activities
- Behaviour modification techniques etc.

The first dimension of parenting behaviour is the Parental acceptance and warmth which appear to influence the degree to which the children internalise the standard and expectations of their parent (Eccles et al 1997). It should be noted by the counsellor s that children whose parents do not hold them in high regard they develop low self-esteem and low self-control and suffer from many anxiety disorders and other emotional and behavioural problems. The second dimension of parenting behaviour is parental strictness and parental standards. The absence of control is associated with maladjustment and high level of aggression.

Where parents are moderately controlling and sets up a high-performance standard and expects increasingly mature behaviour from children are bound to have children showing high aggression. Therefore, the counsellor during parental counselling must make it clear

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to the parent about their parenting style and how it adversely affects the development of child's behaviour. The counselling must focus on helping parents to use permissible parenting style that is, acceptance and low control. They should stay alert for good behaviour and reward it, and reinforce rules consistently.

More over the counsellor should make it clear to the teachers/parents/caretakers/ family members etc., that punishment should not damage the child's self-esteem. The punishment should be swift and consistent if the child is punished, he/she should be explained the reason for punishment. The best strategy is to punish an undesirable response and reward the positive alternative behaviour. For example, many troublesome behaviours in children may take the form of attention seeking. Punishment of these responses will be more effective if parents and teachers provide the child with more acceptable ways to gain attention.

## 4.8 EXTERNALIZING PROBLEMS

What is Externalizing Behaviour?

The externalizing behaviour definition is negative behaviour that is acted out by an individual and is directed toward the environment. An individual with externalizing behaviour is not able to express their negative emotions in a healthy way. These individuals express their negative emotions by acting out towards other individuals or objects, rather than acting negatively toward themselves. The main characteristics of externalizing behaviour are aggression, defiance, and a lack of emotional control and self-control. Physical aggression, verbal aggression, vandalism, lying, cheating, and stealing are symptoms of externalizing behaviours.

**Externalizing Behaviour Examples**

As with internalizing behaviour, there are also many examples of externalizing behaviour that present themselves when an individual is undergoing great anguish. Below are a few of these examples, which vary widely in severity of their personal effects and effects on others:

- Verbal irritability
- Increased alcohol or drug use
- Overeating or undereating
- Impulse-control Issues
- Outbursts
- Confrontational behaviour
- Physical and verbal aggression
- Violent outbursts or behaviour

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### Causes of Externalizing Behaviour

There are varying causes of externalizing behaviours that may cause children, adolescents, and adults to act out negatively toward their environment. Externalizing tendencies can be displayed as early as the age of two. Children that seem to have a more challenging temperament are more likely to have externalizing behaviours than children who have a mild temperament. In addition, it has been found that boys are more likely than girls to have externalizing behaviours. Although it may be more common in boys, studies have found that the level of aggression is the same for both boys and girls with externalizing behaviours.

The environment, family, and personal factors may cause a child to have externalizing behaviours. For example, at the family level, children that have an insecure attachment to their parents are more likely to display externalizing behaviours than children with a secure attachment style. At the environment level, a household that is chaotic or unpredictable may result in a child with externalizing behaviours. At the personal level, children that struggle academically or are bullied and rejected by their peers may display externalizing behaviours. It is not uncommon for a child or adolescent to act out negatively in school to deflect attention from their learning issue.

In addition, externalizing behaviours may result from neurodevelopmental or emotional disorders, such as attention deficit hyperactivity disorder (ADHD) or Oppositional Defiant Disorder (ODD). It is common for externalizing behaviour to co-exist with various emotional disorders. Hormone fluctuation and physiological changes that result from puberty may also contribute to externalizing behaviours in adolescents. Adults may also display externalizing behaviours, such as antisocial behaviours and aggression. In adulthood, externalizing behaviours are often linked to substance abuse, workplace issues, relationship problems, and anti-social or criminal behaviour.

It is important to identify externalizing tendencies as early as possible to reduce the risk of children and adolescents having externalizing behaviours in adulthood. Since externalizing behaviours are directed outward, they are generally easy to identify. Vandalism and delinquency are common externalizing behaviours that occur during adolescence. Physical and verbal aggression, theft, cheating, and lying are also signs of externalizing behaviour.

### Consequences of Externalizing Behaviour

There are many consequences of externalizing behaviour that can have a negative impact on an individual's life. During childhood, externalizing behaviours may cause school-related issues, such as academic problems, detention, suspension, or complete expulsion from school. Children that display externalizing behaviours are more likely to be bullied

or rejected by their peers than children who do not have externalizing behaviours. Additionally, children with externalizing behaviours are more likely to engage in promiscuous sexual activity, alcohol, and drug use as adolescents.

Adolescents that display externalizing behaviours may find themselves in trouble with the law or in juvenile detention due to vandalism, theft, or physical assault. It has been shown that children and adolescents with externalizing behaviours are at an increased risk of engaging in violent or criminal activity as adults. Additionally, it has been shown that externalizing behaviour in childhood and adolescence can lead to alcohol and drug addiction in adulthood.

## 4.9 INTERNALIZING PROBLEMS

What is Internalizing Behaviour?

Internalizing behaviour can simply be defined as a set of negative behaviours that are directed towards oneself internally (as opposed to externally) in order to cope with varying stressful situations and circumstances. These behaviours are referred to as being internalized because much of what goes on is either inside the individual's head or physical body. The individual chooses to, in a way, hold all of their stress inside and attempts to deal with it on their own, as opposed to releasing it outward where others may be affected or become aware of the situation. For example, an individual exhibiting internalizing behaviour might start mentally withdrawing from the world around them, feeling guilty or responsible for unpleasant external situations, and might even begin experiencing physiological symptoms such as increased blood pressure, shortness of breath, and decreased appetite.

**Internalizing Behaviour and Externalizing Behaviour**

When examining internalizing behaviour, it is essential to explore its opposite, externalizing behaviour. Externalizing behaviour is a set of behaviours that are directed outward from the individual and manifest themselves in many forms. Milder forms of externalizing behaviour include the impulse to spend money or increase alcohol consumption. More severe examples of this type of behaviour can include emotional outbursts, aggressive behaviour, and even physical violence under some circumstances. Both internalizing and externalizing behaviours are human responses for dealing and coping with a variety of stressors throughout our lives. Of the two, internalizing behaviour might seem to be the lesser of two evils, in that it is an internal struggle within the individual; however, depending on the circumstances the symptoms associated with this behaviour could negatively impact that person's colleagues, loved ones, and dependents.

**Internalizing Behaviour Examples**

Internalizing behaviour examples can come in a variety of forms depending on the individual and his or her circumstances. Below are just a few examples of what one might experience when attempting to internalize stress, anxiety, fear, etc:

- Feelings of sadness or depression
- Over-analyzing situations

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- Mentally or physically withdrawing from the outside world
- Internal apathy for family, friends, etc.
- Unjustified feelings of guilt or responsibility for negative circumstances
- Increased blood pressure
- Loss of appetite
- Nausea
- Headaches

**Causes of Internalizing Problems**

The causes for an individual directly or indirectly choosing to internalize their problems are as wide-ranging as the situations they find themselves in. A number of factors influence how the individual handles and copes with problems, including age, sex, socioeconomic status, family history, etc. For instance, children are more likely to exhibit internalizing behaviour if they have been victims of various types of physical or mental abuse. If children do not feel like they are safe to outwardly express their problems and feelings, then they may tend to keep to themselves and internalize these issues. Some studies have shown that adults who have had very controlled and compassionless childhoods tend to experience more internalizing behaviour than most. It is more likely that these individuals have experienced anxiety, depression, and negative self-image growing up. As adults, they naturally feel less inclined to

## 4.10 DEVELOPMENTAL PROBLEMS AND SPECIFIC DEVELOPMENTAL DELAYS

In the preceding para we said that poverty, illiteracy and prejudices are the major barriers in the development of the children in our country. Like other third world countries, India lacks adequate resources for the smooth running of various child welfare programmes. The majority of the Indian population struggles hard to make both ends meet and is in no position to meet the nutritional health needs of the children. To make matters worse, literacy, particularly female literacy, is rather low and it has its own implications for child development. Regarding illiteracy, let us examine the present social reality of the Indian population as presented in the given table.

<table>
<tr><th>S.No.</th><th colspan="2"></th><th>%</th></tr>
<tr><td>1.</td><td colspan="2">Percentage of Population Living in Villages</td><td>74.29</td></tr>
<tr><td rowspan="2">2.</td><td rowspan="2">Literacy Percentage</td><td>Male</td><td>73.00</td></tr>
<tr><td>Female</td><td>50.00</td></tr>
<tr><td rowspan="2">3.</td><td rowspan="2">Literacy Rates for Females</td><td>Urban</td><td>72.00</td></tr>
<tr><td>Rural</td><td>43.00</td></tr>
</table>

We are aware about the role of mothers in rearing their children. Majority of the rural mothers are illiterate and, as such. are ignorant about the facts of health and hygiene.

Because of the lack of resources \ye are not able to provide adequate facilities in terms of nutrition, safe delivery, and other health needs of the child. As such, the survival of children during the early years of life is largely uncertain. It is a general observation that the expectant mother should receive a balanced and rich diet to support herself as well as her child. But this is not possible for majority of the expectant mothers in general and more so in rural areas.

Due to the lack of adequate facilities for health and hygiene, only 58 percent of pregnant women are vaccinated against killer diseases like tetanus. The childbirth, in many cases (7%), takes place at home in the presence of elderly ladies who are often not aware of safe delivery methods and are full of whimsical beliefs. Specialist help is not available at the time of need and women have to manage with less qualified persons. As a result. quite a substantial number of infants die within a few days of their birth. The infant mortality rate has been observed to be 92 and 90 out of 1000 for males and females respectively. The care of child after birth is also full of superstitions in rural areas.

Focussing on the needs of0-6-year-old children, and pregnant and lactating mothers, the Government of India launched an Integrated Child Development Services (ICDS) scheme in 1975. The scheme is meant for children below 6 years of age and expectant and nursing mothers in backward rural areas, urban slums and tribal areas. It provides a package of services consisting ofthe following:

- Supplementary Nutrition
- Immunization Against Major Killer Diseases
- Periodic Health Check-Ups
- Referral and Medical Services
- Monitoring of Growth
- Lion-Formal and Preschool Education
- Nutrition and health education

The specific objectives of ICDS are to:

- Improve the nutritional and health status of children in the age group of 0-6 years.
- Provide environmental conditions needed for physical, social and psyc1iological development of children:
- Reduce the incidence of low birth weight and severe malnutrition among children
- Enhance the capabilities of the mother to provide proper child care.

You may have probably met the Anganwadi workers in your area. It is through these Anganwadis that the lCDS scheme is being implemented. ICDS is the biggest child welfare/ development programme of the country and has emerged as a single major integrated social development programme during the last two decades in the developing countries.

**What is developmental delay?**

Skills such as taking a first step, smiling for the first time and waving "bye-bye" are called developmental milestones. Children reach milestones in playing, learning, speaking,

behaving and moving (crawling, walking, etc.). A developmental delay happens when your child is slow to reach one or more of these milestones.

**What is developmental screening?**

Doctors and nurses use developmental screening to tell if children are learning basic skills when they should, or if they might have problems. Your child's doctor may ask you questions or talk and play with your child during an exam. This shows how the child learns, speaks, behaves and moves.

The nurse or doctor may also ask you questions or give you a questionnaire to fill out. Developmental screening is a tool to find out if your child is on track or needs extra evaluations or treatments. There is no lab or blood test to tell if your child may have a general delay in their development. There are tests for specific syndromes and disorders that cause developmental delays and your provider will tell you whether any of those are needed.

Because there is a wide range of growth and behavior for each age, it is natural for children to reach a milestone earlier or later than a general trend. Your child's doctor will look at the big picture and let you know if anything else is needed.

**Why is developmental screening important?**

When a developmental delay is not found early, children don't get the help they need right away. This can make it hard for them to learn and make developmental delays worse. The sooner children get help, the better off they will be in the long term.In the United States, 17% of children have a developmental or behavioral problem, such as autism spectrum disorder (ASD), intellectual disability or Attention Deficit/Hyperactivity Disorder (ADD or ADHD).

**Causes of Developmental Delay**

There is not one cause for delays in development. Factors that may contribute can occur before a child is born, during the birth process, and after birth. These could include:

- Genetic or hereditary conditions like Down syndrome
- Metabolic disorders like phenylketonuria (PKU)
- Trauma to the brain, such as shaken baby syndrome
- Severe psychosocial trauma, such as post-traumatic stress disorder
- Exposure to certain toxic substances like prenatal alcohol exposure or lead poisoning
- Some very serious infections
- Deprivation of food or environment

In some cases, it may not be possible to find the cause of the developmental delay.

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**Signs and Symptoms of Developmental Delay**

There are many different signs and symptoms of delay that can exist in children and often vary depending upon specific characteristics. Sometimes you may see signs in infancy, but in other cases they may not be noticeable until your child reaches school age. Some of the most common symptoms can include:

- Learning and developing more slowly than other children same age
- Rolling over, sitting up, crawling, or walking much later than developmentally appropriate
- Difficulty communicating or socializing with others
- Lower than average scores on IQ tests
- Difficulties talking or talking late
- Having problems remembering things
- Inability to connect actions with consequences
- Difficulty with problem-solving or logical thinking
- Trouble learning in school
- Inability to do everyday tasks like getting dressed or using the restroom without help

If there is an underlying medical reason that causes the developmental delay, identification and treatment of that condition may improve your child's developmental skills. In fact, children reach developmental milestones at their own pace, and some move faster than others. Two siblings in the same family may reach milestones at different rates. Minor, temporary delays are usually no cause for alarm, but an ongoing delay or multiple delays in reaching milestones can be a sign there may be challenges later in life. Delay in reaching language, thinking, social, or motor skills milestones is called developmental delay.

Developmental delay may be caused by a variety of factors, including heredity, complications during pregnancy, and premature birth. The cause isn't always known. If you suspect your child has developmental delay, speak with their paediatrician. Developmental delay sometimes indicates an underlying condition that only doctors can diagnose. Once you get a diagnosis, you can plan for therapies or other early interventions to help your child's progress and development into adulthood.

**Therapies for Developmental Delays**

Although there is no cure for developmental delay, therapies directed to the specific area of delay are very effective in helping children catch up to their peers. These types of therapies may include:

- **Physical Therapy**
  Physical therapy is often helpful for children with delays in gross motor skills.
- **Occupational Therapy**
  This can address fine motor skills, sensory processing and self-help issues.

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- **Speech and Language Therapy**
  Speech therapy is typically used to address problems in the areas of understanding and producing language and speech sounds.
- **Early Childhood Special Education**
  Early childhood special education provides stimulation for early developmental skills, including play skills.
- **Behavioural therapy**
  This may be needed in some children for behavioural difficulties that affect socially appropriate behaviours.

Many genetic and environmental factors figure into a child's development and can contribute to delays. Even women who have a healthy pregnancy and proper care during and after pregnancy can have children with developmental delays. Although causes of delays can be hard to pinpoint, there are many treatments and support services available to help. The sooner you can diagnose a delay, the better it will be for your child's development into adulthood.

## 4.11 LANGUAGE DISORDERS

Language is the rule-based use of speech sounds to communicate (Sternberg, 2000). Language disorders or language impairments involve the processing of linguistic information. Problems that may be experienced can involve grammar (syntax and/or morphology), semantics (meaning), or other aspects of language. Disordered language may be due to a receptive problem, that is, a difficulty in understanding speech sounds (involving impaired language comprehension). It can also be due to an expressive problem, that is, a difficulty in producing the speech sounds (involving language production), that follow the arbitrary rules of a specific language.

A language disorder can also be due to problems in both reception and expression. Examples include specific language impairment and aphasia, among others. Language disorders can affect both spoken and written language, and can also affect sign language; typically, all forms of language will be impaired. Note that these are distinct from speech disorders, which involve difficulty with the act of speech production, but not with language. Language disorders, therefore, refer to the following: The use of speech sounds in combinations and patterns that fail to follow the arbitrary rules of a particular language is a language disorder.

For instance, the lack of communication etiquette is considered a language disorder. Talking out of turn, not talking when it is your turn, or not responding when you are expected to could be disorders if frequently observed in one's language behaviour. The delay in the use of speech sounds relative to normal development in the physical, cognitive, and social areas is another language disorder. Most language disorders are often diagnosed in conjunction with other developmental delays for instance, health, sensory, motor, mental, emotional, and behavioural development.

Language disorder is a disorder that is found in the development or use of the knowledge of language. It shows the breakdown in the development of language abilities on the usual developmental schedule. The disorders that come under language disorders are:

Autism, Learning Disability, Specific Language Impairment, Developmental Phonological Disorders Aphasia, Dyspraxia, etc.

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**We shall discuss the most common language disorders in detail:**

**Aphasia**

Aphasia is an impairment of language functioning caused by damage to the left hemisphere of the brain (Garrett, 2003; Hillis &Caramazza, 2003). There is different type of aphasias, example; Broca's aphasia and Wernicke's aphasia. Wernicke's aphasia is caused by damage to the left temporal lobe of the brain. It is characterised by notable impairment in the understanding of spoken words and sentences. People with Wernicke's aphasia have generally fluent phonetic and syntactic but semantically coherent speech. This coherence is exhibited through the creation of nonsense words for realworld concepts and improper substitutions of function words for content words (e.g., nouns, verbs). It also typically involves the production of sentences that have the basic structure of the language spoken but that make no sense.

They are sentences without any meaning, e.g. 'Yeah, that was the pumpkin furthest from my thoughts' and 'the scroolishprastimer ate my spanstakes' (Hillis &Caramazza, 2003). In the first case, the words make sense, but not in the context they are presented. In the second case, the words themselves are neologisms, or newly created words. Treatment for patients with this type of aphasia frequently involves supporting and encouraging nonlanguage communication (Altschuler et al., 2006). Broca's aphasia is caused by damage to the brain's premotor area, responsible, in part, for controlling motor commands used in speech production. A person suffering from Broca's aphasia exhibits speech containing excess pauses and slips of tongue, and s/he has trouble finding words when talking. The person also fails to make use of function words such as a, the, and of.

For this reason, Broca's aphasics also produce ungrammatical sentences (Tartter, 1987). Furthermore, they have problem using syntactic information when understanding sentences (Just & Carpenter, 1987). For example, while a Broca's aphasic has no trouble understanding a sentence such as "The bicycle that the man is holding is blue", but s/he has trouble comprehending a sentence such as "the dog that the woman is biting is grey." This difference is due to the fact that while the first sentence can be understood using real-world knowledge (e.g. bicycle, not people, are blue), the second sentence cannot (because it is unlikely that a woman would bite a dog). Because understanding the second sentence requires correctly using syntactic information, which Broca's aphasics have difficulty doing, the sentence poses problem for them (Berndt &Caramazza, 1980).

Broca's aphasia differs from Wernicke's aphasia in two key aspects. First is that speech is agrammatical rather than grammatical, as in Wernicke's. Second is that verbal comprehension is largely preserved. Diseases like Broca's and Wernicke's aphasia, while tragic, tell us much about the critical functions of certain regions of the brain. Notably, their symptoms suggest that (at least certain) phonological, syntactic, and semantic, language information is stored and processed separately in the brain. Global aphasia is the combination of highly impaired comprehension and production of speech. It is caused by lesions to both Broca's and Wernicke's areas.

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Aphasia following a stroke frequently involves damage to both Broca's and Wernicke's areas. In one study, researchers found 32 % of aphasias immediately following a stroke in Broca's and Wernicke's areas (Pedersen, Vinter, & Olsen, 2004). Anomic aphasia involves difficulties in naming objects in retrieving words. The patient may look at an object and simply be unable to receive the word that corresponds to the object. Sometimes, specific categories of things cannot be recalled, such as names of living things (Warrington & Shallice, 1984).

**Specific Language Impairment**

Specific language impairment (SLI) is a developmental language disorder in the absence of frank neurological, sensorimotor, nonverbal cognitive or social emotional deficits (see Watkins, 1994). SLI is used to refer to problems in the acquisition and use of language, typically in the context of normal development. Children with SLI lag behind their peers in language production and language comprehension, which contributes to learning and reading disabilities in school.

One of the hallmarks of SLI is a delay or deficit in the use of function morphemes (e.g., the, a, is) and other grammatical morphology (e.g., plural -s, past tense - ed). Individuals with SLI exhibit problems in combining and selecting speech sounds of language into meaningful units (phonological awareness). These problems are different to speech impairments that arise from difficulties in coordination of oral-motor musculature (Cohen, 2002). Symptoms include the use of short sentences, and problems producing and understanding syntactically complex sentences.

SLI is also associated with an impoverished vocabulary, word finding problems, and difficulty learning new words, whereas the basic tasks for development of phonology and syntax are completed in childhood, vocabulary continues to grow in adulthood (Bishop, 1997). Some researchers claim that SLI children's difficulty with grammatical morphology is due to delays or difficulty in acquiring a specific underlying linguistic mechanism. For example, difficulty in acquiring the rule that verbs must be marked for tense and number ("he walks", not "he walks") (Rice & Wexler, 1994). These children have a deficit in processing brief and/or rapidly changing auditory information, and/or in remembering the temporal order of auditory information.

Children with SLI have poor short-term memory for speech sounds (example, Gathercole, 1998). In a number of recent studies short-term memory for speech sounds has been shown to correlate highly with vocabulary acquisition and speech production. This has led to the hypothesis that a primary function of this memory is to facilitate language learning. Moreover, among SLI children, about 50% will go on to experience reading difficulties and develop dyslexia (Bishop &Snowling, 2004).

**Developmental Phonological Disorders**

"Developmental Phonological Disorders, also known as phonological disability or phonological disorders, are a group of language disorders that affect children's ability to develop easily understood speech by the time they are four years old, and, in some cases, their ability to learn to read and spell. Therefore, Phonological disorders involve a

difficulty in learning and organising all the sounds needed for clear speech, reading and spelling" (Bowen, 1998).

Individuals with this Communication Disorder of childhood demonstrate impairment in their ability to produce sounds as expected for their developmental level. Some children with developmental phonological disorders have other speech and language difficulties such as immature grammar and syntax, stuttering or word-retrieval difficulties. The cause of phonological disorder in children is largely unknown. It has been suggested that this disorder has a genetic component due to the large proportion of children who have relatives with some type of similar disorder.

However, there is no available data to support these observations. Developmental phonological disorders may occur in conjunction with other communication disorders such as stuttering, specific language impairment (SLI), or developmental apraxia of speech. No matter what combination of difficulties a child with a developmental phonological disorder has, appropriate speech-language pathology treatment is usually successful in eliminating or at the very least, reducing the problem (Bowen, 1998).

**Symptoms**

A child with language disorder may have one or two of the symptoms listed below, or many of the symptoms. Symptoms can range from mild to severe.

Children with a receptive language disorder have difficulty understanding language. They may have:

- A hard time understanding what other people have said
- Problems following directions that are spoken to them
- Problems organizing their thoughts

Children with an expressive language disorder have problems using language to express what they are thinking or need. These children may:

- Have a hard time putting words together into sentences, or their sentences may be simple and short and the word order may be off
- Have difficulty finding the right words when talking, and often use placeholder words such as "um"
- Have a vocabulary that is below the level of other children the same age
- Leave words out of sentences when talking
- Use certain phrases over and over again, and repeat (echo) parts or all of questions
- Use tenses (past, present, future) improperly

Because of their language problems, these children may have difficulty in social settings. At times, language disorders may be part of the cause of severe behavioural problems.

**Exams and Tests**

A medical history may reveal that the child has close relatives who have also had speech and language problems. Any child suspected of having this disorder can have

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standardized receptive and expressive language tests. A speech and language therapist or neuropsychologist will administer these tests.

A hearing test called audiometry should also be done to rule out deafness, which is one of the most common causes of language problems.

**Treatment**

Speech and language therapy are the best approach to treating this type of language disorder. Counselling, such as talk therapy, is also recommended because of the possibility of related emotional or behavioural problems.

**Outlook (Prognosis)**

The outcome varies, based on the cause. Brain injury or other structural problems generally have a poor outcome, in which the child will have long-term problems with language. Other, more reversible causes can be treated effectively.

Many children who have language problems during the preschool years will also have some language problems or learning difficulty later in childhood. They may also have reading disorders.

**Possible Complications**

- Difficulty understanding and using language can cause problems with social interaction and the ability to function independently as an adult.
- Reading may be a problem.
- Depression, anxiety, and other emotional or behavioural problems may complicate language disorders.

**When to Contact a Medical Professional**

Parents who are concerned that their child's speech or language is delayed should see their child's doctor. Ask about getting a referral to a speech and language therapist. Children who are diagnosed with this condition may need to be seen by a neurologist or children's developmental specialist to determine if the cause can be treated.

Call your child's doctor if you see the following signs that your child does not understand language well:

- At 15 months, does not look or point at 5 to 10 people or objects when they are named by a parent or caregiver
- At 18 months, does not follow simple directions, such as "get your coat"
- At 24 months, is not able to point to a picture or a part of the body when it is named
- At 30 months, does not respond out loud or by nodding or shaking the head and asking questions
- At 36 months, does not follow 2-step directions, and does not understand action words

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- Also call if you notice these signs that your child does not use or express language well:
- At 15 months, is not using three words
- At 18 months, is not saying, “Mama,” “Dada,” or other names
- At 24 months, is not using at least 25 words
- At 30 months, is not using two-word phrases, including phrases that include both a noun and a verb
- At 36 months, does not have at least a 200-word vocabulary, is not asking for items by name, exactly repeats questions spoken by others, language has regressed (become worse), or is not using complete sentences
- At 48 months, often uses words incorrectly or uses a similar or related word instead of the correct word

## 4.12 CHILD PSYCHOPATHOLOGY

**What is Psychopathology?**
It is the study of individual differences, deviant or maladaptive behaviors and processes. Scientific understanding is, in large measure, the ability to describe precisely the functional relations between entities or events. The ability to set apart such entities or events from one another and to describe their properties in terms of observable phenomena is a precursor to understanding the relations between them.

**What is child psychopathology?**
Child psychopathology refers to the scientific study of mental disorders in children and adolescents. Oppositional defiant disorder, attention-deficit hyperactivity disorder, and autism spectrum disorder are examples of psychopathology that are typically first diagnosed during childhood. Mental health providers who work with children and adolescents are informed by research in developmental psychology, clinical child psychology, and family systems. In addition, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood is used in assessing mental health and developmental disorders in children up to age five.

**What causes child psychopathology?**
The etiology of child psychopathology has many explanations which differ from case to case. Many psychopathological disorders in children involve genetic and physiological mechanisms, though there are still many without any physical grounds. It is absolutely imperative that multiple sources of data be gathered. Diagnosing the psychopathology of children is daunting. It is influenced by development and contest, in addition to the traditional sources.

Interviews with parents about school, etc., are inadequate. Either reports from teachers or direct observation by the professional are critical. (author, Robert B. Bloom, Ph.D.) The disorders with physical or biological mechanisms are easier to diagnose in children and are often diagnosed earlier in childhood. However, there are some disorders, no matter

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the mechanisms, that are not identified until adulthood. There is also reason to believe that there is co-morbidity of disorders, in that if one disorder is present, there is often another.

**Stress**

Emotional stress or trauma in the parent-child relationship tends to be a cause of child psychopathology. First seen in infants, separation anxiety in root of parental-child stress may lay the foundations for future disorders in children. There is a direct correlation between maternal stress and child stress that is factored in both throughout adolescent development. In a situation where the mother is absent, any primary caregiver to the child could be seen as the "maternal" relationship. Essentially, the child would bond with the primary caregiver, and may exude some personality traits of the caregiver.

In studies of child in two age groups of pregnancy to five years, and fifteen years and twenty years, Raposa and colleagues (2011) studied the impact of psychopathology in the child-maternal relationship and how not only the mothers stress affected the child, but the child's stress affected the mother. Historically, it was believed that mothers who had postpartum depression might be the reason their child has mental disorders both earlier and later in development. However, this correlation was found to not only reflect maternal depression on child psychopathology, but also child psychopathology could reflect on maternal depression.

Children with a predisposition to psychopathology may cause higher stress in the relationship with their mother, and mothers who have psychopathology may also cause higher stress in the relationship with their child. Child psychopathology creates stress in parenting which may increase the severity of the psychopathology within the child. Together, these factors push and pull the relationship thus causing higher levels of depression, ADHD, defiant disorder, learning disabilities, and pervasive developmental disorder in both the mother and the child. The outline and summary of this study is found below: ""In looking at child-related stress, the number of past child mental health diagnoses significantly predicted a higher number of acute stressors for mothers as well as more chronic stress in the mother-child relationship at age 15. These increased levels of maternal stress and mother-child relationship stress at age 15 then predicted higher levels of maternal depression when the youth were 20 years old.

Looking more closely at the data, the authors found that it was the chronic stress in the mother-child relationship and the child-related acute stressors that were the linchpins between child psychopathology and maternal depression. The stress is what fueled the fires between mother and child mental health. Going one step further, the researchers found that youth with a history of more than one diagnosis as well as youth that had externalizing disorders (e.g., conduct disorder) had the highest number of child-related stressors and the highest levels of mother-child stress. Again, all of the findings held up when other potentially stressful variables, such as economic worries and past maternal depression, were controlled for.

Additionally, siblings- both older and younger and of both genders, can be factored into the etiology and development of child psychopathology. In a longitudinal study of maternal

depression and older male child depression and antisocial behaviors on younger sibling's adolescent mental health outcome. The study factored in ineffective parenting and sibling conflicts such as sibling rivalry. Younger female siblings were more directly affected by maternal depression and older brother depression and anti-social behaviors when the indirect effects were not place, in comparison to younger male siblings who showed no such comparison.

However, if an older brother were anti-social, the younger child- female or male would exude higher anti-social behaviors. In the presence of a sibling conflict, anti-social behavior was more influential on younger male children than younger female children. Female children were more sensitive to pathological familial environments, thus showing that in a high- stress environment with both maternal depression and older- male sibling depression and anti-social behavior, there is a higher risk of female children developing psychopathological disorders. This was a small study, and more research needs to be done especially with older female children, paternal relationships, maternal-paternal-child stress relationships, and/or caregiver-child stress relationships if the child is orphaned or not being raised by the biological child to reach a conclusive child-parent stress model on the effects of familial and environmental pathology on the child's development.

**Temperament**

The child-parent stress and development are only one hypothesis for the etiology of child psychopathology. Other experts believe that child temperament is a large factor in the development of child psychopathology. High susceptibility to child psychopathology is marked by low levels of effortful control and high levels of emotionality and neuroticism. Parental divorce is often a large factor in childhood depression and other psychopathological disorders. This is more so when the divorce involves a long-drawn separation and one parent bad-mouthing the other.

That is not to say that divorce will lead to psychopathological disorders, there are also other factors such as temperament, trauma, and other negative life events (e.g. death, sudden moving of home, physical or sexual abuse), genetics, environment, and nurture that correlate to the onset of a disorder. Research has also shown that child maltreatment may increase risk for various forms of psychopathology as it increases threat sensitivity, decreases responsivity to reward, and causes deficits in emotion recognition and understanding.

Found in "The Role of Temperament in the Etiology of Child Psychopathology", a model for the etiology of child psychopathology by Vasey and Dadds (2001) proposed that the four things that are important to the development of psychopathological disorders is:

- biological factors: hormones, genetics, neurotransmitters
- psychological: self-esteem, coping skills, cognitive issues
- social factors: family rearing, negative learning experiences, and stress
- child's temperament

Using an array of neurological scans and exams, psychological evaluations, family medical history, and observing the child in daily factors can help the physician find the etiology

of the psychopathological disorder to help release the child of the symptoms through therapy, medication use, social skills training, and life style changes.

Child psychopathology can cause separation anxiety from parents, attention deficit disorders in children, sleep disorders in children, aggression with both peers and adults, night terrors, extreme anxiety, anti-social behavior, depression symptoms, aloof attitude, sensitive emotions, and rebellious behavior that are not in line of typical childhood development. Aggression is found to manifest in children before five years of age, and early stress and aggression in the parental-child relationship correlates with the manifestation of aggression.

Aggression in children causes problematic peer relationships, difficulty adjusting, and coping problems. Children who fail to overcome acceptable ways of coping and emotion expression are put on tract for psychopathological disorders and violent and anti-social behaviors into adolescence and adulthood. There is a higher rate of substance abuse in these children with coping and aggression issues, and causes a cycle of emotional instability and manifestation psychopathological disorders.

**Future of child psychopathology**

The future of child psychopathology- etiology and treatment has a two-way path. While many professionals agree that many children who have a disorder do not receive proper treatment, at the rate of 5-15% that receive treatment leaving many children in the dark. In the same boat are the physicians who also say that not only do more of these disorders need to be recognized in children and treated properly, but also even those children who show some qualifying symptoms of a disorder but not to the degree of diagnosis should also receive treatment and therapy to avoid the manifestation of the disorder. By treating children even with slight degrees of a psychopathological disorder, children can show improvements in their relationships with peers, family, and teachers and also improvements in school, mental health, and personal development. Many physicians believe the best prevention and help starts in the home and the school of the child, before physicians and psychologists are contacted.

## 4.13 CHAPTER SUMMARY

In this unit we have been dealing with the topic of counselling children. We started with the various disorders' children suffer from such as the learning disability, Attention Deficit, etc. We also delineated the causes of these disorders, nature, course, symptoms and treatment of these disorders. We also discussed the techniques of counselling that are suited to children suffering from the different disorders. We then discussed the Autism Spectrum Disorder, delineated the causes and pointed out the various techniques of counselling that would help in these cases. Then we discussed the general counselling techniques and pointed out the problems faced by children in middle schools and the strategies one should use to help these children. Other techniques discussed included self-monitoring, self-efficiency and self-defeating behaviours

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## 4.14 REVIEW QUESTIONS

### SHORT ANSWER TYPE QUESTIONS

1. **Describe multi-sensory approach.**
2. **What is child psychopathology?**
3. **What do you understand by Developmental Phonological Disorders?**
4. **List the therapies for developmental delays.**
5. **Describe Internalizing and externalizing Behaviour?**

### LONG ANSWER TYPE QUESTIONS

1. **What causes child psychopathology? Describe the same in detail.**
2. **What is developmental screening? Why is developmental screening important?**
3. **What are the causes of internalizing problems?**
4. **Discuss the techniques for helping children suffering with ASD?**
5. **What are the symptoms of ADHD? List the casual factors in ADHD.**

## 4.15 MULTIPLE CHOICE QUESTIONS

1. **______________ is the study of individual differences, deviant or maladaptive behaviors and processes.**
   a. Psychopathology
   b. Behaviour Modification
   c. Psychological Assessment
   d. None of these

2. **What is the full form of SLI?**
   a. Special Language Impairment
   b. Specific Language Impairment
   c. Single Language Impairment
   d. None of these

3. **________________ are a group of language disorders that affect children's ability to develop easily understood speech by the time they are four years old, and, in some cases, their ability to learn to read and spell.**
   a. Phonological Disorders
   b. Developmental Phonological Disorders
   c. Phonological Disability
   d. All of the above

4. **What is the full form of ASD?**
   a. Attention Spectrum Disorder
   b. Autism Spectrum Deficit
   c. Autism Spectrum Disorder
   d. None of these

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5. **_________________ definition is negative behaviour that is acted out by an individual and is directed toward the environment.**
   a. Externalizing Behaviour
   b. Internalizing Behaviour
   c. Behaviour Modification
   d. Attention Spectrum Disorder

6. **_________________ is a kind of disorder where inadequate development may be manifested in language, speech, math, or in motor skill area.**
   a. Learning Disability
   b. Phonological Disorders
   c. Psychopathology
   d. Behaviour Modification

7. **_________________ refers to a wide variety of thought processes and intellectual abilities, including attention, memory, academics and every day knowledge, creativity, imagination, problem solving etc**
   a. Physical Development
   b. Environmental Development
   c. Social Development
   d. Cognitive Development

8. **_________________ is an impairment of language functioning caused by damage to the left hemisphere of the brain**
   a. Externalizing Behaviour
   b. Psychopathology
   c. Aphasia
   d. Internalizing Behaviour

9. **What is the full form of PDD?**
   a. Pervasive Development Deficit
   b. Pervasive Development Disorder
   c. Pervasive Development Disability
   d. None of these

10. **_________________ is a set of negative behaviours that are directed towards oneself internally (as opposed to externally) in order to cope with varying stressful situations and circumstances.**
   a. Externalizing Behaviour
   b. Behaviour Modification
   c. Attention Spectrum Disorder
   d. Internalizing Behaviour

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UNIT V

# PSYCHOTHERAPY WITH CHILDREN

**STRUCTURE**


5.1 Learning Objective
5.2 Introduction
5.3 Psychological Therapies or Counselling for Children
5.4 Techniques of Therapy
5.5 Play Therapy
5.6 Behaviour Modification
5.7 Family Therapy
5.8 Group Therapy
5.9 Chapter Summary
5.10 Review Questions
5.11 Multiple Choice Questions

## 5.1 LEARNING OBJECTIVE

**After completing this unit, you will be able to:**

- Learn about psychological therapies or counselling for children.
- Know about various techniques of therapy.
- Learn about play therapy.
- Understand behaviour modification.

## 5.2 INTRODUCTION

Psychotherapy refers to a variety of techniques and methods used to help children and adolescents who are experiencing difficulties with emotion and behaviour. Although there are different types of psychotherapy, each relies on communication as the basic tool for bringing about change in a person's feelings and behaviour. Psychotherapy may involve an individual child, group, or family. For children and adolescents, playing, drawing, building, and pretending, as well as talking, are important ways of sharing feelings and resolving problems. Psychotherapy helps children and adolescents in a variety of ways. They receive emotional support, resolve conflicts with people, understand feelings and problems, and try out new solutions to old problems.

Goals for therapy may be specific (change in behaviour, improved relations with friends) or more general (less anxiety, better self- esteem). The length of psychotherapy depends on the complexity and severity of problems. In this unit we would be discussing the different types of psychotherapies which have been found to be effective with children and adolescents. The first half of this unit will cover psychotherapy with children, which will include psychodynamic psychotherapy (such as play therapy, working with parents), cognitive-behaviour therapy (behaviour modification, individual therapy, etc.) and family therapy. The second half would discuss about the most effective psychotherapies with adolescents for disorders such as depression, anxiety and conduct problems.

## 5.3 PSYCHOLOGICAL THERAPIES OR COUNSELLING FOR CHILDREN

**What is Child Counselling?**

Child Counselling is a type of therapy that focuses on young children, teens, and adolescents with one or more mental illnesses. It also provides aid to youths, who have experienced trauma, and/or who are experiencing a dysfunctional or stressful home environment. Many of the issues these children face mimic the issues adults face in their day-to-day lives. Some of these common issues include anxiety, depression, and grief. The goal of child Counselling, however, is to break down problems into manageable parts, so children can better understand and cope with them.

**Who is Child Counsellor?**

Child counsellors are mental health specialists, who offer invaluable insight into your child's social and emotional development and mental health. It is important to understand that many times "glitches" in these areas may not be visible to the people closest to the child. That is where child counsellor s come in. These individuals have the knowledge

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and expertise to recognize, identify, pinpoint, assess, diagnose, and treat a wide range of mental health conditions, adjustment issues (divorce, new school, bullying, grief, etc.), and psychological distress. More specifically, child counsellor s, also sometimes referred to as child therapists and child psychologists (depending on the level of education and licensure), have been trained to "get into the minds of children," so they can help them make sense of what is going on in their minds, bodies, and lives.

**What are the Functions of Child Counsellors?**

Child counsellor s perform many services to vulnerable youth. Most importantly, these mental health professionals have the know-with-all to help your child receive the help he/she needs to resolve his/her issues and resume a healthy and productive life. It is important to understand that children, who are suffering from mental health issues or psychological distress, may not share these concerns with their parents. That doesn't happen because your child doesn't love you; rather, it occurs because he/she fears disappointing you.

Therefore, the aim of child counsellor s is to help children better interpret the issues they are experiencing and/or the trauma that occurred – in a way they can process and understand. When a child's social and emotional issues and psychological distress are left untreated, it can negatively impact his/her educational aspirations and developmental milestones.More importantly, it can cause delays that persist well into adulthood. Keep in mind, however, that children of all ages, from toddlers and pre-schoolers to teens and adolescents, can benefit from Counselling sessions.

Ultimately, this form of Counselling aims to help children work through their emotions, so they can live normal healthy lives without the lasting effects of fear, confusion, anxiety, or trauma. The good news is you can play an important part in your child's mental health simply being observant.If you notice that your child's behaviour has suddenly and/or dramatically changed, or something feels "off" with your child, schedule a consultation with your child's paediatrician or search for a child counsellor for a more in-depth assessment. Sound judgment can ensure that your child receives the best treatment possible for his/her condition or issue.

**When Should You Seek Child Counselling for Your Child?**

When a child is suffering from mental, social or emotional, or psychological distress and/or trauma, it can be hard to cope with, especially when you feel like nothing is working or there's nothing you can do to remedy the situation. That is where a child counsellor can be extremely beneficial. This mental health professional can identify the underlying issues that are affecting your child's overall health and well-being, so he/she can quickly receive the treatment he/she needs to feel better. The truth is many children are unable to fully process the complexities that accompany the emotional and/or psychological issues they are experiencing, so Counselling may be just what your child needs to work towards mental wholeness.

In addition, child Counselling can be invaluable to children who suffer from obsessive-compulsive disorder, post-traumatic stress disorder, or general anxiety disorder. It is common for parents, pediatricians, and teachers to seek Counselling services for children

if they feel they are in need of professional help. Why? Well, because child counsellor s can observe, assess, and identify the root cause of your child's distress.

Remember, the main goal of child Counselling is to use the knowledge and expertise of a trained child counsellor to calm your concerns and help your child get the help he/she needs to function properly. A child counsellor can provide both you and your child with the tools needed to deal with issues and any mental health condition in a healthy and productive way. More so, this specialist can help both you and your child navigate uncomfortable, scary, anxiety-provoking, and challenging times with less stress and turmoil.

As a parent, you want nothing but health and happiness for your child, but sometimes situations occur that you simply can't "fix" on your own – especially when you are as emotionally-invested in the situation as you are as a parent. That is when it's best to lean on someone with expertise in the area. Therefore, you should seek Counselling for your child, when you notice that your child is struggling or behaving uncharacteristically. A child counsellor will teach him/her helpful techniques that place his/her mental health and well-being at center stage.

**What Kinds of Issues Do Child Counsellors Treat?**

Well, child counsellor s treats a variety of issues. For instance, they treat children who have experienced trauma or upsetting events like the loss of a parent, pet, loved one, siblings, home, etc. And, they also treat children, who have witnessed or experienced abuse and/or intimidation. Basically, child counsellor s treats any issues that cause children social or emotional distress and/or any mental health condition that is affecting a child's life. The goal of these professionals is to help your child identify and cope with any issue or issues they are experiencing in a healthy way. Some of the most common issues that child counsellor s treat includes:

- Divorce
- Grief and the death of a loved one, pet, home, etc.
- Witnessing or experiencing a trauma event(s)
- Mental health conditions and psychological distress (i.e. anxiety and depression)
- Bullying
- Sexual, emotional, and/or physical abuse
- Relocation issues (i.e. changing schools, homes, families, and/or cities/states)
- Family substance abuse or addiction

**How Can You Tell If Your Child Needs Counselling?**

Well, there are some signs that may signal that your child needs Counselling. For instance, a child, who has begun to act "out of character" and/or one who has suddenly begun to have developmental problems or rebel – in ways that are not considered "normal behaviour" for children of that age, may need to talk to a professional.

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In addition, if your child has experienced a significant trauma (i.e. abuse, the death of a loved one or pet, uprooting, divorce, chronic illness, etc.) recently or in the past, but has not received treatment or therapy for it, he/she will most likely benefit from child Counselling.

**So, what are some signs that my child is in distress and could benefit from Counselling?**

*Common signs of mental health issues or psychological distress include:*

- Unprovoked aggression
- Leakage of urine
- Difficulty adjusting to social situations and/or new situations
- Recurrent nightmares, night terrors, and/or sleep difficulties like insomnia
- Low grades or a sudden academic decline
- Constant worry and anxiety
- Social withdraw from activities your child once liked or loved to do
- A noticeable and/or sudden loss of appetite and/or extreme weight loss
- Repetitively performing rituals and routines like hand-washing
- Suicidal ideations (thoughts) or attempts
- Your child responds to voices he/she hears in his/her head
- Spending most of his/her time alone or engaging in voluntary social isolation
- Alcohol and/or drug use, abuse, or addiction
- Increased physical complaints, despite a healthy report from a medical professional
- Engaging in self-harm practices, such as cutting oneself

What are Some Common Goals of Child Counselling?

Common goals of child counselling vary, depending on the child's issue(s). However, it typically focuses on and addresses issues in a child's life that are significantly impacting his/her growth, development, mental health, and well-being. The aim is to help your child learn tools, techniques, and methods that can better prepare him/her for any challenges he/she faces – now and in the future. Therefore, a common goal of child Counselling is helping your child successfully cope with challenging situations that trigger the following emotions:

**Anxiety**

One of the main benefits of Counselling for children is that it teaches them how to effectively manage emotional distress and anxiety – by themselves. More specifically, children learn how to prevent panic attacks, and deal with anxiety in healthier ways.

For example, an anxious child may learn breathing exercises, stress management/relaxation techniques for when he/she gets "worked up," how to control his/her muscles, so they do not tense up when he/she is stressed, positive self-talk, and the importance of

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talking to someone when feeling overwhelmed, mentally exhausted, confused, distressed, depressed, and/or anxious.

A child counsellor can help your child understand that keeping these feelings bottled up inside only makes everything worse. By sharing these concerns and fears with a professional or at least a trusted friend or relative, your child can get the help he/she needs to deal with, manage, and/or resolve issues that are causing them turmoil.

Therefore, Counselling can provide your child with an important toolbox of coping mechanisms that he/she can use when he/she experiences anxiety.

**Trauma**

The truth is some children are exposed to disturbing situations that traumatize them – events no child should bear witness to or experience. The negative and heart-breaking effects of trauma can include shock, disbelief, detachment, emotional or social numbness, fear, anxiety, and depression. And, unfortunately, in some cases, it can lead to post-traumatic stress disorder (PTSD).

PTSD symptoms may include a strong desire to avoid trauma-related people and/or places, intense and upsetting memories, flashbacks, and/or nightmares, sleep issues like insomnia, and uncontrollable anger, aggression, and/or agitation. The good news is child Counselling can give children suffering from PTSD and outlet to share their feelings, fears, and concerns.In other words, it can give these children a voice – one, in which they can talk about what happened to them and how it made them feel then and how it makes them feel now. It can also encourage these individuals to share their feelings, regardless of what they are, instead of keeping them bottled up inside.

Lastly, Counselling can help these children understand that they are not to blame for what happened to them. They are survivors – not victims or perpetrators.So, to sum it up, child counsellor s can teach your child that it's okay to talk about what happened to him/her. In fact, it's healthy to do so. And, they can teach your child a variety of coping mechanisms he/she can use when the "going gets rough." In other words, when your child experiences a memory or flashback that distresses him/her, he/she will be able to pull a tool out of his/her toolbox to deal with it.

These tools may include deep breathing exercises, taking a time-out to regroup, talking to a trusted friend or relative about how he/she is feeling, practicing stress management/ relaxation techniques, focusing on the positive, and looking at the event or experience in a different way (reframing).

**Divorce**

When a marital union ends, it can be very distressing for a child. In fact, it is common for children to blame themselves for the divorce. It is also common for these children to feel that because they caused the end of the marriage, they are unlovable.Then there's the unfortunate consequence of divorce child custody issues. Sometimes custody arrangements are amicable, but sometimes they are tense a custody battle between parents.

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Having to choose between parents can make children feel uneasy, anxious, and guilty, especially when it comes to who they want to live with. In addition, children, whose choices don't align with their parents or siblings often feel sad, confused, distressed, and overwhelmed. The good news is child counsellor s can teach children, who are going through or who have gone through a divorce how to cope with their conflicting and confusing feelings through a wide range of techniques, such as deep breathing, art or music therapy, positive self-talk, journaling, exercising, and talking to a trusted friend or relative about their feelings and thoughts.

**Grief**

The death of a loved one, pet, friend, home, school, and/or health can lead to a considerable amount of grief. If it is distressing to an adult, you know it's ten times worse for a child, who does not have the maturity level, life experiences, or coping mechanisms that an adult has.In fact, for children going through the grieving process, it can be extremely difficult to wrap their heads around. In fact, they may become enveloped in confusing, conflicting, and fluctuating feelings like numbness, denial, loss, sadness, despair, depression, anxiety, and anger/rage. They miss the person, pet, place, or thing they loved so dearly and do not know how to channel the pain into something healthier. These children may develop irrational thought patterns like they too will die or someone else they love will leave. They may honestly believe that the loss was due to something they did or did not do.

Furthermore, they may feel immeasurable guilt that they could have done something to prevent the loss – but did not. Child counsellor s help children better understand the grief process while teaching them that is okay to experience conflicting and confusing emotions. Counsellor s explain to children that grief is a normal emotion that often comes in waves. They also explain to children that it's important to experience them to heal from the loss. These specialists also encourage children to talk about the loss as much and as often as possible until they are able to process it in a way that makes sense for them.

There is no time limit on how long one should grieve and there's no right or wrong way to do it. However, it is important that you, as a parent, keep an eye on your child, and if he/she appears to be sinking further and further away and not taking steps towards healing after a year – make an appointment with a child counsellor.A child counsellor will teach your child coping strategies like how important it is to share his/her feelings with a trusted loved one or friend, channelling grief into creative pursuits like music, journaling, and/or art, and using his/her voice to share loving memories of the person, place, or thing the child has lost.Mental health professionals teach grieving children that there are many layers of the grieving process and each one is important and must be experienced to successfully heal.

**Change**

For many children, change (i.e. changing schools, moving to a new city or state, being adopted or entering the foster care system, remarriage, divorce, going to live with another relative, the loss of a loved one or pet, etc.) can be traumatic.Adults, like you and me, have the tools to accept and adapt to these changes, but many times, children don't. So,

although changes may not significantly impair your ability to function, it may have a totally different effect on your child.

What effect? Well, children, who have experienced a significant change in their lives, may have a hard time expressing how they really feel about it. More specifically, a big change can lead to anxiety, low self-esteem, self-doubt, uncertainty, anxiety, depression, fear, phobia, worry, and/or anger/rage towards their parents – and everyone else.While these are normal reactions to change, in general, some children may have a hard time moving past these feelings by themselves. That's where child counselling comes into play.

Child counsellor s teach children how to effectively cope with the change by focusing on the positive (and unchanging) aspects of their lives. They also teach children how to practice positive self-talk, when they feel themselves becoming overwhelmed with all the changes in their lives.Lastly, they teach children how to breathe deeply when they are having a hard time coping with the "newness" of it all. The goal of these specialists is to help your child understand (and accept) that change is natural, and their feelings are temporary. Eventually, he/she will adjust and those feelings will fade.

**Low Self-Esteem & Self-Confidence**

The truth is some children struggle with low self-esteem and self-confidence. When this occurs, it can also lead to anxiety, depression, substance abuse, eating disorders, and even thoughts of self-harm and suicide. A child with low self-esteem may feel unlovable, empty, and worthless. As a result, he/she may begin to believe that his/her loved ones and friends would be "better off" without them. Child counsellor s can help this child improve his/her self-esteem and self-confidence in a myriad of ways. For instance, a child counsellor may teach a child with low self-esteem and self-confidence how to look at the big picture and dig deeper to find the root cause of the issues.

He/she may also help this child better understand how negative thoughts and self-talk is causing him/her to feel bad – mentally and physically. This specialist can also explain to a child how positive self-talk can dramatically improve his/her self-esteem, self-confidence, and overall life.Some of the things your child will learn in child Counselling include the benefit of using positive affirmations to boost self-confidence and self-acceptance and the importance of talking to a loved one or trusted friend about distressing feelings and thoughts. A child counsellor can even help your child if his/her low self-esteem and self-confidence stems from something more serious like an eating disorder.

**What are the Different Types of Child Counselling?**

There are many different types of child Counselling, such as cognitive-behaviour therapy, trauma-focused cognitive-behavioural therapy, and alternative therapies.

**Cognitive-Behaviour Therapy (CBT)**

The goal of cognitive-behavioural therapy (CBT) is to help children change negative thought patterns and behaviours by reframing the way they think about issues and events. The aim is to help children convert negative thoughts into more positive ones, so they can have a healthier response to the issues, themselves, and the world around them.

More specifically, CBT encourages children to challenge their belief systems, when it comes to themselves, so they can accurately view themselves and the situation through a more realistic and positive lens. Therefore, CBT can provide your child with the tools he/she needs to effectively cope with challenging and stressful situations when they arise.

**Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT)**

The goal of trauma-focused cognitive-behavioural therapy (TF-CBT) is to help children heal from the effects of trauma. Similar to CBT, these counsellor s teach children how to view the trauma in a more realistic manner – without blaming themselves.TF-CBT also teaches children techniques they can use if they experience a flashback, with the goal of working through those memories from a place of control and understanding. As a result, TF-CBT can provide your child with the ability to use these tools when or if they become distressed from the memory of the trauma.

**Alternative Therapies**

A child, who is experiencing mental health issues or psychological distress may benefit from alternative therapies like music and/or art therapy, exercise, sports therapy, movement therapy, equine therapy, mindfulness, and/or aquatic therapy.

**What Should You Look for in a Child Counsellor?**

There are several things you should consider when looking for a child counsellor. Firstly, the counsellor must be a good fit for your child. Why? Well, because there is a good chance your child will be uncomfortable, anxious, and/or a little (or a lot) embarrassed about seeing a child counsellor. It's unknown and scary to a child. Does that mean I'm crazy? You and I know that is not the case, but a child may not.

So, it is important that you find a counsellor that will "mesh" with your child. The truth is it may take a while before your child feels comfortable, so the counsellor needs to know how to "break the ice" with him/her. If there is a disconnect or your child expresses unease or displeasure with the counsellor, you will need to find another one. Why? Because Counselling will be a bust if your child does not trust his/her counsellor.

In addition, it is important that you research potential counsellor s – in advance. Consider his/her credentials – training qualifications, approach, and client reviews. All of those things are important. It is also imperative that the counsellor specializes in child Counselling. Why? So, you can feel reassured that he/she knows how to use therapy techniques in a way that will actually help your child – not hinder him/her.

And, because your child's mental health and well-being are paramount, do not hesitate to check the counsellor 's references. If all of that checks out, make an appointment to meet with him/her. Do you feel comfortable with the counsellor? Does your child? If you both feel comfortable, proceed. But if you don't get a good vibe – go back to the drawing board and start again until you find one that meets your comfort level. It takes a village, after all. The good news is most counsellor s offer free consultations, so you can find one that best fits your child's personality with ease.

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## 5.4 TECHNIQUES OF THERAPY

Therapists use various therapy techniques to address issues specific to each child's needs and those of their family. The therapy technique may depend on the nature of the problem, the child's age, and other factors. The sections below look at some child therapy techniques in more detail.

**Parent-child interaction therapy**

Parent-child interaction therapy (PCIT) helps parents interact with the child and manage their behaviours. It may also improve the parent-child bond. With PCIT, parents receive in-the-moment coaching from a therapist through an earpiece. A 2017 meta-analysis Trusted Source suggests that PCIT significantly reduces parent- and child-related stress regardless of session length, location, and issue.

**Child-centered play therapy**

Child-centered play therapy (CCPT) is a play-based intervention. It utilizes the playroom as a safe space to help children process their feelings through symbols and play. The Counselling relationship can support healing and positive change, decrease negative behaviours, and improve overall functioning. CCPT therapy allows children to explore issues using toys and the play environment, enabling them to lead their own healing.

**Cognitive behavioural therapy**

In cognitive behavioural therapy (CBT), therapists teach children how thoughts cause feelings that affect behaviours. They help children identify distorted and harmful thinking patterns and replace them with more appropriate ones to improve their mood and behaviour. Trauma-focused CBT is a specialized form of CBT. It helps children cope with traumatic experiences.One 2020 clinical trialTrusted Source found that trauma-focused CBT reduced post-traumatic stress caused by a parent's death. Similarly, a 2021 trial found that CBT was effective in treating prolonged grief disorder in children and teenagers.

**Acceptance and Commitment Therapy (ACT)**

It helps a child understand and accept their inner emotions. ACT therapists help children and teens use their deeper understanding of their emotional struggles to commit to moving forward in a positive way.

**Dialectical behaviour therapy**

Dialectical behaviour therapy (DBT) is a form of behaviour therapy for high risk cases, such as teenagers with suicidal ideation. It uses a combination of individual and group sessions with additional coaching calls to teach people the coping strategies and skills necessary to handle conflict and extreme emotions.DBT teaches interpersonal effectiveness, mindfulness, distress tolerance skills, and emotional regulation skills.

**Applied behavioural analysis**

Applied behavioural analysis is a well-known early form of therapy for autistic children. It focuses on rewarding desirable behaviours to increase their frequency and minimize less acceptable behaviours.It teaches behaviours in real-life settings and addresses learning, self-management, and communication.

### Interpersonal Therapy (IPT)

It is a brief treatment specifically developed and tested for depression, but also used to treat a variety of other clinical conditions. IPT therapists focus on how interpersonal events affect an individual's emotional state. Individual difficulties are framed in interpersonal terms, and then problematic relationships are addressed.

### Psychodynamic Psychotherapy

It emphasizes understanding the issues that motivate and influence a child's behaviour, thoughts, and feelings. It can help identify a child's typical behaviour patterns, defences, and responses to inner conflicts and struggles. Psychoanalysis is a specialized, more intensive form of psychodynamic psychotherapy which usually involves several sessions per week. Psychodynamic psychotherapies are based on the assumption that a child's behaviour and feelings will improve once the inner struggles are brought to light.

### Supportive Therapy

It gives children and teens support in their lives to cope with stress, identify helpful and unhelpful behaviours, and improve self-esteem.

### Play therapy

In play therapy, a therapist uses games, drawings, blocks, puppets, and art to observe and identify themes or patterns and gain insight into the child's issues.A 2020 systematic review suggests that play therapy improves behaviour and attitude and reduces post-operative pain in children.

### Group therapy

Group therapy uses peer interaction and group dynamics to improve skills and target specific behaviours depending on the group type. One or several therapists may lead a group therapy session. A 2020 study that involved 30 children of divorced parents found that group play therapy helped them improve their self-control strategies and resiliency.

### Family therapy

Family therapy aims to understand the family's interaction and communication patterns. It also aims to provide support and education to help the family function more positively.

Psychotherapy is not a quick fix or an easy answer. It is a complex and rich process that, over time, can reduce symptoms, provide insight, and improve a child or adolescent's functioning and quality of life.

At times, a combination of different psychotherapy approaches may be helpful. In some cases, a combination of medication and psychotherapy may be most effective. Child and adolescent psychiatrists are trained in different forms of psychotherapy and, if indicated, are able to combine these forms of treatment with medications to help alleviate the child or adolescent's emotional and/or behavioural problems.

### When does a child need therapy?

Although occasional tantrums and outbursts are normal for many children, persistent or sudden changes in a child's behaviour may indicate a need to visit a mental health professional. A child may need therapy if they experience:

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- Repeated displays of defiant behaviour
- Problems in different areas of life, such as family, relationships, or academics
- Excessive worry
- Persistent sadness
- Low energy levels
- A lack of concentration
- Changes in appetite
- A sudden change or loss of interest in previously valued hobbies or interests
- Thoughts of self-harm
- Social withdrawal
- Sleep pattern changes
- A lack of personal hygiene
- Physical complaints that do not have a cause or do not respond to treatment

In younger children, behaviours that indicate a need to visit a mental health professional may not be as easy to detect. However, they may include:

- Clinginess
- Separation anxiety
- Bedwetting
- Excessive fearfulness
- Agitation and irritability

**Explaining therapy to a child**

A parent or caregiver should try to explain therapy to a child in an age-appropriate way. For example, they may be able to offer more information depending on the child's age and ability to understand.Parents and caregivers may wish to describe therapists as "feelings doctors" to younger children.

If they intend to be part of the process, they can also share that therapy can help them communicate, play, and understand each other better. With older children and teenagers, parents and caregivers can involve them in the decision-making process. Decisions may include choosing the clinic, therapist, and schedule.

**How to find a child therapist**

Parents and caregivers can ask their paediatrician for a referral. If the child is in school, a school social worker or counsellor can also offer recommendations. Parents and caregivers can also search website directories that list psychologists by state and specialty. Some examples include:

- American Psychological Association
- Good Therapy

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- The U.S. Health Resources and Services Administration

**Approximate costs involved with child therapy**

The cost of therapy varies depending on location, type of therapy, specialization, therapy length, insurance coverage, and the therapist's training and reputation. However, costs typically range from $65 to $200. Some therapists may charge up to $250 per session. People with insurance coverage can expect insurance co-pays amounting to $10 to $50.

**The best online therapy options for children**

According to the American Psychological Association, online therapy can be an affordable, convenient, and accessible way to receive therapy. Below are some online options that offer therapy to children and teenagers.

## 5.5 PLAY THERAPY

In the early days of psychodynamic child therapy, verbal interpretation of the unconscious meaning of the child's play was thought crucial to symptom remission and developmental advance. In this early view, resolution is only achieved via interpretation. But interpretation, per se, is no longer emphasised as the primary agent of change in child work; rather, what is thought to be curative is enhancing the child's symbolic, imaginative, and mentalising capacities by increasing the range, depth, and emotional richness of his play. This expansion of the child's capacity to acknowledge various aspects of his self-experience in the safety of play and fantasy is, many believe, what allows developmental progress. Mentalisation in play leads to the development of structures for containing feelings and understanding oneself and others.

The capacity to play is rooted in early relationship experience. Beginning with the earliest playful exchanges with the mother, the child slowly develops the capacity to recognise that he and she have separate and unique minds, and that ideas and feelings are not concrete realities, but rather states that, in play, can be reworked and transformed. The development of these capacities depends upon the establishment of intimate, secure relationships, which permit the discovery of the self and the other, and their separation. In relationships that are disturbed, however, these capacities are also disturbed; putting things into words and into play can be terrifying and disorganising.

It is for these reasons that the child's capacity to establish a relationship with the therapist (and, conversely, the therapist's capacity to establish a relationship with the child) is central to the treatment. Play therapy is at the core two people, the child and the therapist, playing together. Children enter treatment with varying capacities to play, to talk, and to establish a relationship with the therapist. Most often these variations are linked to the nature and severity of developmental disruptions, emotional disturbance, and trauma. Sometimes the first job of the therapist is to help the child play, even a little. This may mean helping the child with the rudiments of telling a coherent story, it may mean helping him to imagine the inner life of the characters he has created, it may mean helping him find solutions in play that help to contain the intense feelings generated.

Because the relationship is so central to moving development forward, regularity is thought to be an especially crucial aspect of the process of play therapy. The processes

inherent to the development of the capacity to pretend fully and imaginatively are complex, and require sustained periods of connection with the therapist. For this reason, children are typically seen at least once a week, and many clinicians prefer to work with them twice or three times a week. In many clinical settings this may not be feasible, but there is evidence that increased frequency is critical to developmental change in seriously disturbed children. Equally critical to the child's progress is consistency. Children find change and disruption difficult, as their defences are typically relatively tenuous or overly rigid; in either case, their capacity to engage in treatment is greatly helped by the therapist's sensitivity to the impact of these changes.

## 5.6 BEHAVIOUR MODIFICATION

Historically, techniques of change based on behavioural theory, such as behaviour modification, preceded more cognitive approaches. Behaviour modification applies the theory of classical and operant reinforcement to a wide range of childhood clinical problems such as anxiety disorders (phobias, obsessive-compulsive disorder) conduct problems and early developmental problems (sleep disturbance, enuresis). This approach is based on the notion that problem behaviours are likely to recur if the consequences of such behaviours are rewarding to the child.

Formal treatments of this kind begin with a functional analysis, in which the antecedents and consequences of problem behaviours are systematically recorded so as to determine environmental and transactional patterns and responses that support these behaviours. Interventions are planned to alter these behavioural patterns by focusing on reducing rewarding consequences, and increasing the positive consequences of pro-social behaviours. This approach is most commonly applied by working with the parent, using reported behaviour of the child in the school or home environment. Improvements with respect to reduced frequency or severity of problem behaviours are explicitly celebrated or rewarded.

For example, parents are encouraged not to respond to angry outbursts or tantrums in young children with rewarding responses (attention, raised excitement) and to encourage more pro-social behaviours in achieving wishes or negotiating conflict. Alternatively, treatment focuses on the behaviour and interactions taking place within the treatment session and explicitly structured sessions as opportunities to change the child's behaviour. For example, in the Parent-child Game, therapist directly prompts parents (through a one-way screen using an earpiece) to follow behaviour modification principles in changing a child's behaviour. Parent training has become one of the most widely used of the behavioural approaches.

This method has been most comprehensively developed and evaluated by Webster-Stratton (Webster-Stratton and Herbert, 1993). The training can be delivered to parents either individually or in a group, and is typically brief (eight to 12 sessions) with a carefully prepared curriculum for each session. Video clips are used to illustrate common parent-child conflicts, and the emphasis is on structured homework exercises that facilitate the generalisation of skills learned in therapy to the family environment. Initial sessions focus on positive interactions between the parent and child, particularly those that occur within

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the context of play. Behavioural principles of selective attention and reinforcement are illustrated and practiced through homework tasks, along with more cognitive components such as problem solving, negotiating turn taking and emotional recognition.

**CHECK YOUR PROGRESS**

1. **How does a therapist explain therapy to a child?**
2. **What are the ways to find a child therapist?**
3. **Who is Child Counsellor?**
4. **What do you understand by support therapy?**
5. **When does a child need therapy?**

## 5.7 FAMILY THERAPY

Family and systemic therapies believe that intervention must address the interactional patterns between people as well as their intra psychic processes. Gurman et al. (1986) have defined family therapy as any psychotherapeutic endeavour that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family.

The last 10-20 years has seen a major change from individual to family systemic therapeutic approaches to children and families in clinical practice, within both the health and social services. However, it is important to recognise that family therapy is not about the creation, or maintenance, of traditional nuclear families. Family therapists have to recognise the diversity of configurations that families today bring to the task of rearing children and should strive to maintain a respectful and non-judgmental approach to these differing choices.

**Children and Young People in Family Therapy**

Although family and systemic therapies have become one of the predominant forms of working with children's emotional and behavioural problems, surprisingly little has been written about children's perceptions of family work or about ways in which children might be more fully engaged in the therapeutic process. Most therapeutic models rely heavily on verbal communication and so might be seen to exclude younger children.

In the past family therapy has been criticized for ignoring children and, in effect, conducting therapy in their presence without involving them. Children's worlds are often full of play, creativity, and activity and therapy must incorporate these concepts if it is to be meaningful to children. Different schools of family therapy have addressed these concerns in different ways. These are:

- Structural family therapy (Minuchin et al., 1967; Minuchin, 1974) assumes that problems in the child arise from underlying problems in the structure and organisation of the family. The therapist is interested in how the family makes decisions, and how the boundaries between individuals and subsystems within the family lead to relative engagement or distancing.

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- The therapist is often directive, attending to sequences and patterns of behaviour, and seeking to bring about change using techniques such as enactment and the encouragement of family members to practice new ways of behaving and communication in the session which ensures that all family members, including even quite small children are actively involved in therapy

**Brief Solution-Focused Therapy**

This therapy assumes that problems are maintained by the way difficulties are viewed and by the repetitive, behavioural sequences surrounding attempts to solve them. Families are seen as constantly changing and it is assumed that families will already have solutions to their own difficulties. The therapist sets clear goals with the family and focuses on solutions not problems.

Underlying this emphasis on competence and solutions is a focus on challenging unhelpful beliefs about the child and the problem as part of the process of generating new solutions. This focus on solutions can be helpful when working with children who are often worried that being brought for therapy is just another context in which they will be blamed for family difficulties. Solution-focused work is often active and, like structural therapies, can involve tasks and between session homework these practical activities provide a further opportunity for children to be actively engaged.

**Narrative Therapy**

This therapy draws on the way that we all make sense of our experience by creating personal accounts or narratives. Therapy is a form of conversation that encourages reflection and can transform problem-saturated narratives into more positive accounts. The emphasis on language can be off-putting for children but techniques such as externalisation, which assist in separating the person from the problem, can help the child to feel less blamed and join the child with the family in fighting the problem. Narrative therapists also see those with problems as having expertise in solving them that may help children to feel engaged and less blamed, and the emphasis on narrative suggests the possibility of links with stories and storytelling ideas familiar to children.

Narrative therapists also look for unique outcomes and positive exceptions concepts similar to the search for solutions and exceptions by solution-focused therapists, and this too may help children to feel less blamed. There are a few recent studies looking at children's perspectives on therapy. Stith et al. (1996), for example, explored the experience of 16 children from 12 families in a qualitative study. Children, interviewed alone, wanted to be included in therapy and were keen to know more about their families, be involved in generating solutions and not feel blamed for problems. They did not want to be the sole focus of discussion.

Even primary school children understood the purpose of therapy and found talking about problems helpful but their willingness to be involved increased with time and with the amount they knew about why their families were coming to therapy. There are many important differences between approaches to the treatment of children. Treatments have been extended from traditional inpatient and outpatient settings to community contexts.

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There is an increased tendency, across orientations, to offer treatment in context: in relation to the family and perhaps the school, rather than focusing on the child alone.

**FUNCTIONAL FAMILY THERAPY**

This attempts to modify such dysfunctional family patterns by altering parental monitoring and disciplinary strategies. Parents are taught to use basic social learning principles for managing youth behaviour. Several additional components complement the core behavioural approach including family sessions designed to improve communication and increase family reciprocity, and sessions aimed at facilitating negotiation among family members.

**Multisystemic Therapy**

This is an integrative and comprehensive approach to treating youth conduct problems and antisocial behaviour. Unlike traditional, comprehensive treatments that remove the adolescent from his or her social environment through placement in residential treatment settings, MST aims at restructuring multiple levels of the youth's environment in order to promote pro-social functioning. Based on Bronfenbrenner's (1979) ecological model of development, individual behaviour is viewed within the context of multiple, nested contexts.

Relevant context is not limited to the family, as in functional family therapy, but extended to the school, neighbourhood, peer group, and broader community, as well as to linkages among these systems. MST draws upon methods from a number of empirically based treatments. For example, interventions at the family level might include communication training as well as methods from strategic or structural family therapy. Integration of specific interventions is guided by a core set of principles.

MST begins with the assumption that the purpose of assessment is to understand the fit between identified problems and the functioning of multiple systems. Psychiatric diagnosis is not the primary aim, instead MST therapists attempt to identify processes at multiple levels that support or impede adaptive functioning. In turn, therapeutic interventions attempt to use systemic strengths, for example, a committed extended family, as levers for change. All interventions are present focused and action oriented. Typically, many interventions focus on specific contingencies that sustain problematic behaviours. Therapist and family agree upon specific, well-defined goals, and progress is closely monitoring, including family feedback on treatment fidelity.

## 5.8 GROUP THERAPY

**What Is Group Therapy?**

Group therapy is a form of psychotherapy that involves one or more therapists working with several people at the same time. This type of therapy is widely available at a variety of locations including private therapeutic practices, hospitals, mental health clinics, and community centers.

Group therapy is sometimes used alone, but it is also commonly integrated into a comprehensive treatment plan that also includes individual therapy.

### Types of Group Therapy

Group therapy can be categorized into different types depending on the mental health condition it is intended to treat as well as the clinical method used during the therapy. The most common types of group therapy include:

- **Cognitive behavioural groups**, which center on identifying and changing inaccurate or distorted thinking patterns, emotional responses, and behaviours.
- **Interpersonal groups**, which focus on interpersonal relationships and social interactions, including how much support you have from others and the impact these relationships have on mental health.
- **Psychoeducational groups**, which focus on educating clients about their disorders and ways of coping; often based on the principles of cognitive behaviour therapy (CBT).
- **Skills development groups**, which focus on improving social skills in people with mental disorders or developmental disabilities.
- **Support groups**, which provide a wide range of benefits for people with a variety of mental health conditions as well as their loved ones.

Groups can be as small as three or four, but group therapy sessions often involve around eight to 12 people (although it is possible to have more participants). The group typically meets once or twice each week, or more, for an hour or two.Group therapy meetings may either be open or closed. New participants are welcome to join open sessions at any time. Only a core group of members are invited to participate in closed sessions.

### Group Therapy Techniques

What does a typical group therapy session look like? In many cases, the group will meet in a room where the chairs are arranged in a large circle so that members can see every other person in the group. The precise manner in which the session is conducted, and any group therapy activities, depend largely on the goals of the group and the therapist's style. Some therapists might encourage a more free-form style of dialogue, where each member participates as they see fit. Other therapists have a specific plan for each session that might include having participants practice new skills with other members of the group.

### What Group Therapy Can Help With

Group therapy is used to treat a wide variety of conditions, including:

- Attention-deficit/hyperactivity disorder (ADHD)
- Depression
- Eating disorders
- Generalized anxiety disorder
- Panic disorder
- Phobias
- Post-traumatic stress disorder (PTSD)

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- Substance use disorder

In addition to mental health conditions, CBT-based group therapy has been found to help people cope with:

- Anger management
- Chronic pain
- Chronic illness
- Chronic stress
- Divorce
- Domestic violence
- Grief and loss
- Weight management

After analysing self-reports from people who have been involved in the process, Irvin D. Yalom outlines the key therapeutic principles of group therapy in "The Theory and Practice of Group Psychotherapy."

- **Altruism**: Group members can share their strengths and help others in the group, which can boost self-esteem and confidence.
- **Catharsis**: Sharing feelings and experiences with a group of people can help relieve pain, guilt, or stress.
- **The corrective recapitulation of the primary family group**: The therapy group is much like a family in some ways. Within the group, each member can explore how childhood experiences contributed to personality and behaviours. They can also learn to avoid behaviours that are destructive or unhelpful in real life.
- **Development of socialization techniques**: The group setting is a great place to practice new behaviours. The setting is safe and supportive, allowing group members to experiment without the fear of failure.
- **Existential factors**: While working within a group offers support and guidance, group therapy helps members realize that they are responsible for their own lives, actions, and choices.
- **Group cohesiveness**: Because the group is united in a common goal, members gain a sense of belonging and acceptance.
- **Imparting information**: Group members can help each other by sharing information.
- **Imitative behaviour**: Individuals can model the behaviour of other members of the group or observe and imitate the behaviour of the therapist.
- **Instils hope**: The group contains members at different stages of the treatment process. Seeing people who are coping or recovering gives hope to those at the beginning of the process.

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- **Interpersonal learning**: By interacting with other people and receiving feedback from the group and the therapist, members of the group can gain a greater understanding of themselves.
- **Universality**: Being part of a group of people who have the same experiences helps people see that what they are going through is universal and that they are not alone.

**Benefits of Group Therapy**

There are several advantages of group therapy.

- **Support, Safety and Encouragement**
  Group therapy allows people to receive the support and encouragement of the other members of the group. People participating in the group can see that others are going through the same thing, which can help them feel less alone. The setting allows people to practice behaviours and actions within the safety and security of the group.
- **Role Modeling**
  Group members can serve as role models for other members of the group. By observing someone successfully coping with a problem, other members of the group can see that there is hope for recovery. As each person progresses, they can, in turn, serve as a role model and support figure for others. This can help foster feelings of success and accomplishment.
- **Insight on Social Skills**
  By working with a group, the therapist can see first-hand how each person responds to other people and behaves in social situations. Using this information, the therapist can provide valuable feedback to each client.
- **Affordability**
  Group therapy is often very affordable. Instead of focusing on just one client at a time, the therapist can devote their time to a much larger group of people, which reduces the cost for participants.

**Effectiveness of Group Therapy**

Group therapy can be effective for depression. In a study published in 2014, researchers analysed what happened when individuals with depression received group cognitive behavioural therapy (CBT). They found that 44% of the patients reported significant improvements. The dropout rate for group treatment was high, however, as almost one in five patients quit treatment.

An article published in the American Psychological Association's *Monitor on Psychology* suggests that group therapy also meets efficacy standards established by the Society of Clinical Psychology (Division 12 of the APA) for the following conditions:

- Bipolar disorder
- Obsessive-compulsive disorder (OCD)
- Panic disorder
- Social phobia
- Substance use disorder

## 5.9 CHAPTER SUMMARY

Consistency is the key to management of problem behaviours in children. Coupled with this, there should be acceptance, respect and positive interactions with the child. Management of the problem behaviour is multi-faceted. All the stakeholders including parents, teachers, the peer group, and the child himself need to be involved in the management of problem behaviour. Counselling aims at establishing a warm and genuine relationship with the child. It facilitates the child opening up and expressing his fears, anxieties and concerns in the secure atmosphere of counselling. Counsellor analyses the problem, understands it from different perspectives, and suggests intervention plans to manage and overcome the problem behaviour. There are different approaches to counselling such as, Psychoanalytical counselling: focuses on the early childhood experiences of the client. It aims at catharsis through the technique of free association. It uses play, drawing, painting, drama and dance as medium that facilitate free expression of child's feelings and emotions. Client centered counselling/person centered counselling: is a non-directive approach to counselling. The therapist is non-critical, non-judgemental and non-evaluative. It emphasizes the innate potential of the individual to solve his problems. The therapist is required to extend unconditional positive regard and genuineness in the counselling relationship. Cognitive behavioural therapy: the focus is on cognitions and thoughts of the child that is causing the problem behaviour. The child is helped to identify the irrational and dysfunctional thought patterns and change them to rational positive thoughts and self-talk. A daily record of dysfunctional thoughts can be maintained by the child/adolescent in which the situation, thoughts, feelings and behaviour can be recorded.

## 5.10 REVIEW QUESTIONS

### SHORT ANSWER TYPE QUESTIONS

1. **What are the benefits of group therapy?**
2. **Define Altruism.**
3. **List different techniques of therapy.**
4. **What are the different types of child counselling?**
5. **What do understand by psychodynamic psychotherapy?**

### LONG ANSWER TYPE QUESTIONS

1. **Describe behaviour modification in detail.**
2. **What group therapy can help with?**
3. **What do you understand by functional family therapy?**
4. **What are the types of types of group therapy?**
5. **Explain multisystemic therapy in detail.**

## 5.11 MULTIPLE CHOICE QUESTIONS

1. **_______________ aims to understand the family's interaction and communication patterns.**
   a. Family Therapy

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b. Group Therapy
c. Multisystemic Therapy
d. Supportive Therapy

**2. What is the full form of CBT?**
a. Child Behavioural Therapy
b. Cohesive Behavioural Therapy
c. Cognitive Behavioural Therapy
d. None of these

**3. What is the full form of PTSD?**
a. Post-Traumatic Stress Disease
b. Post-Traumatic Stress Disorder
c. Post-Therapy Stress Disorder
d. None of these

**4. __________________ is a brief treatment specifically developed and tested for depression, but also used to treat a variety of other clinical conditions.**
a. Interpersonal Therapy
b. Group Therapy
c. Multisystemic Therapy
d. Child Behavioural Therapy

**5. __________________ gives children and teens support in their lives to cope with stress, identify helpful and unhelpful behaviours, and improve self-esteem.**
a. Family Therapy
b. Group Therapy
c. Multisystemic Therapy
d. Supportive Therapy

**6. What is the full form of PCIT?**
a. Parent-Child Interactive Therapy
b. Parent-Child Interaction Therapy
c. Parent-Child Interpersonal Therapy
d. None of these

**7. __________________ is a type of therapy that focuses on young children, teens, and adolescents with one or more mental illnesses.**
a. Child Counselling
b. Interpersonal Therapy
c. Group Therapy
d. Multisystemic Therapy

**8. What is the full form of ACT?**
a. Acceptive and Commitment Therapy
b. Acceptance and Cognitive Therapy
c. Acceptance and Commitment Therapy
d. None of these

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**9. ____________________ therapy assumes that problems are maintained by the way difficulties are viewed and by the repetitive, behavioural sequences surrounding attempts to solve them.**

a. Brief Solution-Focused Therapy
b. Child Counselling
c. Interpersonal Therapy
d. Group Therapy

**10. _________________ refers to a variety of techniques and methods used to help children and adolescents who are experiencing difficulties with emotion and behaviour.**

a. Interpersonal Therapy
b. Multisystemic Therapy
c. Supportive Therapy
d. Psychotherapy

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# ANSWER KEY

**UNIT I**

| QUESTION | ANSWER | QUESTION | ANSWER |
|---|---|---|---|
| 1 | a. | 6 | a. |
| 2 | b. | 7 | a. |
| 3 | d. | 8 | d. |
| 4 | c. | 9 | d. |
| 5 | d. | 10 | a. |

**UNIT II**

| QUESTION | ANSWER | QUESTION | ANSWER |
|---|---|---|---|
| 1 | b. | 6 | a. |
| 2 | a. | 7 | a. |
| 3 | c. | 8 | c. |
| 4 | d. | 9 | a. |
| 5 | b. | 10 | d. |

**UNIT III**

| QUESTION | ANSWER | QUESTION | ANSWER |
|---|---|---|---|
| 1 | a. | 6 | a. |
| 2 | b. | 7 | d. |
| 3 | c. | 8 | b. |
| 4 | c. | 9 | a. |
| 5 | a. | 10 | c. |

**UNIT IV**

| QUESTION | ANSWER | QUESTION | ANSWER |
|---|---|---|---|
| 1 | a. | 6 | a. |
| 2 | b. | 7 | d. |
| 3 | d. | 8 | c. |
| 4 | c. | 9 | b. |
| 5 | a. | 10 | d. |

**UNIT V**

| QUESTION | ANSWER | QUESTION | ANSWER |
|---|---|---|---|
| 1 | a. | 6 | b. |
| 2 | c. | 7 | a. |
| 3 | b. | 8 | c. |
| 4 | a. | 9 | a. |
| 5 | d. | 10 | d. |

# NOTE

# NOTE

# School Counseling

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