UNIT 1 INTRODUCTION TO SCHOOL PSYCHOLOGY

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1.0 INTRODUCTION

In the second unit (Branches and fields of psychology) of the first block of your BPC-001 course, you have read about *educational psychology* and *school psychology* under *applied fields* where the principles and discoveries of psychology are utilised in educational/school settings. This is the rapidly growing field of psychology through, out the world and hence is this full course on school psychology with four blocks and sixteen units in total covering the field of school psychology in basics as well as broader perspectives is highly relevant and important. In this unit we will be learning all about school psychology how it developed its roles and functions etc. We start with Introduction to School

Psychology and elucidate the major Domains of School Psychology which includes the Child Development and Learning, Problematic Behaviour of School Children, etc. We then present the role of school psychologists and therapeutic interventions with school children in the school settings. Every profession has a professional association which advances its cause. School psychology too has a professional association and we have put across the professional associations of school psychologists which includes American Psychological Association, National Association of School Psychologists, International School Psychology Association and in India we have Indian School Psychology Association. This is followed by substantiating the school psychology as a profession. We then present the professional journals in school psychology which includes School psychology international and school psychology quarterly. Then we have a section discussing the challenges before school psychology in India.

1.1 OBJECTIVES

On completing this unit, you will be able to:

- Define school psychology;
- Describe the characteristic features of school psychology;
- Elucidate the major domains of school psychology;
- Delineate the role of APA in advancing school psychology;
- Discuss the importance of research in promoting school psychology;
- Explain the roles and functions of school psychology;
- Describe the characteristic traits required of a school psychologist; and
- Analyse the importance of a school psychologist in a school setting.

1.2 INTRODUCTION TO SCHOOL PSYCHOLOGY

The name *school* brings out some buried, colourful memories of childhood for most of us. After listening to this word, we revert back for a few seconds to our childhood when we were a school going student. While many children used to have fun with friends in and around the school most of the times, few could also be seen praying teacher be on leave that day or forget about the test particularly when they had not done the homework or were not prepared for the test. Some subjects we used to learn fast and easily whereas some subjects we used to avoid being difficult to understand and learn. Few teachers used to be our favourites for helping us overcome our difficulties in learning while students used to fear some teachers for their strictness and nature.

Those privileged students had to face the jealousy of the rest most of the class who were teachers' favourite for being studious, active, smart, intelligent or extraordinary. The beginnings of holidays were celebrations while re-openings of the school after the end of holidays happened to be a nightmare little less than exams. The mother used to be perceived relieving her *some displaced frustrations* on the kids for not doing well in studies/exams, fathers were found most of the times busy with their office work or meetings' aftereffects even at home. Passing the class with a respectable (or sometimes tolerable) percentage and promotion in the next one used to be the most pleasant surprise for few students and relief

for their parents/teachers. But, gone are the days now. Let's come back to *psychology* which, you have seen in the first unit (Introduction, definition and concept of psychology) of the first block of your BPC – 001 course, scientifically studies behaviour and cognitive (mental) processes.

You might have heard about *Chandigarh* sometime, somewhere. Yes, you are right. It is famous for its rock garden and is also known as the *city beautiful*. But, during October 2010, it was in news for some rather unexpected reactions of a few students. A student, after getting zero marks in mathematics' internal assessment exam, posted objectionable remarks and abusive comments on Facebook and shared with many other co students who also got involved and supported him for his outburst. The school, taking disciplinary action, rusticated and banned the entry of 16 students in the school premises for three months which, amending after requests from the parents, the school reduced later and directed the students to do community service in the school premises. The matter even reached Punjab and Haryana High Court against the punishment but the Hon'ble court refused to intervene (Times of India, Oct. 09, 2010 and Oct. 25, 2010, Dainik Bhaskar, Nov. 09, 2010).

In an another instance that happened in Tamil Nadu's Dindigul district, a tenth standard student hanged himself in the school premises because his English teacher had reprimanded him for forging his signature in the answer sheet (Times of India, August 14, 2010).

You might have witnessed altercations among the classmates in the school but, in an unexpected incident, a student in Delhi shot at a junior student with pellet gun as the junior had taunted the accused and commented on his batting style in a cricket match. Besides the pistol, a knuckle duster was also recovered from the accused. Furthermore, the students of this school were reported possessing surgical blades, knives and chains also (Hindustan Times, July 30, 2010).

Yet in one another shocking incident in Mumbai, a *Class III* student, during a *minor* fight, stabbed his classmate with a pair of scissors (italics added for emphasis, Times of India, Oct. 14, 2010).

With all your understanding of the subject (by subject here we mean both: subject of *psychology* on one hand, and subject as a *person* on the other hand whose behaviour you study as a student of psychology), how many and what observations can you make out of these above quoted real life examples? We shall deal here with one major underlying factor that there were some definite behavioural problems with these students and they were in need of some kind of help that is psychological help.

Referring back once again to the second unit (Branches and fields of psychology) of the first block of your BPC-001 course, you have gone through *clinical psychology* also besides educational psychology. Blending both of these fields, it may be said in broader terms that school psychology is that field of psychology which applies the principles and discoveries of educational psychology and clinical psychology for the diagnosis and treatment of the students' (covering children as well as adolescents) various behavioural and learning problems. Having a close look at following section will clarify it further.

1.2.1 Goals of School Psychology

School psychologists work within the educational system to help children with emotional, social, and academic issues. The goal of school psychology is to collaborate with parents, teachers, and students to promote a healthy learning environment that focuses on the needs of children.

School psychology is still a relatively young profession. The National Association of School Psychology (NASP) was established and formally recognised as a doctoral specialty by the American Psychological Association (APA) in 1968. In 2002, *U.S. News and World Report* named school psychology one of the top ten "hot professions." Many school psychologists in the field are retiring, creating a demand for qualified school psychologists.

A few of the duties that a school psychologist might perform on a regular basis include:

- Helping students with behavioural problems
- Evaluating students experiencing academic difficulties
- Developing academic or behavioural plans for students
- Aiding students with crisis situations.

1.2.2 Traits Required of a School Psychologist

Problem solving ability, collaboration, lots of patience with kids and adults, oral and written communication, flexibility, understanding of educational measurement and evaluation principles, know where to find the information you need, must not take self too seriously, take advantage of professional growth opportunities. Know your strengths and weaknesses. If you are not confident about a certain topic or issue/s, make it a goal for yourself to learn -as you have to be confident and competent about various issues impacting students and their families, patience, understanding and empathy. Good conferencing skills, report writing and willingness to continue to learn and grow as a professional.

As a school psychologist, the professional will be assisting students who are striving to improve their mental health and become productive citisens. They will speak not only with the students but with their parents and teachers as well to gain insight into the nature of students' psychological dysfunction, if any, as well as proper courses of treatment.

They will also be measuring and assessing students' learning abilities through the use of intelligence tests such as the Stanford-Binet Intelligence Quotient Test, the Universal Nonverbal Intelligence Test, and the Woodcock-Johnson Test, among others.

Students with learning disabilities or physical handicaps will also come within their purview, because these children may require special guidance and assistance as they make their way through the educational system.

1.3 MAJOR DOMAINS OF SCHOOL PSYCHOLOGY

Just as each branch and field of psychology has its prescribed areas of study and research, school psychologists also work on definite lines as prescribed by the

field of school psychology. Let's have a look at major domains of school psychology which will further clarify our understanding of this field.

1.3.1 Child Development and Learning

Family is considered to be the smallest unit of society and mother is considered to be the first and foremost teacher of a child. The child enters the school system later, mostly starting from the play school. His psycho-social development takes place during his socialisation and he starts learning to cooperate and other life skills from others. In your BPC – 002 course (Developmental psychology), you have gone through various developmental phases and stages of a child's life in sufficient details. However, the scenario is not as glittering always and for every child. We come across few kids in and around the school who exhibit signs and symptoms of various development disorders which you read in the forth unit also (Screening and assessment for developmental disorders) of second block of your BPC – 002 course.

To help a child grow normally and learn efficiently, we must have a sound knowledge and background of child development besides a clear insight into his learning. Do you remember *Ishaan Awasthi* (Darsheel Safary) of Taare Zameen Par (Like Stars on Earth *or* Stars upon the Ground) – a movie produced and directed by Aamir Khan in which he (Aamir Khan) also played the role of art teacher and Ishaan's tutor as Ram Shankar Nikumbh? Ishaan played the role of a dyslexic child whose parents failed to understand his condition but Ram helped him overcome his disability and re-gain his confidence. This movie, released in 2007, besides leading people in general to re-look into the problem and gain new insights also led the experts like neurologists and psychiatrists to explain dyslexia further in reference to the theme of this movie (see Chakravarty, 2009; Rao and Krishna, 2008). About the developmental factors in children, you are going to study in details in the next (second) block of this course.

1.3.2 Problematic Behaviour of School Children

In the starting paragraphs of this unit, you read about some instances in which the school children exhibited various forms of problematic behaviours. For the systematic study of these problem behaviours, it is necessary to classify or categorise them so that proper description and treatment could be done in order to help the children. Two agencies at international levels have contributed a lot in this direction. World Health Organisation (WHO) publishes *International Classification of Diseases* (ICD) and currently the 10th Revision of this international standard diagnostic classification is in use and is referred to as ICD-10. Its Chapter V deals with Mental and Behavioural Disorders and has Blocks F00-F99 where disorders of psychological development are dealt with in F80-F89. For example, the Code of *Learning disability* (also known as learning disorder or learning difficulty) in ICD – 10 is F81.9. Another guide, commonly used in United States and in varying degrees in other parts of the world, is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that is published by the American Psychiatric Association. Presently the 'Text Revision" of the DSM-IV (DSM-IV-TR, published in 2000) is in use and organises various disorders or disabilities into five levels (axes). It covers, for example, learning disorders under 'Disorders usually first diagnosed in infancy, childhood, or adolescence' and includes reading disorder (315.00), mathematics disorder (315.1), disorder of written expression (315.2) and learning disorder – not

otherwise specified (315.9). You shall be studying about these classification systems and various behavioural problems along with their etiology etc. in the third block of this course on School Psychology.

1.3.3 Role of School Psychologists

School psychologists, in order to help the school children attain their best in school, studies and life, directly work with students, teachers and parents in order to assess, diagnose and design various treatment plans for students' learning and other disabilities. Thus, the school psychologists have to play a very serious and challenging role in the lives of the school children. Hence, the school psychologists need to be inevitably well conversant with the psychological needs of the school children, symptoms of distress, behavioural problems and treatment plans in order to provide efficient school psychology services. You shall study about school psychology services in details in the forth unit of this very block.

1.3.4 Therapeutic Interventions with School Children

After the identification of some problematic behaviour in the child and its assessment with the help of psychological tests and tools, the next and foremost step of a school psychologist is to design and plan therapeutic intervention. The students may need psychological help ranging from emotional first-aid to days or weeks long systematic therapies in order to overcome their problem. The treatment or therapeutic plan actually depends upon the nature and severity of the problem of the individual child. Here also, the school psychologist must be well trained in using various therapies to help the child up to fullest extent possible. You are going to study about four major therapies in the forth block of your school psychology course.

1.4 PROFESSIONAL ASSOCIATIONS OF SCHOOL PSYCHOLOGISTS

Recognising the importance of the role of school psychologists, to develop the field of school psychology, few associations of school psychologists have been established who share their work and experiences through scientific dialogue and communication like journals, news letters, seminars, workshops and conferences at national and/or international levels. Let's have a glance at few major ones.

1.4.1 American Psychological Association (APA)

It would not be an exaggeration if APA is regarded as the most systematic and expanded professional association in the field of psychology which despite having based in Washington, D.C. has 1, 50,000 members worldwide. With the general mission, "to advance the creation, communication and application of psychological knowledge to benefit society and people's lives", APA has established a special division of School Psychology – *Division 16* among its more than 50 professional divisions. This division has practicing school psychologists who mainly work with and for children, families, teachers and the schooling process. For more information, the official website of APA http://www.apa.org/ can be visited.

1.4.2 National Association of School Psychologists (NASP)

With the goal of enhancing and ensuring the professional competency of school psychologists, advocacy, diversity and developing external relationships and communications; NASP strives for enhancing the learning and mental health of children and youth. It is located in Bethesda, MD and can be accessed online at http://www.naspweb.org/.

1.4.3 International School Psychology Association (ISPA)

ISPA, a Non-Government Organisation speaking on behalf of children, young people and their families, was established in the early 1970s by a group of school psychologists from various parts of the world. Striving for promoting the psychological rights of all children all over the world, ISPA supports and promotes worldwide cooperation amongst school and educational psychologists. For more details, ISPA can be reached at http://ispaweb.org/.

1.4.4 Indian School Psychology Association (InSPA)

At national level in India, the InSPA which is an affiliate of International School Psychology Association, USA was established in the year 2009 as a voluntary non-profit organisation at Puducherry by a group of leading psychologists under the leadership of renowned psychologist Professor B. Mukhopadhyay. With a major focus on the development and growth of the field of school psychology, InSPA is not only emphasising on the professional development and training of psychologists in school settings in lines with the guidelines issued by ISPA and NASP but is also striving to introduce school psychology as a subject in the curriculum and to get appointed at least one trained school psychologist in each school at all India level. The official website of this registered association is www.ispaindia.org.

1.5 MAJOR JOURNALS AND NEWSLETTERS RELATED TO SCHOOL PSYCHOLOGY

So far, you have read books/textbooks of various subjects. Do you think that these books are updated annually or quarterly incorporating the recent advances of knowledge? It is simply not feasible to revise or update the books so frequently. Then, how to convey/share what we have discovered in our research or even classroom, say, after experimenting a new method of helping students learn faster? This is usually done by the way of journals and news letters which are published periodically and contain the most recent information and researches for others to critically verify and to adopt or adapt. But one thing is sure, these journals and news letters not only lead one to learn but also motivate to do further research and uncover the truth.

While journal(s) or even specific article(s) can be obtained after paying the requisite fee/charge, news letters are generally freely available online also. Some major journals and news letters are detailed below with the recommendations that you should have some for your professional growth, and you should read them regularly as per your interests to know what is happening in school psychology at different places in the world. Later, you may also contribute any article or research paper in some journal. Of course, what generally you read in journals or books has been researched at some point of time by somebody and

presented to you through any journal/news letter/book etc. Here, take a short break and have a look at the *references* given at the end of any unit. You will find the name of the contributor(s) and other details of the work/publication along with the *name of the journal/book* etc. in which their research work was published.

1.5.1 Canadian Journal of School Psychology

It is the official publication of the Canadian Association of School Psychologists. CASP was founded in 1984 to showcase the best practices in school psychology for the member school psychologists and the general public across Canada. This journal is published four times a year by SAGE and can be accessed at http://cjs.sagepub.com/. It's archive of all online issues, since January 1985 can be seen at http://cjs.sagepub.com/content/by/year.

1.5.2 Psychology in the Schools

Wiley, a publishing company, publishes this journal eight times a year. This journal not only carries the research studies but also the opinions and practices of school psychologists. Covering broadly the school psychologists, counselors, teachers, and administrators, its major emphasis is on the practical implications of various phenomena for the psychologists working in the schools. To know more, you may visit http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1520-6807/issues which gives information on all issues of this journal since the publication of its first volume in 1964.

1.5.3 School Psychology International (SPI)

A publication of the International School Psychology Association (see 1.4.3 above), SPI serves as a platform to share ideas and opinions and attempts to improve the quality of mental health by publishing research articles/studies that provide solutions and share innovations in specific reference to school settings and school communities at international levels. Its archive of all online issues (since July 1979) can be seen at http://spi.sagepub.com/content/by/year.

1.5.4 School Psychology Quarterly (SPQ)

The registered trademark of APA (see Section 1.4.1 above) and official publication of APA's Division 16 (School Psychology), SPQ has a major concern with the children, youth and the adults (parents, teachers etc.) who serve them and publishes mainly scientific research studies and literature reviews to promote the field of school psychology. All volumes of SPQ, published by the Division 16 of APA since 1986 can be seen at http://psycnet.apa.org/index.cfm?fa=browsePA.volumes&jcode=spq.

1.5.5 School Psychology Review (SPR)

Through the quarterly publication of SPR, NASP (see 1.4.2 above), as per its motto of helping the children achieve their best in life and school, provides a platform to the scholars to share and communicate their original, data – based research work and practices for the advancement of psychology and education in general and school psychology in particular. All archived issues of SPR (since Volume 1, 1972) can be found at http://www.nasponline.org/publications/spr/sprissues.aspx.

1.5.6 Newsletters Related to School Psychology

Since the above discussed associations and organisations are professional, their journals or journal articles are to be purchased if one wants to read them and get benefited. However, the publication of news letters is another means of communication and sharing ideas, opinions, information about events and schedules, and sometimes research findings also. Many such newsletters of reputed universities and organisations are available on the web. Depending upon the membership and policies of the organisation, the newsletter may be made available only to the eligible persons through printed hard copy or to all online. Few such major news letters that are available online for all are listed below.

Name University/Organisation URL	: : :	The School Psychologist American Psychological Association http://www.indiana.edu/~div16/psychologist.htm
Name University/Organisation URL	: : :	School Psychology Newsletter University of Wisconsin-La Crosse www.uwlax.edu/schoolpsych
Name University/Organisation URL	: : :	School Psychology Newsletter Fordham University http://www.fordham.edu/
Name University/Organisation URL	: :	School Psychology Program Newsletter University of Wisconsin-Stout http://www3.uwstout.edu/programs/edssp/ resource.cfm
Name University/Organisation URL	: : :	InSPA Newsletter Indian School Psychology Association http://www.ispaindia.org/

1.6 CHALLENGES BEFORE SCHOOL PSCHOLOGY IN INDIA

School psychology, being an emerging field in India, is facing various challenges. Let's have a glance at some major ones of them.

1.6.1 Awareness

The unawareness of most Indian parents just like Ishaan's parents about his dyslexia which was highlighted in Taare Zameen Par movie, is not unusual or exaggeration. Most of the parents and teachers as well as the society are not aware about the actual psychological processes and factors underlying the poor performance in schools and behavioural problems of their wards. The school psychologists have to do a lot in this direction to sensitise the parents and community about various behavioural problems of the children because these are harmful not only for the suffering child him/herself but also for other co students in the class, parents at home, and also for the society in the long run.

1.6.2 Incorporation of School Psychology as a Subject

Although school psychology is a vast field in itself, but it is a matter of great concern that most institutions of high learning, universities and colleges do not even have a paper on school psychology in their curriculum at graduate or post graduate levels. They are still following the same old fashioned optional papers which were introduced decades ago. There is no question on their relevance but neglecting the highly crucial field of school psychology is a matter of great concern here. If this subject is not taught in the universities and/or colleges, from where will the trained school psychologists come to look after the children who are considered the future of any nation and there is nobody for monitoring and fostering their smooth psychological and social development in the schools.

1.6.3 Shortage of Trained School Psychologists

In light of the growing instances of the psychological problems seen in the students in schools, as were discussed in the section 1.2 of this unit, we are in need of at least one school psychologist in each school. The establishment of InSPA by a group of psychologists for this purpose is worth praise but as per the demands and needs for school psychologists in India, supply seems not to be there in near future. It becomes even more challenging when many schools are already struggling from the shortage of subject teachers. Having school psychologists in each school seems neither to be there in stakeholders' priority list nor a topic of discussions. Keeping in view the role of a school psychologist and the number of to be benefited students throughout the country, not only the state or central governments or the school managements are required to make necessary arrangements for this purpose but the parents and society have also to look into their role because it is the parents and the society who are most affected at the end of the road due to the psychological and behavioural problems of the children. School psychological services are as important as providing physical health services to the physically ill person.

1.6.4 School Psychology for Teachers

We started this unit with few news items where the students revealed some problematic conduct. But, there are some times other news as well which also require the attention of psychologists working in the schools. As per the report of Plan International, "corporal punishment is wide-spread in Indian schools, despite being illegal. More than 65% children, its report claimed, said they were beaten" (Times of India, Oct. 27, 2010). In Thiruvidaimaruthur (TN), a 16 year old boy studying at a government higher secondary school poured kerosene and set himself ablaze and committed suicide because his teachers punished him for possessing a cigarette lighter (Times of India, August 20, 2010). In yet another shocking instance of corporal punishment resulting in serious injuries, a class I student lost her vision of left eye after a teacher allegedly thrashed her for not doing her homework in Jhunjhunu district, in Jaipur (Times of India, August 21, 2010). Later, Rajasthan High Court, taking a serious note of the matter, issued show cause notices to the state government and CBSE, asking them to explain their failure in checking corporal punishments (Times of India, Oct. 06, 2010).

In a village of Jind district of Haryana, the teachers after taking liquor (*sharaab*) in school created a mess and the aggrieved villagers locked them up in the school itself and locked the school as well. Later they re-opened the school on the

assurance that the accused teachers will be transferred from that school (Dainik Jagran, August 28, 2010). In Lucknow, a school teacher was booked and a case was registered against him on charges of voluntarily causing hurt for beating a nine-year old student because the child did not take out his textbook. The student suffered ear injuries and had to be taken to the hospital as he had fainted (Times of India, Oct. 31, 2010). In Ajmer also, in an another case of corporal punishment, a teacher was booked for slapping repeatedly a three-and-a-half-year old girl when the kid drew some lines in her notebook in the class and was smiling on her creativity (Times of India, Oct. 11, 2010). Besides these, as reported by Plan International also, the news of sexual abuse of students by teachers are not new and uncommon.

So, do only students need psychological help? Definitely not. The above quoted *few* examples reveal that such teachers need psychology help more than the students. Hence, it is another area where the school psychologists have to work harder for not only the physical safety of the school children but also to save them psychologically from such teachers because once exposed to such trauma, the life never remains the same for the victim students.

1.7 LET US SUM UP

This unit introduces the readers to the specialised field of school psychology. A lot of real life examples, reported in media, are there which reveal the dire need of having trained school psychologists in the schools for the better learning and psychological growth of the students. Although the B. Ed. curriculum now consists of a paper of *educational psychology* in India but the topics covered therein seem requiring major revision because the teachers, having even the B. Ed. degree, still need to be more sensitised towards the child's rights. The growth and development of school psychology in India is very challenging and a lot needs to be done. But, the future prospects of the field are very bright.

1.8 UNIT END QUESTIONS

1) Explaining psychology, write a descriptive note on school psychology.
2) Critically appraise major domains of school psychology.
3) What role the professional organisations play in the development and growth of a discipline? Explain in specific reference to school psychology.
4) What is role of state/central government in controlling corporal punishment in schools?
5) Besides class teacher(s), why is a school psychologist required in each school?

1.9 SUGGESTED READINGS AND REFERENCES

Merrell, K., Ervin, R., & Gimpel, G. (2006). *School Psychology for the 21st Century, Foundation and Practice.* New York: The Guilford Press.

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Chakravarty, A. (2009). Taare Zameen Par and dyslexia savants. *Annals of Indian Academy of Neurology*, *12*(2), 99 – 103.

Dainik Bhaskar (Nov. 09, 2010). *Facebook mamle mein High Court ka dakhal se inkar* (English translation: Refusal of High Court from intervening in Facebook matter), p. 04.

Dainik Jagran (August 28, 2010). Adhyapakoon ne school mein pi sharaab, gramin bhadke (English translation: Teachers took liquor in school, villagers enraged), p. 09.

Hindustan Times (July 30, 2010). *Boy shoots at junior with pellet gun in school*, p. 04.

Rao, T.S.S. and Krishna, V.S.T. (2008). Wake up call from 'Stars on the Ground'. *Indian Journal of Psychiatry*, *50*(1), 2 – 4.

Times of India (August 14, 2010). *Reprimanded student hangs himself*, p. 01.

Times of India (August 20, 2010). *Punished for 'smoking' TN teen immolates self*, p. 09.

Times of India (August 21, 2010). *Girl loses vision after being beaten by teacher*, p. 05.

Times of India (Oct. 06, 2010). *HC notice to Rajasthan govt, CBSE*, p. 09.

Times of India (Oct. 09, 2010). *School suspends 16 for Facebook comment*, p. 04.

Times of India (Oct. 11, 2010). *Teacher booked for slapping 3-yr-old*, p. 03.

Times of India (Oct. 14, 2010). *Boy stabs classmate with a pair of scissors*, p. 10.

Times of India (Oct. 25, 2010). *Community service to make students 'mend' ways*, p. 03.

Times of India (Oct. 27, 2010). *More than 50% Indian kids face sexual abuse*, p. 06.

Times of India (Oct. 31, 2010). *Teacher booked for beating student*, p. 10.

UNIT 2 DEFINITION, CONCEPT, DESCRIPTION, GOALS AND OBJECTIVES OF SCHOOL PSYCHOLOGY

Structure

2.0 Introduction

2.1 Objectives

2.2 Concept and Definitions of School Psychology

2.3 Goals and Objectives of School Psychology

2.4 Role and Functions of School Psychologists

- 2.4.1 Assessment
- 2.4.2 Intervention
- 2.4.3 Consultation
- 2.4.4 Prevention
- 2.4.5 Research and Professional Development

2.5 Let Us Sum Up

2.6 Unit End Questions

2.7 Suggested Readings and References

2.0 INTRODUCTION

There can be no doubt that schools have a duty to use all effective means needed to maintain a safe and disciplined learning environment.

- American Psychological Association Zero Tolerance Task Force (2008).

In the first unit of this block, we have seen a lot many real life examples where school students revealed various types of problematic behaviour. While the schools are supposed to provide them specialised psychological help, their teachers and parents are also required to be made sensitised and aware on this matter. It is in this background of the first unit that we shall start this second unit with various definitions to make a clear picture of the concept of school psychology. We shall also study the goals and objects of school psychology; the roles and functions of school psychologists; and the ethical issues in school psychology in this unit.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- define school psychology;
- elucidate the goals and objectives of school psychology;
- explain the roles and functions of school psychologists;
- describe the ethics in school psychology; and
- discuss the need of school psychology in India.

2.2 CONCEPT AND DEFINITIONS OF SCHOOL PSYCHOLOGY

In the first unit, we saw that blending the fields of educational and clinical psychology, school psychology broadly applies the principles and discoveries of educational psychology and clinical psychology for the diagnosis and treatment of the students' (covering children as well as adolescents) various behavioural and learning problems. First, let's examine how do the psychologists define school psychology. Then we shall try to conceptualise this field further with the definitions of school psychologists.

Reid (1999), writes, "School Psychology is a profession whose members help teachers, parents, and students to understand, prevent, and solve problems. As a specialty within the profession of psychology, school psychology is founded on respect for the dignity and worth of each student and a commitment to understanding human behaviour for the purpose of promoting human welfare".

Burden (2000) regards school psychology "as a profession of applied educational psychologists" (p. 467).

Reynolds and Miller (2003) write that "school psychology is a field of psychology that is closely aligned with educational psychology" (p. 13).

Fagan (2003) says, "School psychology is an applied psychology specialty that blends the knowledge bases of education and psychology into a professional practice that delivers services to clients of various ages, primarily those of school age (preschool to college), in a variety of settings, primarily public and private elementary and secondary schools".

According to ISPA website, "The term *school psychology* is used in a general form to refer to professionals prepared in psychology and education and who are recognised as specialists in the provision of psychological services to children and youth within the contexts of schools, families, and other settings that impact their growth and development". Thus, as per ISPA, this term also includes educational psychologists.

The APA's Division 16, on its website under 'Archival Description of the Specialty School Psychology' defines school psychology as, "a general practice and health service provider specialty of professional psychology that is concerned with the science and practice of psychology with children, youth, families; learners of all ages; and the schooling process".

On Wikipedia (an online, free encyclopedia), we find the school psychology defined as, "a field that applies principles of clinical psychology and educational psychology to the diagnosis and treatment of children's and adolescents' behavioural and learning problems". About clinical psychology, Wikipedia writes, "clinical psychology is an integration of science, theory and clinical knowledge for the purpose of understanding, preventing, and relieving psychologically based distress or dysfunction and to promote subjective well-being and personal development". And, Wikipedia explains educational psychology as, "the study of how humans learn in educational settings, the effectiveness of educational interventions, the psychology of teaching, and the social psychology of schools

as organisations". Here, to make the concept of school psychology more clear, it is also important to read what Kumar (2004) writes, "even though school (and also college) psychology has many things common with educational psychology, the school psychologists (also often known as school counselors) are more concerned with the *problems of individual students* than with the general principles of education".

Besides the above definitions, the field of school psychology is also defined in terms of what do the *school psychologists* do? While searching for the literary origins of the term *school Psychologist*, Fagan (2005) found and reported that "the origin of the term in the American literature occurred as early as 1898 in an article by Hugo Munsterberg". In order to further conceptualise the field of school psychology, let's have an idea what, according to experts, do the school psychologists do.

The American Psychological Association (APA), while enlisting careers in psychology on their website, describe that, "school psychologists work directly with public and private schools. They assess and counsel students, consult with parents and school staff, and conduct behavioural interventions when appropriate" (retrieved from http://www.apa.org/careers/resources/guides/careers.pdf, on Nov. 11, 2010).

The APA's Division 16, after defining school psychology on its website under the section 'Archival Description of the Specialty School Psychology' writes further, "The basic education and training of School Psychologists prepares them to provide a range of psychological assessment, intervention, prevention, health promotion, and program development and evaluation services with a special focus on the developmental processes of children and youth within the context of schools, families, and other systems.

School psychologists are prepared to intervene at the individual and system level, and develop, implement, and evaluate preventive programs. In these efforts, they conduct ecologically valid assessments and intervene to promote positive learning environments within which children and youth from diverse backgrounds have equal access to effective educational and psychological services to promote healthy development".

The National Association of School Psychologists (NASP) on its website describes that, "School psychologists help children and youth succeed academically, socially, behaviourally, and emotionally. They collaborate with educators, parents, and other professionals to create safe, healthy, and supportive learning environments that strengthen connections between home, school, and the community for all students".

The Canadian Psychological Association (CPA) in their Professional Practice Guidelines for School Psychologists in Canada start the Preface with the following quotation of Sheridan and Gutkin, "…School psychologists are the most highly trained mental health experts in schools. In addition to knowledge about prevention, intervention, and evaluation for a number of childhood problems, school psychologists have unique expertise regarding issues of learning and schools. It is [school psychologists'] ethical responsibility to become involved in programs aimed at problems that are broader than assessing and diagnosing

what is wrong with a child. As the most experienced school professionals in this area, school psychologists must become invested in addressing social and human ills … Although [school psychologists] will not 'solve' these ills, [they] must have a role in ameliorating their impact on the lives of children."

Mahndiratta (1997) defines the school psychologist as, "a state-certified practitioner of the specialty of school psychology; typically holds at least the master's degree, and serves as a staff member of a public school or school district; generally provides diagnostic and referral services for students and advisory services for school personnel, students, and parents".

The services of School Psychology Centre at the Oklahoma State University aim to maximise the academic, social, emotional, and behavioural success of children, adolescents, and young adults aged 0 – 21. They offer a wide range of assessment, intervention, and consultation services to students, families, and schools (retrieved from http://education.okstate.edu/index.php/school-psychology-center, on Dec. 27, 2010). Similarly, the brochure of School Psychology Programme of Indiana University at Bloomington reads, "School psychology offers individuals an opportunity to work within educational and mental health settings addressing the challenges faced by our children [in schools] that may impede them from reaching their full academic, social – emotional, and behavioural potential for success" (retrieved from http://site.educ.indiana.edu/Portals/207/School%20 Psychology%20brochure.pdf, on Dec. 03, 2010).

On the basis of the above, we may conclude that the professional field of school psychology, following the scientist – practitioner model, applies the principles of educational psychology and clinical psychology for enhancing the learning and mental health, and promoting the intellectual, social and emotional development of all children in the school settings. It is pertinent to mention here that Government of India has declared the nation's children as a *supremely important asset* and strives that our plans and programmes should lead our children to *grow up to become robust citisen, physically fit, mentally alert and morally healthy* (National Policy for Children, 1974). The following recent news may be regarded as a positive step in this direction.

*With school students increasingly exhibiting signs of emotional and behavioural instability, principals are turning to psychologists and counsellors to help sensitise teachers and parents to this issue. (*The Times of India, Chennai, Oct 20, 2010)

Self Assessment Question

1) What do you mean by school psychology? Define it in your own words.

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2.3 GOALS AND OBJECTIVES OF SCHOOL PSYCHOLOGY

Let's see what does the Division 16 of the APA (Division 16 is exclusively dedicated to the field of School Psychology), say about the goals and objectives of this field on its website (http://www.indiana.edu/~div16/goals.html):

"The ultimate goal of all Division activity [or of school psychology in general] is the enhancement of the status of children, youth, and adults as learners and productive citisens in schools, families, and communities.

The objectives *of the Division* of School Psychology are:

- to promote and maintain high standards of professional education and training within the specialty, and to expand appropriate scientific and scholarly knowledge and the pursuit of scientific affairs;
- to increase effective and efficient conduct of professional affairs, including the practice of psychology within the schools, among other settings, and collaboration/cooperation with individuals, groups, and organisations in the shared realisation of Division objectives;
- to support the ethical and social responsibilities of the specialty, to encourage opportunities for the ethnic minority participation in the specialty, and to provide opportunities for professional fellowship;
- to encourage and effect publications, communications, and conferences regarding the activities, interests, and concerns within the specialty on a regional, national, and international basis."

The goal of school psychology described above not only seems to be in tune with our National Policy for Children (1974) but also seems more or less familiar as well as challenging when we read any school's *mission statement*. For example, the mission statement of a public school in Karnal, Haryana reads, "The school aims to produce modern, secular, Indian citisens with a scientific temper, ready to face any global challenge, having gathered the wisdom of the East & West". Analysing minutely this mission statement, you may infer here that this type of missions can effectively be achieved by any school only after applying the principles of psychology in their schools and realising the goals of the school psychology.

You might well recall that in first unit of this block, we discussed some news wherein the students exhibited some unusual behaviours, that is behaviours unexpected of them. Here it is the goal of school psychology to collaborate with the teachers, students and students' parents in order to promote the healthy learning environment in the school settings and to promote the psychological and educational development and personal and social well-being of the students.

As one major objective, the field of school psychology attempts at developing the psychology students as scientists as well as practitioners where they develop a solid knowledge base in the core areas of psychology and education to be a professional school psychologist. They further effectively utilise this knowledge of psychology and education to (a) provide school psychological services to the

students, their families and educators, and to (b) assess, prevent, and intervene in various psychological and educational issues that have an impact on students, families, and institutions and the community.

As a school psychologist, they work on not only improving the academic competence of the students but also improving their emotional and social functioning. Since one of the major goals of school psychology is to help create the positive learning environments for all the students, to achieve this purpose, the school psychologists help the schools to design and develop such a system that has suitable behavioural, affective and adaptive goals for all their students. In order to accomplish the goals and objectives of school psychology, the school psychologists focus on enhancing the appropriate pupil behaviours, and help the teachers, schools and parents to develop such capacities in their students for coping with the conflicts and its resolution, as well as to teach social problem solving, decision making and pro-social behaviours.

You might conclude on the basis of above discussion that school psychology has a definite role to play not only to enhance the status of all the children as learners and productive citisens but also to guide teachers, schools and parents to be a facilitator in this enhancement, for the betterment and well-being of the students. Thus, the school psychology, you are right if you think, is not only challenging but also a comparatively rewarding profession as scientist – practitioner of psychology in the school and educational settings.

Self Assessment Question

1) How can school psychology help a school?

    a) develop and adopt its *mission statement* and

    b) achieve its *mission*? Discuss in your own words.

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Although some of you might have got a rough idea but, to be further sure about it, you might ask – what exactly do these school psychologists do to achieve the goals and objectives of school psychology? Let's find answer to this very logical question in the coming section.

2.4 ROLE AND FUNCTIONS OF SCHOOL PSYCHOLOGISTS

You might recall that you have studied 'the task of psychology' in the sub-section 1.4.5 in the first unit (Introduction, definition and concept of psychology) of first block of your BPC – 001 course; and in section 2.4 of second unit (Branches and fields of psychology) of the same block/course, you have read 'Psychologists: what do they do?' and seen that 4% psychologists work in schools, 50% psychologists provide mental health services in various settings and 18% psychologists provide education and educational services. From there, you might have got a fair idea about what psychologists do in general and what percentage of psychologists are engaged in different areas of psychology.

We have seen in the preceding sections of this very unit that the school psychologists work with the students to help them resolve their academic difficulties, behavioural problems and other related issues which have impact on their learning and well-being. Blending the fields of education and psychology, school psychology tries to fulfill its goal of helping the students become competent and responsible adults. The school psychologists also work with the parents and teachers for designing and developing appropriate techniques to suitably deal with the concerned students' home and school behaviour. According to the National Association of School Psychology (NASP), school psychologists help children and youth succeed academically, socially, behaviourally, and emotionally. They collaborate with educators, parents, and other mental health professionals to create safe, healthy, and supportive learning environments for all students that strengthen connections between home, school, and the community.

NASP describes five *major* areas in which the school psychologists work: (1) consultation, (2) evaluation, (3) intervention, (4) prevention, and (5) research and planning. It is emphasised here that these are the *major* responsibilities and the school psychologists are not limited to these only as they have to achieve the goals and objectives of school psychology by utilising their training and skills in providing school psychological services. The major roles, functions and responsibilities of school psychologists, which are broadly adopted and/or adapted by different nations and institutions, are as follows.

2.4.1 Assessment

As one most important function, the school psychologists assess the student's/ child's problem and evaluate his/her adjustment, academic achievement, learning abilities, scholastic aptitude, psycho-social development, emotional status, personality development, social skills, social competence, etc. They also focus on diagnosing the specific learning disabilities and making the assessment for the child's eligibility for special education programme with the help of various tools and techniques, and examining the effectiveness of various suitable intervention strategies. They also need to examine the school's climate in relation to the child's problems and smooth development.

2.4.2 Intervention

Here working face-to-face with the children, their families, teachers, and the community, the school psychologists help remove/overcome academic, learning, behavioural, adjustment related and mental health problems. They not only

provide psychological counseling to the children and their families but also develop effective intervention strategies for classroom management in order to provide the required behavioural support to enhance the learning opportunities, well-being and mental health of all the children. Wherever required, the school psychologists use suitable therapies at appropriate levels (individual, group or family) for solving the conflicts and learning problems and also to maximise the academic success and psycho-social well-being of the children.

2.4.3 Consultation

This is another very crucial role a school psychologist plays. Here he/she consults with the teachers, parents and community and tries to provide them coordinated support to understand and effectively address the students' academic, behavioural and mental health problems and needs not only with the school but also outside the school settings. He/she provides the information to the concerned about various academic, learning and/or behavioural problems of the children and works collaboratively with parents, teachers and school staff to find effective solutions of these behavioural and/or mental health problems. He/she consults with the school authorities also about administering and implementing effective and smooth classroom management strategies.

2.4.4 Prevention

Since prevention is better than cure, the school psychologists focus on spreading awareness among masses including parents and teachers about the probable factors leading to psycho-social, educational problems and stresses in order to prevent or minimise the occurrence of behavioural and mental health problems. Besides teaching teachers and parents the skills to effectively address behavioural issues, they collaborate with the school staff and community for creating positive school environments and providing school psychological services for improving and promoting mental health and well-being of the children/students.

2.4.5 Research and Professional Development

In order to develop the best intervention strategies for achieving the goals and objectives of school psychology, the school psychologists also conduct research because they have to evaluate the effectiveness of various academic programmes of the school, their behavioural management strategies and various other services which have direct/indirect impact on the learning and development of the children. They also are supposed to find out new ways of effective learning and proper mental growth so that the children could become *robust and productive citisens who are mentally alert and morally healthy*. For this purpose, they conduct training sessions for school staff/personnel on various useful topics to sensitise them on related issues and also share their expertise and experiences with other school psychologists for each others professional development.

Self Assessment Question

1) Out of the above – discussed roles and functions of the schools psychologists, which one is the most important and why? Explain in your own words.

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As was discussed in the beginning, the roles and functions of the school psychologists include the above but are not limited to these. Besides the above, they are also involved in counseling, supervision, planning, advocacy, and sometimes in some administrative functions also. No matter what particular role they are performing, we should remember that the school psychologists have to follow their professional ethics just like any other professional. The APA and NASP have developed various professional ethics for psychologists including school psychologists which, when followed religiously, not only help develop the credibility of the field and school psychological services in the society but also help the field grow and achieve its due status.

2.5 LET US SUM UP

Keeping in view the various real-life school examples where school children exhibit various academic, learning and behavioural problems, there is a strong, rather critical need of school psychologists to provide school psychological services and effectively deal with such situations which have not only direct impact on the complete school environment but also on the society. It is not an exaggeration to say here that all schools are in need of the professional support of school psychologists and school psychology intervention because they are responsible not only for the academic success of the students but they are also accountable for producing productive citisens for the overall development of the nation.

2.6 UNIT END QUESTIONS

1) Is school psychology different from educational psychology? If yes, how?
2) How can the school psychologists achieve their goals in collaboration with community?
3) What are the requirements for the school psychologists to effectively perform their functions?
4) Explain the importance of research for the advancement of school psychology.
5) Elucidate the need of school psychology in India.

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UNIT 3 SCHOOL PSYCHOLOGY: PAST, PRESENT AND FUTURE

Structure

3.0 Introduction

3.1 Objectives

3.2 School Psychology: The Past – How did it begin?

3.3 School Psychology: The Present – Where do we stand?

3.4 Future of School Psychology

3.5 School Psychology for the Protection of Child Rights, Welfare and Well-being

- 3.5.1 Role of the Government
- 3.5.2 Role of the Universities/Institutions
- 3.5.3 Role of the Schools Authorities
- 3.5.4 Role of the Teachers
- 3.5.5 Role of the Parents
- 3.5.6 Role of the School Psychology Associations

3.6 Let Us Sum Up

3.7 Unit End Questions

3.8 Suggested Readings and References

3.0 INTRODUCTION

The second unit of this block makes us realise that being applied in nature, school psychology plays a very important role in the fulfillment of various goals and objectives which may range from resolving the problematic issues related to learning, academic achievement, behaviour etc. in the school to fostering the positive growth and development of the child through various psychological interventions. As Mahatma Gandhi said, "The future depends on what we do in the present", the historical roots of any profession help us understand the present status and foresee the future growth and directions. Hence, in this unit, we are going to study the past of school psychology, understand its present and have an idea about the future of school psychology. This course in general and this unit in particular might serve the purpose of building the base in the field of school psychology as it should broaden the vision further and shape the mission for all those who see the future of a nation in its children.

3.1 OBJECTIVES

By the end of this unit, you will be able to:

- illuminate the past of school psychology;
- describe the present status of school psychology;
- discuss the future of school psychology;
- elucidate the role of various agencies in school psychology; and
- propose a course of action for the promotion of school psychology in India.

3.2 SCHOOL PSYCHOLOGY: THE PAST – HOW DID IT BEGIN?

As the historical journey of any nation, event or a person is always full of knowledge and of immense interest, so is the history of school psychology. To begin with, you would be excited to learn about Arnold Lucius Gesell (1880-1961), who is credited to be the first person hired as 'school psychologist' in 1915 at Connecticut in the United States. As he was primarily appointed for conducting the mental examinations of children (Fagan, 1987), he thought of bridging the gaps between the child study movement, special education and clinical psychology, and thus combined education and psychology for the assessment and evaluation of the children in order to make recommendations for their special teaching (Wikipedia – School Psychology). And, Gertrude Hildreth (1930) has the credit of writing first book on school psychology.

It is Lightner Witmer, however, who is acknowledged as the founder of school psychology [and clinical psychology, see Phillips, 1990, p.7]. Medway and Cafferty (1992) also wrote in the Preface of their book, "In 1907 Lightner Witmer conceived of a new profession using clinical methods in the examination and treatment of individuals with psychological disorders. Witmer termed the new profession *clinical psychology* because the word "clinical" best described his view of employing systematic observation and experimentation to effect change in individuals. Witmer saw mostly children drawn from schools in Pennsylvania and is credited with founding school psychology as well as clinical psychology".

Since "Indian psychology is influenced by the American behaviouristic pattern" (Pandey, 1969), and "In keeping with India's role as a British colony until 1947, Indian psychology was heavily influenced by British traditions" (Clay, 2002), and "For almost a century, academic psychology in India has continued to be an alien discipline. In the beginning of the last century, psychology was imported lock, stock, and barrel from the West" (Dalal, 2011), we need to know how did school psychology emerge outside India.

The timeline of history of school psychology has been developed by Fagan (1990) – dividing it into two parts: the "Hybrid Years" (1890 – 1969) and the "Thoroughbred Years" (1970 to the present). The Hybrid Years described "a period when school psychology was a *blend* of many kinds of educational and psychological practitioners loosely mobilised around a dominant role of psycho-educational assessment for special class placement", and Thoroughbred Years is "a time of growth in the number of training programmes, practitioners, state and national associates and the expansion of literature and regulations, all of which contributed to a stabilised profession entity called *School Psychology*" (Fagan, 1990). Here, few authors remarked that the role as described in Hybrid years "still exists in the Thoroughbred years, but the practitioner is more narrowly defined as school psychologist, typically someone who has a master's or doctoral degree in school psychology from a nationally accredited programme" (Benjamin Jr., DeLeon, Freedheim, and Vandenbos, 2003, p. 38).

Where the first master's degree training programme for school psychologists was initiated in 1928 at New York University, and the first doctoral training programme in 1953 at the University of Illinois (Benjamin Jr. et al., 2003), year

1916 has a great significance in the history of Indian psychology when the first Indian psychology department was established in Calcutta University, and the Indian Psychoanalytical Society was established by Bose in 1921 in Calcutta. As the teaching and learning of psychology, and research in psychology gained gradual momentum, the Indian Psychological Association appeared in 1925. Among others, another major contribution is that of M. V. Gopalaswamy who gave his highly influential contributions by standardising tests of higher mental functions. He was also behind the establishment of an independent Department of Clinical Psychology in 1955 at the All-India Institute of Mental Health (AIIMH, now known as NIMHANS, Bangalore) for the education and training of clinical psychologists.

However, it was during the 1950s when educational psychology and the psychology of personality were given due importance by Indian scholars. In educational psychology, the main areas covered were educational and vocational guidance, selections and placements for jobs, occupational information, reading and comprehension, and teachers' attitudes toward their profession (Dutt, 2006). Also, the establishment of Rehabilitation Council of India had greater impact in the field of special education, and understanding and catering to the special needs of the children and their inclusive education.

As we shall further see in the forthcoming section on the present status of school psychology that as a consequence of this poor start and slow progress, the psychological health, well-being and safety of the school children in India are at stake. So, a lot is yet to be done in this direction.

Self Assessment Question

1) Write a short note on the history of school psychology in your own words.

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3.3 SCHOOL PSYCHOLOGY: THE PRESENT – WHERE DO WE STAND?

School psychology is a relatively unheard of profession in most Indian schools. It remains an area that has not been understood and also largely ignored.

- Aparna Massey (2009)

In subsection 1.4.4 of the first unit of this block, you heave read about Indian School Psychology Association (InSPA) which aims at getting school psychology introduced as a subject in the curriculum and getting at least one trained school psychologist appointed in each school throughout India. Considering the importance of having a trained school psychologist in each school throughout India, even if we think of training one teacher per school in school psychology, it

may not be an easy task. You might wonder – why? According to a report by National University of Educational Planning and Administration (NUEPA), there are at least 1.28 million recognised schools imparting elementary education in 635 districts spread over 35 states and union territories in India (TOI, July 29, 2010). As per simple statistics, if there are 1.28 million schools, we might need to train 1.28 teachers in school psychology. And, to train them in school psychology, their must be enough number of institutions/universities offering courses/training programmes in school psychology and it is not the case, unfortunately. To explore the number of the institutions/universities offering any course in school psychology in India, an extensive random but focused search was done. Of all the central and state universities, the websites of the following few selected Indian universities were surfed and studied during November, 2010 with below-given summarised findings.

Name of the University (and website)	Central/ State Uni.	Psychology Department Estd. in	Programme Covered	Seats	Faculty	Whether School Psychology is on offer
Mizoram University http://www.mzu.edu.in/	Central	1983	MA Psychology	15	5	No
Banaras Hindu University, Varanasi http://www.bhu.ac.in	Central	1949/1962	MA Psychology	DNA	14	No
HP University, Shimla http://hpuniv.nic.in/	Central	DNA	MA Psychology	DNA	DNA	No
JMI http://www.jmi.ac.in/	Central	1986	M.A.(Applied Psychology)	36/24	11	DSNAW
DU http://www.du.ac.in/	Central	1957	MA Psychology	95	14	DSNAW
			M.A.(Applied Psychology)	27		
IGNOU www.ignou.ac.in	Central	2010	MA Psychology	NL	07	No
Guru Jambheshwar University of Science & Technology, Hisar http://www.gjust.ac.in/	State	1996	M.Sc Applied Psychology	45	4	No
Kurukshetra University, Kurukshetra www.kuk.ac.in	State	1971	MA Psychology	50	7	No
M D University, Rohtak http://mdurohtak.com	State	1983	MA Psychology	30	15	No

(DNA = Data Not Available, DSNAW = Detailed Syllabus Not Available on Website, NL = No Limits)

Your attention on the few major points needs to be attracted here.

Almost all the above Universities have Clinical as well as Counselling Psychology on offer at post-graduate levels.

To their students of MA/M.Sc Psychology II Semester and BA/B.Sc Part II, Banaras Hindu University offers a course on Psychology in Education.

HP University, Shimla offers a Group on 'Educational-guidance psychology' and another on 'Developmental psychology' as specialised courses among other courses (with the condition to choose one group only) to their MA – 4th Semester students.

The Department of Applied Psychology at Guru Jambheshwar University of Science and Technology has a thrust area in child psychology and offers optional courses in Child Psychology and Exceptional Children to their 3rd and 4th Semester students of M.Sc. (Applied Psychology).

The specialisation areas of the faculty in many Psychology Departments, which were available there on their websites, were also scrutinised. Only a few are having specialisation in educational psychology and no faculty was seen having specialisation in school psychology, per se.

As you are right now going through it, IGNOU offers School Psychology to the 2nd year students of BA in Psychology programme as an optional course.

Jnana Prabodhini's Institute of Psychology (JPIP) at Pune, recognised by the University of Pune, is offering a regular Post Graduate Diploma in School Psychology since 1993 with 25 seats per batch.

Regarding the status of India in an international study, among 83 countries in which an attempt was made to find out the evidence of school psychology, Jimerson, Skokut, Cardenas, Malone and Stewart (2008) found that, out of total five parameters searched, India fulfilled only one as there were *identifiable professionals employed to fulfill duties characteristics of 'school psychologists'*. However, on the same parameter were also 14 other countries - Benin, Ghana, Jamaica, Kenya, Kuwait, Malta, Marshall Islands, Pakistan, Papua New Guinea, Paraguay, Trinidad and Tobago, Uganda, United Arab Emirates, and Zambia (p. 137).

Other four parameters included in this study but largely missed by us were: availability of regulations (or laws) that require 'school psychologists' to be licensed, registered or credentialed; professional association(s) of 'school psychology' (including division of school psychology within national psychological association); university programme(s) that prepare 'school psychologists' (specific curriculum designed to prepare these professionals); and university programme(s) that provide doctoral level preparation for 'school psychologists'. Eleven countries – Australia, Brazil, Canada, Cyprus, Greece, New Zealand, Romania, South Africa, South Korea, Scotland, and United States, had evidence available for all the above five parameters (Jimerson et al., 2008, p. 137).

You might recall here about the second parameter given in above paragraph that today we have InSPA, established in 2009 i.e. after one year of the publication of this study, you have read about InSPA in subsection 1.4.4 of this Block. But yes, even today, we are largely missing related regulations (or laws) for licensing or registering school psychologists; university programme(s) to prepare school psychologists; and university programme(s) that provide doctoral level preparation for school psychologists. However, few universities are running PG Diploma/Advanced Diploma programmes in Counselling Psychology at their Psychology Department.

To specifically add here – the National Council of Educational Research and Training (NCERT), which offers one-year *International Diploma Course in Guidance and Counselling* (IDGC) in collaboration with Commonwealth of Learning, Canada, emphasises with enough sensitivity that, "The increasing complexities and stresses of modern day living, everyday reports of lack of interest in studies, low achievement, truancy, aggression, behavioural problems, suicide, drug abuse and the like call for provision of guidance and counselling for children and youth in schools. Teachers and other school personnel need to equip themselves with helping skills to promote students' personal, social, educational, career development and adjustment throughout the school years. This, however, requires professional orientation and training," (NCERT Admission Notice, IDGC 2011). Maximum fifty seats per study centre are available in this NCERT diploma at Department of Educational Psychology and Foundations of Education, NCERT, New Delhi and its five Regional Institutes of Education at Ajmer, Bhopal, Bhubaneswar, Mysore and Shillong. So, you can now very well guess that if we have to train 1.28 million teachers in school psychology, this gigantic task is nearly impossible to accomplish with the available infrastructure and facilities in India at present.

Self Assessment Question

1) How many schools in your own locality have school psychologists?

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2) Discuss the present status of school psychology in India.

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3.4 FUTURE OF SCHOOL PSYCHOLOGY

The school education system in my country [India] *has not yet recognised the need for hiring trained school counselors. Some of the schools that do hire counselors undermine their role by assigning them teaching duties and standing in for absentee staff.*

- *Aparna Massey (2009)*

By the discussion so far, you might have noticed that despite huge demands, the profession of school psychology as well as school psychologists are missing in our country. Since recent past, the reputed schools have started appointing qualified counsellors with psychology background but also burdening them with assignments other than counselling as well. At national level, there is no statutory/ regulatory body to set the qualifications or fix the roles and responsibilities of psychologists in general and school psychology in particular. Most universities have psychology departments offering courses other than school psychology, and have separate/independent education departments doing academic and research activities. The faculty at education departments happens to be largely with background in education (M. Ed. and Ph.D. in education).

As far as need analysis for school psychologists in India is concerned, only one reference could be traced while doing an extensive search and that is of P. Ramalingam, Pondicherry University, who presented his work at the 31st International School Psychology Association (ISPA) Conference in Malta in 2009. He concluded, "In the present school system there is no post of a school psychologist or a counsellor on the academic staff from nursery to senior secondary school. There is no teacher of psychology as such among the subject teachers because nowhere in the school curriculum does psychology figure as a content subject. There are in fact no school psychologists to whom students affected by psychological problems could be referred for behaviour modification, or for addressing emotional or learning problems."

In the previous section, we have seen the status of the universities offering psychology programmes in various branches. With specific regard to school psychology, for its development in India, we immediately need, first of all, to set up a professional body for school psychologists like Bar Council of India or the Indian Medical Association. It should not only decide the professional qualifications and training required for being a school psychologist but would also estimate the requirement of school psychology workforce in India. This body may also consider the credentialing/licensing of school psychologists. To proceed in this direction, one needs to know:

- The number of credentialed school psychologists in India,
- The number of practicing school psychologists in India,
- The number of practicing school psychologists engaged in independent practice,
- The number of practicing school psychologists engaged in schools, and
- Current estimated shortage of qualified school psychologists in India.

There is no data available collected empirically for the presence or requirements of school psychologists in India. The reason is as simple. Because, school psychology has yet to (a) get its necessity recognised as well as realised, and to (b) take birth as a profession in India. On the basis of the Future of School Psychology Conference 2002, we may consider the following three crucial dimensions extracted by Short and Palomares (2003) for conceptualising the future and scope of school psychology in India:

Children: The school psychologists should focus on the following two foremost issues related to children:

1) improvement in academic performance and school success for all children, and

2) improvement in their socio-emotional functioning.

Families: With regard to the families of the children, the school psychologists also need to work on:

1) improvement in parenting skills and increase in the ability of the families to support their kids/students, and

2) enhancement in family – school partnership and parental involvement in schools.

Schools: As the most relevant objective of a school psychologist, it includes

1) effective education and instruction for all students, and

2) an increase in child and family services in schools which promote learning and mental health and which are ultimately integrated with the community services.

However, no future can be promised even to the field of school psychology in the absence of programmes and extended services to the children, families and the school faculty. We need to provide opportunities to the prospective psychologists to choose school psychology as a profession by developing and offering educational – training programmes and internships. Such type of specialised graduate and post-graduate programmes would impart knowledge and understanding of the field and help gain required skills including the assessment of psycho-educational functioning of the students. In India, we can very easily see the availability of various programmes for mental health professionals who mainly work in clinics, hospitals etc. But, we are severely lacking such professionally designed graduate and post-graduate programmes or internships for the school psychologists. In the best interest of our country, where we consider the children the future of the nation, we definitely need to immediately start educational-cum-training programmes in school psychology and to stimulate the interest of the people seeking promising careers in psychology in the field of school psychology – which is the necessity at present and will be the demand of the future.

Self Assessment Question

1) Elaborate the statement of Mahatma Gandhi, “The future depends on what we do in the present” in reference to school psychology.

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3.5 SCHOOL PSYCHOLOGY FOR THE PROTECTION OF CHILD RIGHTS, WELFARE AND WELL-BEING

You might be remembering Reid's statement given in the second unit, "School Psychology is a profession whose members help teachers, parents, and students to understand, prevent, and solve problems. As a specialty within the profession of psychology, school psychology is founded on respect for the dignity and worth of each student and a commitment to understanding human behaviour for the purpose of promoting human welfare" (Reid, 1999; Subsection 2.2 of 2nd Unit of this very Block). Read the first sentence of Reid again and think of the consequences if the profession of school psychology and school psychologists are missing in your state/country. Nobody would be there to help teachers, parents and students to understand, prevent, and solve problems. Here, we need to observe and understand what various agencies and social agents are doing and can do for the protection of child rights and promotion of their well-being and welfare.

3.5.1 Role of the Government

Let us have a closer look on some facts and data in the following few lines.

Replying a question (No. 2120), Shrimati Krishna Tirath, Minister of State of the Ministry of Women and Child Development informed the Lok Sabha on 06.08.2010, "178 complaints have been received by the National Commission for Protection of Child Rights (NCPCR) regarding Corporal Punishment, harassment, humiliation and sexual abuse of children in schools during last three years".

Related to the corporal punishment alone in the schools, Smt. D. Purandeswari, Minister of State in the Ministry of Human Resource Development while replying a question (No. 1056) on 03.03.2010, informed the Lok Sabha that NCPCR had received 22 complaints in 2007-08, 37 complaints in 2008-09, and 50 complaints in 2009-10 (till that date).

Replying another question (No. 3513), Shrimati Krishna Tirath informed the Lok Sabha on 16.04.2010 that there had been an increase in the number of cases on excesses on children in schools. The number of complaints received by NCPCR throughout the nation regarding beating, harassment, humiliation and sexual exploitation in schools was 34 during 2007-08, 67 during 2008-09 which increased to 105 during 2009-10.

On the issue of Corporal Punishment in Schools, replying to a question (No. 35), Shri Kapil Sibal, Minister of Human Resource Development informed the Lok Sabha on 23.02.2011, "There have been reports of sporadic cases of corporal punishment by teachers in schools. As the majority of schools are under the purview of State Governments, data on number of such incidents is not centrally maintained by this Ministry. Central Board of Secondary Education (CBSE), has issued instructions to its affiliated Schools not to resort to physical punishment of students. It received 7 complaints in 2009 and 6 complaints in 2010. National Commission for Protection of Child Rights have received 42 and 61 complaints during 2008-2009 and 2009-10 respectively."

The Lok Sabha was also once reported that the commission had also taken suo-moto cognisance of 12 incidents related to corporal punishment in schools. Besides, the complaints relating to excesses on children in schools are referred

by NCPCR to the concerned State Governments/UT Administrators and Authorities for taking appropriate action against the culprits under relevant laws.

The answers submitted in Lok Sabha by the concerned Minister also reveal that while MHRD had written to all the State Governments during December 2007 to prohibit corporal punishment in all schools under their respective jurisdiction, and physical punishment and mental harassment to the children have also been prohibited under Section 17 of the Right of Children to Free and Compulsory Education Act, 2009. Furthermore, the Social Science textbook for class VIII, published by National Council of Educational Research and Training (NCERT), carries the bill of rights for making the children aware of their rights including that against corporal punishment.

With regard to a question on the formulation of a professional code of ethics for school teachers in the country (Question No. 35), Shri Kapil Sibal informed the Lok Sabha on 23.02.2011, "In pursuance of the recommendations of the National Policy on Education (NPE), 1986 (as modified in 1992), the National Council for Educational Research and Training (NCERT) in collaboration with the All India Primary Teachers Federation (AIPTF), All India Secondary Teachers Federation (AISTF), and All India Federation of Educational Associations (AIFEA) had developed, a Code of Professional Ethics for School Teachers in 1997. Recognising the need for revising this Code, the National Council for Teacher Education (NCTE) has formulated a new Code of Professional Ethics for Teachers in consultation with the State Education Departments and representatives of All India Primary and Secondary Teacher Federations."

On the same issue (Code of ethics for school teachers), in response to question number 543, Dr. D. Purandeswari informed Rajya Sabha on 25.02.2011, "the NCTE has developed a Code of Professional Ethics fro School teachers on the recommendations of a Committee constituted for the purpose under the Chairpersonship of Prof. A K Sharma, former Director, NCERT. The Code provides a framework of principles that would guide teachers in discharging their obligations towards students, parents and other stakeholders." It was further informed that, "The Committee has not suggested setting up of a professional body for teachers similar to the Bar Council of India or the Indian Medical Association". Dr. Purandeswari lastly added that, "The NCTE has informed that the Code will be implemented in collaboration with the associations and federations of school teachers."

Not only the above is a reflection on the seriousness of the government and other concerned agencies/statutory bodies on this matter, in the best interest of the school children, a video programme has also been developed and released.

You might have repeatedly seen a promotional video on many television channels, issued by The Ministry of Women and Child Development, GOI in public interest, to try to sensitise the public and make the school going kids aware of their rights. Three snapshots of this video (Star News, March 12, 2011) are given here. It shows a vulnerable school boy in four life situations which he may face in school or on road.

The second situation in this promo is "in the classroom – with the teacher", and the message asks the kids not to tolerate if they are punished or beaten. The teacher, punishing a kid, is depicted here with the parrot face (picture given above and left). The kids in this video are asked to wake up, identify these behaviours including the "bad treatment" by the teachers (picture on the left), and to report it at home.

Then the smiling child in video is heard and the corresponding last message is flashed on the television screen warning the listeners not to do any wrong to the kids as they are aware of their rights (picture on the right). The other three situations in this video include bullying by other students, indecent physical contact by an elder person in school garden, and luring the kid with some toffee etc. by a stranger car driver on the road, way to school or back to home.

However, despite all such various steps, such incidents of excesses on children and corporal punishment are taking place a few of which you have read in previous Units. In Section 1.6.4 of first Unit of this very block, the percentage of children beaten, data reported by Plan International, would have attracted your attention. Regarding this, a question was raised in Rajya Sabha (Question Number 1395) whether the survey report of Plan International was true that more than 65 percent children of the country are subjected to corporal punishment and 50 percent children are sexually exploited. Shrimati Krishna Tirath, Minister of State of the Ministry of Women and Child Development, replied to the question and informed the Rajya Sabha on 22.11.2010 that the report "The Economic Impact of School Violence" by Plan International was based on the statics taken from the 'Study on Child Abuse : India 2007' which was originally published by the Ministry of Women and Child Development.

Here, it is to be understood that the Government has been playing its role by framing and implementing various policies, plans, programmes, schemes and legislations in this direction, but still such undesired episodes like corporal punishment and sexual abuse are severely affecting the kids' lives and the society. Hence, as an additional measure, the appointment of a school psychologist in each and every school for providing specific school psychological services may be considered by the government. However, appointment of a school psychologist in each and every school seems not to be possible step because, there are 1.28 million recognised schools in India. Are we financially strong enough and ready

to appoint 1.28 million school psychologists? Here, another pertinent and related question arises: even if the government becomes ready to appoint a school psychologist per school – do we have so many professionally trained school psychologists in our country? The big and bitter answer is – No. So, sponsoring at least one teacher per school out of the existing staff strength for training in school psychology may be a seemingly feasible solution, but this also is not a feasible step in India as we have just seen in subsection 3.5 that our Universities/ Institutions do not cater to the training needs of the people in school psychology. However, a School Psychology Board, or a Council, or a Regulator may be established/appointed by the government at Central or State levels not only for Research and Development purposes but also for looking into the psychological needs of the children as well as school teachers and making specific recommendations as the case may be.

3.5.2 Role of the Universities/Institutions

Taking a lead from section 3.5 of this unit, the Universities and Institutions which have psychology departments must first equip themselves with the infrastructure and facilities required for education and training in school psychology, and then they should offer it as a professional course/programme with internship and project work. The universities, being a hub for quality higher education and training, should own this responsibility towards society for producing the trained school psychologists in order to protect the rights and promote the welfare and well-being of the children in schools.

3.5.3 Role of the Schools Authorities

Whatsoever may be the mission of the school, having the teachers having an orientation in school psychology, would always be an advantageous situation for the schools because such teachers would not only help the school achieve their targets of spread of knowledge but would also lead to the overall personality development of the students in a healthy and desirable fashion. Hence, the school authorities should encourage/sponsor their teachers to go for some training in school psychology or educational psychology or in guidance and counselling or the like whichever is available with them and feasible.

3.5.4 Role of the Teachers

Each role has some ethics and expectations attached to it. For example, a player is expected to play with the spirit of a game. One who follows it may become great, a legend one day. Let us take an example of Sachin Tendulakar, the cricketer. The editor of The Tribune writes on March 23, 2011, "Cricket is a religion and Sachin Tendulkar is the presiding deity – acknowledged unanimously as one of the greatest players the world has ever seen. What is amazing is that his ethics and integrity are also of the same class as his game. He set yet another example of such sterling standards in the match against the West Indies in Chennai on Sunday when he walked off despite being given not out by umpire Steve Davis. The TV replays had also remained inconclusive."

The teaching role and the teachers also have a very pious place in India since ancient times. In the greatest ever salutation of a teacher, Kabir said:

"Guru Govind dou khade,
kaake laagoon paye?
Balihari guru aapne,
Govind diyo milaye."

Translation:
I am facing both God and my Guru.
Whom should I bow to first?
I shall first bow to my Guru...
because he's the one who showed me
the path to God.

And, Indians celebrate 5th September every year as Teachers' Day in the respect and appreciation for their teachers. Since teachers are in direct contact with the students in the classroom, the most crucial role is of the teachers themselves and hence, every teacher should commemorate S. Radhakrishnan all 365 days of a year in their own role and responsibilities towards children and the society. Many times, however, we come across many instances when teachers' undesirable behaviour is not only harmful to the students but also brings bad name to the whole teaching community in the society. The media also highlights such incidents with enough sensitivity from time to time. An editorial that appeared in Dainik Jagran highlighted the impact of behaviour of the school teachers on their students and unsaid but natural expectations of society from the teachers.

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(An Editorial from Dainik Jagran, Panipat, Haryana)

3.5.5 Role of the Parents

No doubt that teachers bear major responsibility towards their students in the school, but the parents too are equally responsible towards their ward(s). Problems also arise when the parents do not know or understand the importance of quality parenting. They are required to give quality time to their children, talk to them, share their experiences with them, and to observe the behavioural changes in their children. After the school hours, the children are at home. There the parents can minutely observe the behaviour of their children and if there is something unusual, taking the things in right perspectives and to find out the solution (instead of increasing the magnitude of the problem), they should talk to the teachers/ school authorities and to their ward as well.

At this point, stop for a while and analyse the following incident in psychological terms, “A 13 – year – old girl has been arrested on hate crime charges and is accused of helping bully and attack a Muslim girl at their New York City School” (TOI, April 07, 2011). If the parents give their kids enough quality time, try to understand them and their needs, pose full faith in their kids and their teachers, they would find out the amicable solutions to the problems being faced by them and their kids. The findings of a study, conducted by Jennifer H. Pfeifer, Professor of Psychology at University of Oregon, are encouraging and may give parents a sigh of relief that the “children can resist peer pressure when they are at their most vulnerable, thanks to their brain that [can resist and] helps check risky behaviour” (TOI, March 27, 2011). So, the parents also need to understand their role and give their kids a supportive and healthy environment at home.

3.5.6 Role of the School Psychology Associations

You might remember that you have read about various school psychology associations in the first unit of this very block. As is true for the most other associations, the school psychology associations can play a major role not only by organising awareness camps and campaigns for the teachers, school managements and authorities, but also for the parents and community. Also, it is another major duty of such associations for the development of the field by promoting research, spreading the knowledge and sharing experiences by the way of seminars and conferences etc. On the basis of their knowledge and experiences, they should make recommendations to the concerned what is expected of them for achieving the targets.

Self Assessment Question

1) As a school psychologist, what can you do for the growth of school psychology in India?

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3.6 LET US SUM UP

You might be aware that keeping in view the lack of proper sanitation facilities and other poor infrastructural facilities in the schools, NDTV and Coca-Cola India launched a 6-Many schools conduct month long campaign "Support My School" in order to raise funds so that the rural schools could be provided with proper sanitation, access to drinking water and sporting facilities and each child could be provided with a happy, healthy learning environment in the school. Sachin Tendulkar, the cricketer supported this campaign as its ambassador and their other partners included UN Habitat, Charities Aid Foundation and Sulabh. Film star Dia Mirza also came forward and urged people to share their resources and donate for this noble cause for improving the infrastructure in Indian education system.

Besides infrastructure, India is facing shortage of teachers as well. In response to question number 1818, Dr. D. Purandeswari, Minister of State in the Ministry of Human Resource Development informed that Rajya Sabha on 11.03.2011 that, "after the Right of Children to Free and Compulsory Education (RTE) Act, 2009 became operational, the requirement of additional teachers to meet the norms of pupil teacher ration (PTR) was assessed at 5.08 lakh".

However, from the viewpoint of a school psychologist, you would agree that the most crucial issue is of making the schools safe for all children. As a school psychologist, we need to study and explore the 'why' of the undesired behaviour of the students as well as of the teachers in the schools and 'how' to ensure not only the safeguards but also the smooth growth and well-being of the school children. And, most importantly, we must also start celebrating 5th April every

year as National School Psychology Day in India so that people come to know of this field and branch of psychology and start realising its imprortance.

3.7 UNIT END QUESTIONS

1) School psychology in India has not a long past but a long future – discuss.
2) What is the immediate present need to be done for school kids keeping in view the growing instances of bullying and aggression in the school students?
3) How can teachers contribute in ensuring the safeguards of school students?
4) Various agencies can play an important role for the protection, welfare and well-being of school students. Which of these agencies can play the most significant role and how?
5) Propose a course of action for the promotion of school psychology in India.

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UNIT 4 SCHOOL PSYCHOLOGY SERVICES

Structure

4.0 Introduction
4.1 Objectives
4.2 Purposes of Schooling
4.3 School Psychology Services
 4.3.1 Direct Services
 4.3.2 Indirect Services
 4.3.3 Whole School Services
 4.3.4 Research and Programme Evaluation
4.4 Scope of School Psychology Services in India
4.5 Let Us Sum Up
4.6 Unit End Questions
4.7 Suggested Readings

4.0 INTRODUCTION

In the previous three units of this block, you have seen many real life instances where there was undesirable behaviour not only on the part of the students for most of the times but also teachers sometimes. Thinking of those and other similar instances, stopping for a while, can we attribute its reasons, among others, to the 'school culture' also in which the students and the teachers operate? Before proceeding further, have a look on this news. A 17-year-old US student, Robert Butler Jr, opened fire at his Nebraska high school in Omaha, killed the assistant principal, wounded the principal, and also fatally shot himself in his car. Butler had posted on Facebook that the school drove him to violence and that the Omaha school was worse than his previous one (TOI, January 08, 2011). In an another shocking incidence, three girls accused of ragging a junior at a Durgapur engineering college in Bengal were arrested, slapped with non-bailable charges including attempted murder and were sent to jail custody for five days, marking a first in the prosecution of ragging cases in West Bengal (TOI, December 11, 2010).

We all know that culture is very powerful in determining the ways the people behave. Also, while we form some opinion about any school or if we have to admit our ward to any school, somewhere in our mind we examine the culture prevailing in that particular school. If the school staff shares some values, teachers are role model, and they all work harmoniously for the achievement of some mutually agreed goals of the school, such schools are generally considered to have a strong culture and are preferred over others. Commitment, loyalty and support are some of the major characteristics of a strong culture. And, the children brought up in such a school culture would also brought forward similar characteristics and would become a better citisen and a good social human being.

Hence, schools should periodically scrutinise their prevailing culture and look into the reasons of instances of indiscipline, child aggression, bullying, truancy, cheating etc. occurring in their premises. Most of the schools are after their exam

results only to compete with other schools in the vicinity. It puts extra and extreme pressure on the tender young minds of the students besides depriving them of valuable playing time and other activities required for healthy physical and mental growth as well as which are crucial for socialisation and personality development. Here, every person has to take the responsibility of his/her role for fostering and maintaining a positive school culture and environment. The school psychologists here play a very crucial role in the enhancement of the status of children, youth, and adults as learners and productive citisens in schools, families, and communities (see section 2.3 of the second unit of this block). Thus, the rationale for having school psychologists has been very well established. However, it may have little or limited impact unless embedded within the school culture itself.

4.1 OBJECTIVES

On completing this unit, you will be able to:

- illuminate the importance of positive school culture;
- describe the purpose of schooling;
- explain the school psychology services;
- elucidate the need and status of research in school psychology services; and
- critically appraise the scope of school psychology services in India.

4.2 PURPOSES OF SCHOOLING

Since you all have also passed through the schooling stage of your academic journey, before we discuss this topic with you, we shall like to know – what do you think are the basic purposes of schooling?

Self Assessment Question

1) Write a brief note on the purposes of schooling.

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The education system in India has a very long past and the references and instances of *gurus* and *ashramas, gurukulas* and *pathshalas* can be traced back even to the periods of Ramayan and Mahabharta. However, with the advent of information technology, and due to the factors like modernisation, globalisation, industrialisation and urbanisation etc., the education system in India has witnessed great changes. Now-a-days, to compete with the rest, one has to be the best. And, schooling here plays a major role.

In broader terms, the functions and purposes of schooling include not only the discovery of new knowledge and learning of new skills, but also include the maintenance and transmission of culture, encouragement of positive growth,

invention and implementation of change, and inculcating proper moral character. And, thus, giving the society the human beings, who are socially useful and productive citisens – striving for the betterment of society and development of their nation, through schooling is the major purpose of a school.

Generally we count the positive outcomes of schooling but, on the other hand, it is also true that through education and schooling, we intend to provide proper child care in order to minimise the chances of child delinquency, substance abuse, crimes and other ‘at-risk’ conditions which have societal concerns and reflect the deterioration of human values and national character.

These types of purposes of schooling are generally consistent across various types of schools, be it private or government, rural or urban. Remember, in section 2.3 of the second unit of this block, you have read about the mission statement of a school? Here, we can get the idea of the purpose of schooling in light of their particular philosophy or vision of any particular school.

It is a matter of great concern that in the absence of school psychologists in India, so many instances of school indiscipline etc. are frequently seen across the states. One main reason of this is that neither there are school psychologists in the schools nor their parents have enough time at home to cater to the psychological needs of the students. There are counsellors in few schools but they too are allowed only limited role to play. Secondly, their training and practice as a counsellor for counselling is another issue that needs to be addressed at some appropriate platform.

In tune with the purposes of schooling, the importance of the role of school psychologists has been very well acknowledged across the nations because it is the school psychologists who help the schools develop their mission and help the school system achieve various goals. They are professionally trained persons who perform a unique role that other ‘subject teachers’ cannot perform effectively and efficiently. The school psychologists are aware of the crucial relationship between the purposes of the school [and schooling] and the personality structure of the student. For them, besides academic learning and achievement, personal and social learning are equally important. Here, through a variety of school psychology services, they help improve and maintain the academic environment of the school and the mental health status of the students as both significantly affect each other. We shall learn more about school psychology services in the following section.

4.3 SCHOOL PSYCHOLOGY SERVICES

You might recall that you have read ‘the role and functions of school psychologists’ in section 2.4 in the second unit of this block. It is a matter of concern here that “often, teachers take on the role of school psychologists, because there are very few school psychologists in India” (Dutt, 2006). Like Kumar (2004), Dutt (2006) also states that “in India, school psychologists are generally known as counselling psychologists or counsellors”. Interestingly, “those who are termed school psychologists in USA are called psycho-pedagogists in Italy, psychological counsellors in Portugal, and guidance officers in parts of Australia” (Burden, 2000). However, National Association of School Psychologists (2010) in its Position Statement advocates that “School psychologists need to represent

themselves under the title "school psychologist" in order to accurately represent their credentials to the public and to meet their varied responsibilities". Since a 'school psychologist' can also be defined by the functions he/she performs, we shall focus on the services provided by the school psychologists. NASP (1992), in a very comprehensive manner, descried school psychology service delivery as:

School Psychologists provide a range of services to their clients. These consist of direct and indirect services which require involvement with the entire educational system: (a) the students, teachers, administrators, and other school personnel; (b) the families, surrogate caretakers, and other community and regional agencies, and resources which support the educational process; (c) the organisational, physical, temporal, and curricular variables which play major roles within the system; and (d) a variety of other factors which may be important on an individual basis.

The intent of these services is to promote mental health and facilitate learning. Comprehensive school psychology services are comprised of diverse activities. These activities complement one another and therefore are most accurately viewed as being integrated and coordinated rather than discrete services.

School psychology services are not in an organised frame in India as there is no controlling/regulatory body at the central or state levels to look into the matters pertaining to the study of or professional training in school psychology or pertaining to providing psychological services in schools. To provide rehabilitation services, Rehabilitation Council of India (RCI) is there and the field for the clinical psychologists is also somewhat smooth as they have few places to get trained and many to get appointed. But for other branches like sports psychology, industrial psychology, and school psychology, there still is a great need to popularise the discipline and taking it to its due place. As we shall take a stock of school psychology services in this section, we shall see that few of them are conducted in our country by educational psychologists or by counsellors in the schools and few by the clinical psychologists as well, yet the field of school psychology requires the development and adoption of a systematic approach to the study and practice of psychology in the schools in India. The basis of this conclusion is also the study of Jimerson, Skokut, Cardenas, Malone and Stewart (2008), about which you have read in previous unit that out of the selected five important parameters of school psychology, India fulfilled only one, i. e. having "identifiable professionals employed to fulfill duties characteristic of school psychologists".

However, with the recent introduction and implementation of Right to Education Act and in light of other similar acts and provisions for children like special education, inclusive education, etc., we need to plan and implement school psychology services effectively and accurately on all India basis, and in a systematic and unified manner. Like other countries and their psychology associations leading in school psychology, the Australian Psychological Society has also developed guidelines for the delivery of effective services by school psychologists (2008). Similarly, catering to the psychoeducational needs of students in Indian education system, there is a great need to develop and/or adapt school psychology services which generally include the following.

4.3.1 Direct Services

Here the school psychologist directly assesses the students' psychological and educational functioning, mainly focusing on their cognitive, academic socio-emotional and behavioural functioning. This psychoeducational assessment, according to Reschly and Wilson (1995) refers to, "evaluations for diagnosis of handicapping conditions, testing, scoring and interpretation, report writing, eligibility or placement conferences with teachers and parents, re-evaluations." In second unit under sub-section 2.4.2, you have studied that the school psychologists are also involved in intervention. Reschly and Wilson (1995) described interventions as, "direct work with students, teachers, and parents to improve competencies or to solve problems, counseling, social skills groups, parent or teacher training, crisis intervention". To effectively design and implement an intervention, the school psychologist administers intelligence tests (IQ-tests) to measure the cognitive abilities of the students and to classify them into applicable disability categories. The students' academic achievement is also assessed by the school psychologists in order to identify their academic strengths and weaknesses, and may include the identification of broad skill areas or any specific skill.

The school psychologists are also required to assess the academic environment of the school because it is also a significant factor affecting not only the students' learning but also their mental health. Remember the case of Robert Butler Jr? And, when we are talking about assessment by the psychologists, how can one forget about personality and behavioural assessment? To understand one's students, a school psychologist has also to collect data about their personality traits, socio-emotional functioning and affective difficulties by using appropriate personality tests and techniques.

Of course, this assessment is done so that the school psychologists could provide psychological treatment and counselling to the students as per the needs. Here, we need to remember that the psychologists are trained people in psychologically treating and counselling, and thereby helping people (here, students) overcome their mental health and/or behavioural problems. In context to the schools and students, the school psychologists are to provide direct services by treating these psychological, educational and behavioural problems of the students because these have a serious impact on the learning, academic achievement and life. As you have seen in the third unit of this block, there are facilities to provide training in counselling in many of the Indian Universities and at NCERT, both at Master's and Diploma levels. Now-a-days, mostly reputed schools acknowledge the meaning of having a counsellor in schools and appoint the professionally trained Counsellor to help their students excel in studies and also for their overall personality development.

4.3.2 Indirect Services

Psychologists necessarily are not always involved in providing direct services to the students. Another way is to advice, counsel or consult with the parents, teachers, principals, associated other school staff, and other stakeholders who are in good contact with the students and deal with them in school setting or at home and affect their educational or psychological conditions. So, many times, the school psychologists work with other adults to help the children in need. This aspect is termed as the "paradox of school psychology" (Gutkin and Conoley,

1990) where a psychologist has to utilise his/her abilities working with the adults so that effective services to the children could be provided. As the main mode of indirect intervention, the school psychologists use 'consultation' in the best interest of the children where he requires some specific interventions to be implemented by the class teacher in the school and/or by the parents at the home.

Examples of such indirect service can be generally seen in real life and in movies too, like Taare Zameen Par. Although Aamir Khan did not play the role of a school psychologist in this movie, but remember the views of Dutt (2006), discussed earlier in this unit that, "often, teachers take on the role of school psychologists". Similar role is played by the teachers in Teacher-Parent Meetings in the schools where, in the best interest of the students, the teachers advice the parents how to deal with their child at home regarding any particular psycho educational, behavioural or emotional problem.

This consultation may or may not depend on any formal assessment (as seen under direct services). It may or may not depend on the observations of the classroom behaviours of the students. Or, it may be a mix of both (formal assessment plus observation of classroom behaviour). Here, it is important to note that the school psychologists not only provide consultation to devise and design the programmes for the treatment but also for the prevention of psycho educational problems in the first instance as well as the prevention of future occurrences of the problems at hand. Their ultimate target is to support and assist the children by providing them a learner-friendly academic environment in the school and at home which also fosters their mental health, through their teachers, school staff, and parents.

Consultation as indirect intervention includes mental health consultation as well as behavioural consultation. Also, if required, the school psychologists provide group consultations to the group so that the problem could be discussed and identified by all associated, every group member could help design and understand the treatment/intervention strategy, and every group member could effectively implement the intervention and evaluate its effectiveness in terms of the desired changes in the child/student.

4.3.3 Whole School Services

As can be judged from the heading itself, the school psychologists also provide psychological services to support the whole school populations so that no child is left. Wherever any problem is visible on an individual level, that particular student is helped out by specific interventions on one-to-one basis. But, at a broader level and particularly working on 'prevention is better than cure' philosophy, the school psychologists also focus on such intervention plans that work on the whole school populations. The school psychologists here assist the students, and support the teachers and parents with appropriate plans related to maximising academic achievements and minimising the behavioural, social and emotional problems. Awareness campaigns against ragging and anti-bullying programmes are examples of such whole school services provided by the school psychologists.

Here, it is also to be understood that some cases may be beyond the scope and training of a school psychologist. He may make referrals of such cases to the appropriate programmes to the clinical psychologist or to any other professional

as the need may be. So, beyond his/her qualifications and training, he/she may also sometimes need some external specific support from other trained professionals and programmes in order to help the child/school.

4.3.4 Research and Programme Evaluation

Although research is one of their important activities for the development of the profession, yet in a national survey it was found that most of the psychologist's time (54%) was spent in assessment but only 1% of school psychologists' time was utilised in research activities (Smith, 1984). In 2002, Hosp and Reschly reported that psychoeducational assessment still accounts for over half of their role and less than 10% time is devoted to systems-organisational consultation and research-evaluation. Here it is to be understood that these data pertain to foreign countries where school psychology is in existence and practice, and where the school psychologists are supposed to utilise their time in designing and conducting research of a psychological and educational nature. Under these circumstances, we can judge the state of research in school psychology in our country where this branch is yet to develop. The school psychologists are also engaged in planning, designing, developing and evaluating the intervention/ prevention programmes in psychology and education for the school students.

For research and programme evaluation, you can see that, they are also required to sharpen their professional skills by reading books and journals, discussing issues and cases with colleagues, and participating in professional activities at seminars/conferences etc. They need to do active supervision of the students' cases and whenever appears some difficult or any complex case, seek the help and assistance from their professional colleagues.

Self Assessment Questions

1) On the basis of above services, what type of training in psychology would you suggest for the school psychology students?

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2) The school psychologists play a crucial role in meeting the learning and mental health needs of all students. Comment.

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4.4 SCOPE OF SCHOOL PSYCHOLOGY SERVICES IN INDIA

As you have read in the preceding paragraphs, the teachers assume the role of school psychologist, even if they do not have any qualifications, background knowledge or experience in psychology. And, counselling psychologists or counsellors are also playing the role of a school psychologist. There is a paper of educational psychology in B. Ed. training. Can it serve as the basis of psychological assessment? The quality training in assessment in B. Ed. should be minutely scanned and researched. Secondly, even after that, how many B. Ed. trained teachers perform the function of psychological assessment in their schools? Although few Indian scholars/psychologists have developed/adapted the

We have in India standardised psychological tests and tools as per the Indian conditions, yet the availability of these standardised psychological tests and tools in schools in India for psycho educational assessment purposes is doubtful. Few reputed private schools might have managed few psychological tests and tools as they have appointed trained counsellors in their schools.

Secondly, still there is one another bigger problem, that is related to awareness about the psychological states and conditions of the children as was intelligently highlighted by movie Taare Zameen Par. Most parents, even for the psychological problems of their child prefer to go first to the pediatricians who can not offer comprehensive psychological assessment and treatment of their child. The frustrated parents either due to lack of awareness or due to social stigma, do not go to the psychologist and spend their money, time and energy finding out the medical cure of the psychological problems of their child.

It reveals the alarming and immediate need of the school psychology services in India. The growing cases of depression and suicides, and delinquency and other behavioural problems among school students reveal that we need not only to provide the mental health education to our students through lectures on psychological issues but also to provide coping strategies training so that they may alleviate conflicts and overcome stress and depression etc.

Without proper school psychology services and school psychologists, present education system may not be able to effectively help the students face the challenges they are encountering in their daily lives. The goals and objectives of education and schooling can efficiently be achieved if we either appoint professionally trained school psychologists in all schools or make some provisions by creating infrastructure for the in-service training of at least one teacher per school in school psychology for providing school psychology services.

It is pertinent here to conclude with the report of P. Ramalingam, who presented his research paper titled, "Need Analysis for School Psychologists in India" at the 31st International School Psychology Association (ISPA) Conference in Malta in 2009, that "the teachers who handle classes at primary, secondary and higher secondary levels are developing a keen interest in introducing school psychology in the school curricula. Mostly teachers who have psychology as a subject of studies in their B. Ed. course are willing to develop themselves as school psychologists to promote a separate discipline at the school level. The study

indicates that there is a pertinent need for the school psychologists in Puducherry as is the case in India too."

4.5 LET US SUM UP

In this course, we have come across a lot of such real-life examples in which we have felt a great need for a trained and professional school psychologist who could provide the target groups the school psychological services. In this unit, we also have seen that various types of school psychological services are available to help the students and schools like psychological and psycho-educational assessment, academic and behavioural interventions for the students, etc. The school psychologists are also actively involved in parent skill straining, social skills training, and study skills training. One of their important roles pertains to the evaluation of special education services and the evaluation of other intervention/prevention programmes. They are also involved in crisis intervention and in-service training, and depending upon the specific requirements they coordinate their services with outside agencies, psychiatrists and other professionals. Individual and group counselling, and family therapy are also other feathers of their cap. This is the significance of their psychological services in the schools that has made them an integral part of the school system throughout the world.

4.6 UNIT END QUESTIONS

1) The culture of the school can make or mar the very purpose of schooling. Critically evaluate.

2) If you have to psychologically treat the truancy behaviour of a student, what would you plan and why? Also, how would you implement your plan?

3) Why is it important for the school psychologists to devote more time to research?

4) What would be the potential harms if the school psychology services are not made available or offered to the students?

5) The future of school psychology services in India is bright. Comment.

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UNIT 1 CONCEPT OF LIFESPAN DEVELOPMENT

Structure

1.0 Introduction
1.1 Objectives
1.2. Lifespan Development
- 1.2.1 Meaning of Development
- 1.2.2 Emergence of Lifespan Development
- 1.2.3 Lifespan Studies
- 1.2.4 Concept of Lifespan Development

1.3 Features of Lifespan Development
1.4 Stages in Lifespan Development
1.5 Research Methods for the Study of Lifespan Development
1.6 Let Us Sum Up
1.7 Unit End Questions
1.8 Glossary
1.9 Suggested Readings and References

1.0 INTRODUCTION

In this unit we are going to introduce you to the concept of lifespan development and discuss the emergence of the concept, some key features of lifespan development, the different stages in lifespan development, as well as the research methods to study lifespan development. This unit first discusses the meaning and emergence of Lifespan development along with the Lifespan studies and their salient features followed by the stages in the lifespan. Finally the unit deals with the research techniques that are employed for the study of lifespan development. In this way understanding the process of development and how it is related to skills, abilities and general behaviour will help the student to acquire knowledge about the development of humans at different stages and the very many problems one comes across etc.

1.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain Lifespan development;
- Identify the key features of Lifespan development;
- Explain how behaviour changes through life as a function of development and the interaction of biopsychosocial factors overtime; and
- Analyse research methods used in measuring Lifespan development.

1.2 LIFE SPAN DEVELOPMENT

Lifespan development is a process beginning at conception that continues until death. Lifespan development can be defined as a methodical, intra individual change associated with progressions corresponding to age. Levinson has put forward that the lifespan consists of four 25 years. The first 25 years belong to childhood and adolescence, the second 25 years to early adulthood, the next 25 years to middle adulthood and the last 25 years to late adulthood.

According to lifespan development concept, the lifespan development is multidimensional, multidirectional, plastic, multidisciplinary and contextual. The human development domains consist of the physical domain, the cognitive domain and the social domain. The physical domain consists of the physical changes during growth, the cognitive domain refers to how humans learn and the social domain is in regard to the development of social skills and developing relationships. All disciplines such as sociology, psychology, medicine, biology, anthropology etc., are interested in the lifespan development and thus understanding of lifespan development requires viewing human development from various perspectives. Thus one could state that human development is a multidisciplinary study of how people change and how they remain the same over time. It reflects the complexity and uniqueness of each person and each person's experiences as well as commonalities and patterns across people. There are four interactive forces that combine to shape human development and these are : (i) Biological (ii) Psychological (iii) socio cultural and (iv) Life cycle forces.

i) *Biological* structure or environment of human includes glands, nervous system, respiratory system etc. All these affect the individual's personality. For example, if pituitary glands do not work in normal ways then the individual's physical growth will be affected and this will bring about a change in the person's personality. Biological forces include all genetic and health related factors that affect development. They provide raw material (in case of genetics) and set boundary conditions (in the case of one's health) for development. Example for this could be Prenatal development, brain maturation, puberty, menopause, facial wrinkling and change in cardio-vascular functioning, diet, exercise etc.

   First of all the height of the body grows up due to biological development. However if the growth is abnormal it would affect the individual's personality and mental state. For instance, being too tall can make some people feel inferior and being too short can make some not only inferior but also can make them dependent on others for many things.

   Secondly, biological factors also determine the responsiveness of an individual, such as one may be more impulsive and emotional than others, one may get more easily excited than others etc. To give an example a person being too jumpy can make others tease the person or paste some paper bag with some label behind etc. At the same time being too bovine makes others consider the person a joker and attach funny notices as "Kick Me" etc. on one's back or make others feel like taking away the person's belongings and not return for some time thereby reducing the person to tears.

Thirdly our growth and development depend on the glandular balanced secretions. The Rosicrucians defined seven glandular types based on the predominance of the gonads, adrenals, pancreas, thymus, thyroid, pituitary and pineal glands. Each glandular type has a particular bony formation and skin type, musculature and hairyness.

Nutrition too plays a significant role in the physical growth and development. For instance access to common salt, access to iodine, access to zinc, and the presence of lead and copper contaminations all these affect the physical growth and even produce abnormalities in physical development.

Hereditary factors also are extremely important which to an extent determines even the ways in which one behaves in society. Some have more predisposition to be aggressive and angry while in some cases a person may be hereditarily predisposed to calmness and prefer being alone rather than with people. Some are more gregarious while some are withdrawn . Some are more intelligent than others. All these factors are part of hereditary factors.

ii) *Psychological* forces include all internal perceptual, cognitive, emotional and personality factors that affect development. These factors determine variations among individuals. Example for this would be Intelligence, self confidence, honesty, self esteem. Although a child's mental development presupposes a kind of network in which internal and external factors are intertwined, it is possible to unravel their distinct, respective roles. The internal factors are presumably responsible for the strict sequence of developmental phases, the chief determinant of which is the growth of the organs.

The problem of the relations between functional maturation and functional learning now arises. During the course of mental development new activities emerge that must necessarily have their source in the functional activation of matured organic structure. Unless the child is able to find that physically he can indulge in many activities, learning will have no value. Hence physical growth is important which may influence personality development.

It has been said that play is the activity uniquely appropriate to the child. Play is a stage in the total development of the child that disappears of its own accord at succeeding periods. Indeed, play is mingled in all of the child's activity so long as that activity remains spontaneous and untouched by objects introduced for educative purposes. At the beginning, games are purely functional; then come games of make-believe and games of practical skill.

In his play the child repeats the impressions of events he has just experienced. He reproduces; he imitates. For the very young child, imitation is the only rule of the game so long as he is unable to go beyond the concrete, living model to abstract instructions.

Initially, children's comprehension is no more than the assimilation of others to themselves and themselves to others, and in this process imitation plays an important role. Imitation, as the instrument of this fusion, demonstrates a contradiction that explains certain contrasts on which play thrives.

Imitation is not random; the child is very selective. He imitates people who enjoy the most prestige in his own eyes, those who evoke his positive, affectionate feelings. At the same time, the child "borrows" or becomes these persons. Always totally immersed in what he is doing, he accordingly imagines and wishes himself to be them. But soon his latent awareness of this borrowing arouses in him feelings of hostility against the person serving as a model, whom he cannot eliminate. He finally comes to resent this person whose absolutely incontestable and frustrating superiority he often continues to experience.

Between the ages of six and seven it becomes possible to disengage the child from his spontaneous activity and to divert his interest to others. Until comparatively recently, productive labour, including factory work, began at this age. Indeed, in some colonial countries this is still the case. In France, the child enters school at this age and tackles the demands of formal education—which include self-discipline.

Two contradictory elements are basic to all imitation. One is a plastic union in which the external impression is taken in and then discharged again gently from its strange receptacle, leaving only those elements that are able to be incorporated into existing mental structures. The result is a new, albeit rudimentary, capacity. The second and active aspect, equally important to the first, is execution and completion. The ensuing act requires tentative, and sometimes obvious, gropings. Separation and recombination of suitable elements are operations whose often long-enduring imperfections indicate the difficulties these processes involve. In particular, the rediscovered gestures and movements may not yet be in the right order. Taken by themselves they by no means reproduce the model; they must conform to the requirements of an internal prototype. However, as they become more explicit, they make possible and even encourage objective comparisons with the external model. Alternation between these two contrary but complementary phases of intuitive assimilation and controlled execution may then assume a more or less rapid cadence until the imitation appears adequate.

iii) *Socio-cultural* forces include interpersonal, societal, cultural and ethnic factors that affect development. To understand development we need to know how people and environments interact and relate to each other. The family, peers, coworkers and social institutions and culture influence development. Knowing the culture from which the person comes provides information about important influences that appear throughout the lifespan. Example for this is poverty.

iv) *Life cycle* forces reflect differences in how the same event affects people of different ages. Each individual is a product of a unique combination of these forces. No two individuals even in the same family experience these forces in the same way. Even identical twins have different friendship networks partners and occupations. Robert V. Kail and John C. Cavanaugh wrote in "Human Development: A Life-Span View" that the influence of life-cycle forces "reflects the influences of biological, psychological, and socio-cultural forces at different points in the life span." Age, physical and mental well-being, financial status, and social support systems are crucial factors in the

developmental life cycle. According to Erikson, the life cycle goes through 8 stages starting from infancy to old age and the life forces during each stage influences the development of the individual.

The four forces, viz., biological, psychological, social and cultural forces as well as life cycle forces provide the best in understanding the bio-psycho-social framework for a comprehensive understanding of human development. For instance Pregnancy can bring happiness and anticipation for one woman, but can also bring about anxiety and concern for another.

Psychologists have developed different viewpoints for understanding development. Some consider development at particular points in the lifespan, while others take a more holistic view. A contemporary view of development that covers all aspects of human behaviour throughout the entire life cycle from conception to old age is the concept of lifespan development.

Self Assessment Questions

1) Discuss the biological forces in human development.

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2) What are the psychological forces influencing human development?

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3) Describe the socio-cultural forces in human development

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4) Elucidate the life cycle forces which influence human development

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1.2.1 Meaning of Development

The term 'Development' is not limited to growing larger. Instead it consists of a progressive series of quantitative and qualitative changes that occur in an orderly, coherent way leading the individual towards maturity. The term 'Progressive' signifies that the changes are directional leading forward rather than backward. The quantitative changes are the changes in quantity or amount such as increase in size, height, weight, circumference of the body vocabulary etc. The qualitative changes are the changes in kind, structure, organisation and function.

The terms 'orderly and coherent' suggest that development is not a haphazard, casual type, but there is a definite relationship between each stage and the next in the developmental sequence. Each change is dependent upon what preceded it and it, in turn affects what will come after. Development results in new characteristics and new abilities in the individual. It consists of a transition from lower to higher stages of activity or function.

From the moment of conception until death the individual is constantly changing, he is never static. There is some development at each stage in the life span of the individual, but more development occurs in the early years of life than after maturity is attained. During adulthood changes do continue but at a slower rate until deterioration that characterises old age (senescence) sets in. Thus development is a continuous process which starts even before birth. Birth is only an incident in the long succession of changes and not the beginning.

1.2.2 Emergence of Life Span Development

In the past most of the scientific literature on development focused on childhood and adolescent years. This was because the changes that occur during these early years are rapid in rate and obvious and observable, especially the physical, mental and personality differences which are not as readily detectable in later life as in early years. It was also assumed that the adult can be understood in terms of childhood experiences since the adult was perceived as an end product rather than as a continuously developing individual. Also the life expectancy was relatively short and few researchers directed their energies toward the study of the entire life cycle. The physical and behavioural changes in adulthood were so subtle that their significance in the developmental sequence was ignored for many years.

Interest in adult development and ageing evolved only in the late 1940's. The rapid growth of the adult population and longer life expectancy gave rise to a number of problems to the adults themselves as well as to their families, employers and the society. This created a need to pay attention to the developmental changes in the adult years of life. In addition, by studying the events of adulthood like marriage, parenthood or occupational status, the entire life cycle can be placed in a more balanced perspective. Recently a new theoretical view of studying growth and development of behavioural changes of the entire life cycle from conception through old age emerged as a pursuit of scientific research. It emphasises on development as a lifelong process and that each period of a person's life span is influenced by what has already occurred and will effect the periods that follow.

1.2.3 Life Span Studies

The life span studies in U.S. grew out of programs designed to follow children over a period of years, through adulthood. Major studies began around 1930s. The Berkeley Growth Study, the Oakland Growth Study and the Fels Research Institute Study have also yielded information on long term development.

G. Stanely Hall (1844-1924) one of the first psychologists became interested in aging. In 1922 he published a book on 'Senescence: The last half of life'. Sixty years later, Stanford University opened the first major research unit devoted to aging. In 1946 National Institutes of Health (NIH) were reporting findings on topics like emotional aspects of aging, intellectual ability and emotional reaction time. Hall in 1904 published work on 'adolescence', which provoked much discussion. He also developed a normative approach which is effective in explaining about life span development.

1.2.4 Concept of Life Span Development

The concept of lifespan development views human development from the biopsychosocial frame work. It is multiple determined and cannot be understood within a single framework.

The assumptions underlying this concept are as follows:

Development is a continuous life long process of growing up and growing old beginning at conception and ending with death. No single period in a person's life can be understood without knowing what occurred before and what comes after.

Development is affected by social, environmental and historical changes. Thus the experiences of one generation may not be the same as that of another.

Life span development does not consist of one series of changes in behaviour that begins at conception, accumulates, with age and end with death.

Developmental behaviours may periodically rise, be transformed or eliminated as life continues.

New patterns of development may cause social change by influencing society. Even social change can influence development. Making Law against the punishment of children at home and in schools is due to its harmful effects on personality development of the child.

Self Assessment Questions

Fill in the blanks

1) Qualitative changes in development include ....
2) Emergence of lifespan is because of ....
3) The biopsychosocial framework in development involves ....factors.
4) Define and describe life span development in detail

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5) Discuss physical development in humans and indicate the various forces that influence the growth and development.

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6) What is the meaning of development? How does it differ from growth?

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7) Discuss how the concept of development emerged.

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8) Delineate the concept of life span development.

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1.3 FEATURES OF LIFE SPAN DEVELOPMENT

Development is a complex phenomenon Baltesetal (1999) identified four key features of life span development. These features are multidimensionality, plasticity, historical context and multiple causation.

1) **Multidimensionality:** Development involves both growth and decline as people grow in one area they may slow in another and at different rates. For e.g.: People's vocabulary ability tends to increase throughout life but reaction time tends to slow down with ages. Many predictable behaviour changes occur through maturation as a result of growth of central nervous system as long as the needed environment is present.

2) **Plasticity:** One's capacity is not predetermined. Many skills can be learned or improved with practice even in later life. For example people can learn ways to remember information to deal with decline in memory ability with age. However, there is a limit for the potential improvement which is set by heredity.

3) **Historical context:** Each of us develops within a particular set of circumstances determined by the historical time in which we are born and the culture in which we grow up. *Example,* Economic problems due to depression in 1930's, competition was less. As economy expanded advancement was rapid, more carriers opened when these individuals were in the twenties. Now in late 1990's conditions are different competition is great opportunities limited and prospects for advancement lower.

4) **Multiple causation:** Development results from biological, psychological, socio-cultural and life cycle forces. *For e.g*: Even two children growing up in the same family have different experiences if one has a developmental disability and the other does not.

   The relative impact of these factors on the lifespan development vary. The age related biological factors are most important in childhood and old age. The age related abilities and behaviour develop naturally with advancing age, *e.g*. Motor skills like skating, cognitive skills like grouping of objects into categories and social behaviours like the proper way to behaviour in school.

5) **History related events:** These events are more important in early adulthood and have a maximum effect because at that time the individual is more affected by his / her social interaction with others. *For e.g*: War, economic recession, changes in the roles of males and females etc. Even the life experiences of people born in the same year (cohort) are similar and these can have lifelong effects upon the individual.

Behaviour related to *unique life events* refer to the events that are experienced by the individual and are not related to age or social conditions. Example; death of the parent, moving to a new city etc. In old age the unique life events are most influential, but the importance of age related factors increases. All these factors combine to affect an individual's development throughout life.

Self Assessment Questions

1) What are the features of life span development?

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2) Discuss critically each of these features.

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1.4 STAGES IN LIFE SPAN DEVELOMENT

Another important aspect used by developmental psychologists is stages of development. As the individual grows many behaviours occur in a certain order and in certain groupings. Each of these groupings of behaviour is called a stage of development. The skills learned during one stage are the necessary building blocks for the new skills that define the next stage.

For example the behaviour also remains stable for a time after a new stage is reached until behaviour indicating a new stage is seen. Our life span is divided into eight major stages or periods. These are:

Stages of development	Major developments
1) Prenatal stages (conception to birth)	• Formation (basic body structure and organs)
	• Physical growth is most rapid of all life span stages
	• Vulnerability to environmental influences is great
2) Infancy and babyhood(Birth to age 3)	• New born is dependent , incompetent
	• All senses operate at birth
	• Physical growth and development of motor skills are rapid
	• Ability to learn and remember
	• Is present in early weeks of life
	• Attachment to parents and others develop at the end of first year
	• Self awareness develops in the second year
	• Comprehension and speech develop rapidly
	• Interest in other children increases
3) Early childhood (3 years to 6 years)	• Family still focus of life but other children become more important
	• Gross and fine motor skills improve

	• Ply, imagination become more elabourate
	• Cognitive immaturity
	• Behaviour is egocentric
	• Independence, self control and self care increases
4) Late childhood ((6 years to 12 years)	• Physical growth slows
	• Peers become important
	• Concrete logical thinking develops
	• Egocentricism diminishes
	• Memory and language skills increase
	• Cognitive ability improves
	• Athletic skills improve
	• Self concept develops
5) Adolescence (12 years to 20 years)	• Physical changes are rapid and profound
	• Reproductive maturity is attained
	• Search for identity becomes central
	• Abstract thinking develops
	• Adolescent geocentricism persis in some behaviours
	• Peers help to develop and test self concept
	• Good relationships with parents
6) Early adulthood (20 years to 40 years)	• Most people marry and become parents
	• Physical health at the peak
	• Career choices are made Intellectual abilities become complex
	• Sense of identity continues to develop
7) Middle adulthood (40 years to 60 years)	• Search for meaning in life assumes importance
	• Menopause in women
	• Problems solving skills and wisdom are high

	• Caring of children and elderly parents may cause stress.
	• Empty nest syndrome due to children leaving the home
	• Midlife crisis . Career success at the peak. Burnout occurs
8) Late adulthood (60 years and above)	• Health and physical ability declien
	• Intelligence and memory deteriorates
	• Slowing down of reaction time
	• Retirement creates more leisure time but reduces income in life.
	• Need to find purpose in life to face the impending death.

Human development is divided into two major phases: Early phase and Later phase. The early phase constitutes prenatal stage, childhood and adolescence and is characterised by rapid age related increases in physical size and abilities. These changes also occur in the late phase (early, middle and late adulthood) but more slowly. People's abilities continue to develop as they adapt to the environment.

Self Assessment Questions

Fill in the blanks

1) Development is .... process
2) Development is affected by ....,...............,................changes.
3) Human development characterised by multi dimensionality and plasticity is fundamental to the ....perspective.
4) When certain groups of behaviour occurs in the same order and in certain groupings they form ....

1.5 RESEARCH METHODS FOR THE STUDY OF LIFE SPAN DEVELOPMENT

Since development is a continuous process that occurs over a life time, special research techniques are employed to study it. These are: 1) Longitudinal method, 2) Cross sectional method, 3) Sequential method and 4) Time lag method.

1) **Longitudinal Method:** This method is used to study developmental changes in the same individual or group, over a period of time. The same individual is tested at different ages. This method describes *age changes.* This method is sensitive to individual patterns of change. It avoids cohort effects.

   The method also has some disadvantages such as the following:

   1) it is time consuming and expensive.

2) It is expensive to keep up with a large sample for a long period.

3) Another problem is that of constancy of the sample over the course of research and the difficulty to maintain contact with the sample for several years in a highly mobile society.

4) Some subjects may loose interest and may not continue.

5) These dropouts may be different from their peers and this fact also may distort the outcome.

6) Another short coming is that the results can be affected by repeated testing.

7) Due to practice effect people tend to do better in later tests.

Example: Case study of a juvenile delinquent.

2) **Cross- Sectional Method:** This method studies the developmental changes by testing individuals of different ages at the same time only once. This method describes *age differences.* This helps to get the norms or standards of typical pattern of development for different ages. This method is faster and cheaper than the longitudinal method. It does not loose subjects who dropout of the study since the subjects are tested only once.

The major drawback of this method is that it is affected by cohort effects meaning that differences among age groups could result from environmental conditions as well as developmental processes.

Example: Studying sociability or aggressive behaviour of 7 years old.

3) **Sequential Method:** This is a more complex method designed to overcome the drawback of longitudinal method and cross-sectional method. This method combines the best features of both the longitudinal and cross-sectional methods. People in a cross-sectional sample are tested more than once and the results are analysed to determine the differences that show up overtime for the different groups of subjects. This method gives a more realistic assessment. This method can isolate cohort effects, where age related changes are due to dropouts or some other cause.

4) **Time Lag Method:** The concept of this method is to study the development of individuals of different age groups in different years to determine the effect of historical events on behaviour. This method is rarely used in Developmental Psychology, because it takes a long time and large numbers of subjects are required and have to be of the same age at the time of testing.

Self Assessment Questions

Fill in the blanks

1) The .... method is used when the personality development is traced from childhood to adulthood.

2) When we want to study the social ability of seven year olds the method used is ....

3) .... is the method used to determine cohort the effects.

1.6 LET US SUM UP

In this unit we have discussed the following points:

The concept of development as a progressive series of qualitative and quantative changes that occur in an orderly coherent way leading the individual towards maturity.

Development as a continuous life long process.

The biopsychosocial frame work of development which assumes that the four interactive forces biological psychological socio-cultural and life cycle forces combine to shape development.

The recent emergence of concept of life span development and life span studies.

The key features of life span perspective viz, multidimensionality, plasticity, historical context and multiple causation.

The various stages in the Lifespan of the individual like prenatal stage, infancy, childhood, adolescence, early adulthood, middle age and old age which undergo changes in physical, mental and personality that are related to the development of various skills and abilities and behaviour in general.

Special research techniques employed for the study of development such as longitudinal, cross-sectional and sequential and time lag methods have been discussed.

1.7 UNIT END QUESTIONS

1) What is Development? Explain the factors that shape development?
2) What are the key features of Lifespan development?
3) Mention the various developmental stages in the Lifespan of an individual.
4) What research methods are used to study Lifespan development?

1.8 GLOSSARY

Coherent : Each change is dependent on what occurred before it and inturn, affects what will occur after.

Cohort : People born in the same year.

Cross sectional method : A method used to study lifespan development in which individuals of different ages are studied at the same time.

History related events : Events that occurred at a particular historical (past) time.

Longitudinal method : Where the development of the same individual is studied over a long period of time.

Stage : When certain groups of behaviour occur in a certain order and in certain groupings they constitute stage.

Time lag method : Time lag method is to study development of different age groups in different years to determine the effects of historical events on the behaviour.

1.9 SUGGESTED READINGS AND REFERENCES

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UNIT 2 COGNITIVE DISABILITY OF CHILDREN (MENTAL RETARDATION, LEARNING DISABILITY)

Structure

2.0 Introduction

2.1 Objectives

2.2 Mental Retardation

2.2.1 Classification of Mental Retardation (MR)

2.2.2 Causes of Mental Retardation

2.3 Prevention of Mental Retardation

2.3.1 Educational and Vocational Training

2.3.2 Rehabilitation and Management

2.4 Learning Disability

2.4.1 Defintion

2.4.2 Types of Learning Disabilities

2.4.3 Causes of Learning Disability

2.4.4 Characteristics of Learning Disability

2.4.5 Diagnosis, Identification/Assessment of Learning Disability

2.4.6 Impact of Learning Disability

2.4.7 Intervention

2.4.8 Role of Parents

2.5 Let Us Sum Up

2.6 Unit End Questions

2.7 Glossary

2.8 Suggested Readings

2.0 INTRODUCTION

The subject of disability requires now almost total attention as 10%-20% of the child population has some disability or the other and require intervention. Disability refers to limitations or lack of ability to perform activities that are considered normal for the individual. It is a consequence of impairment. Cognitive disability refers to limitations in the cognitive abilities in the individual. Both mental retardation and learning disabilities are cognitive disabilities. In contrast to mental retardation individuals with learning disability are delayed in specific cognitive skills, not in all areas of mental functioning. They also do not have severe social problems like those found in mentally retarded. This unit will be dealt in two sections. The first section discusses about mental retardation etc. definition, classification, causes (etiology), educational and vocational training and finally the rehabilitation programmes and management of mental retardation.

In the second section we shall study about learning disability. This will comprise its definition, types of learning disabilities, its etiology, characteristics educational programmes for learning disabled and the effect this disability has on the learning

child. This comprehensive over view will broaden your understanding of these two types of cognitive disability in children.

2.1 OBJECTIVES

After you have completed this unit, you should be able to:

- Define mental retardation and learning disability;
- Identify these disabilities in children;
- Describe the different forms of mental retardation;
- Explain the different types of learning disabilities;
- Identify the various educational and vocational programmes provided them; and
- Analyse the rehabilitation programmes provided for the mentally retarded.

2.2 MENTAL RETARDATION (MR)

Mental retardation is a cognitive disability. It is also known as intellectual disability. The American Association on Mental Retardation (AAMR) defines mental retardation as a condition characterised by sub average intellectual functioning with deficits in adaptive in two or more skill areas like communication, selfcare, home living, social skills, community use, self direction, health and safety, functional academics, leisure and work. Mental retardation manifests before the age of eighteen. An IQ score of less than 70 is the criterion for mental retardation.

2.2.1 Classification of Mental Retardation (MR)

Mental retardation is classified in different ways by medical practioners, psychologists and educationists:

A) **Medical Classification**

Based on the causes of Mental retardation, medical practioners have classified mental retardation as:

1) Organic mental retardation which is caused by specific organic or physical problems Down's syndrome.
2) Familial mental retardation does not involve biological damage but represents the lower end of the normal distribution of intelligence

B) **Educational classification**

Educationists have classified mental retardation according to the functional ability of the individual as

1) Educable mentally retarded
2) Trainable mentally retarded and
3) Custodial mentally retarded.

C) **Psychological classification**

Psychologists classified mental retardation based on IQ level in to four mild levels mild mental retardation (50-70), moderate (49-35) severe (34-20) and profound (below 20).

The levels along with IQ scores associated with each level are shown in the table below.

Table: Level of MR and IQ

Level of MR	IQ level	Educators
Mild	50 - 70	Educable
Moderate	49 - 35	Trainable
Severe	34 - 20	Trainable
Profound	Below 20	Custodial

The profound severe and moderate levels in AAMR system are organic in origin, the mild level is familial.

i) **Mild Mentally Retarded**

About 85% of mentally retarded individuals with IQ score (50-70) fall in this category. They are sometimes called educable mentally retarded. These individual benefit from academic education but at older age than the non retarded and can support themselves during adulthood but need assistance under social and economic stress. They can function adequately in unskilled and semi skilled jobs. Mild MR is not usually detected until the child enters school.

ii) **Moderate Mentally Retarded**

About 10% of mentally retarded persons with in IQ 35-50 are classified as moderately mentally retarded. They develop intellectual skills of a non retarded 7 or 8 year old. With this level of functioning they can work in unskilled or semi skilled jobs under supervision. They may learn to talk and communicate during preschool period. They can learn to care for themselves but do not live independently and need care from relatives or in institutions. They can adapt well to supervised life in the community.

iii) **Severely Mentally Retarded**

About 4% of mentally retarded people MR are severely retarded (IQ 20-40). Before age of five, they should poor motor development and no communicative speech. At special schools they are taught self help skill like dressing, feeding and toileting. They require constant supervision. Their mortality rate in high.

iv) **Profoundly Mentally Retarded**

About 1% of mentally retarded people are profound mentally retarded (IQ below 20). They are deficit in both intellectual capacities and adaptive behaviour and they require custodial care. Their life expectancy is shorter than the normal.

2.2.2 Causes of Mental Retardation

There are two broad categories of factors that cause Mental Retardation. These are: (i) Organic causes and (ii) Socio psychological factors. However,the multifarious factors that cause mental retardation cannot be isted but the major ones are being presented below.

Prenatal causes: That is before birth certain things may happen to the mother which may affect the fetus or the growing organism and cause mental retardation.

This includes chromosomal disorders which will lead to the development of Down's syndrome, Fragile X syndrome, Prader Will syndrome etc.

Also the single gene disorders can cause inborn errors of metabolism, such as phenylketanuria, galactosemia, hypothyroidism, Tay Sachs disease etc. Brain malformation such as genetic microcephaly, hydrocephalus and myelomeningocele. Other conditions of gentic origin leading to Rubstein TRabi syndrome De Lange syndrome. If the mother ingests any drugs or suffer from certain diseases such as meningitis, ruebella etc., or is exposed to pollutants, heavy metals, harmful medications, may all lead to mental retardation.

In the third trimester that is in late pregnancy, diseases such as heart and kidney diseases, diabetes and placental dysfunction etc. may cause mental retardation. So also during labour, severe prematurity, very low birth weigth, birth asyphyxia, birth trauma etc. can lead to mental retardation.

After birth, in the first four feeks, severe jaundice or hypoglycemia etc. may occur which all can lead to mental retardation. After the child grows up in infancy and childhood period, any brain infection, tuberculosis, encephalitis, head injury, meningitis etc. including severe and prolonged malnutrition can cause mental retardation.

Other factors

Genetics factors

Chromosomal abnormalities like trisomy 21, trisomy 13, trisomy 18 or fragile X syndrome are associated with mental retardation.

Metabolic disturbances and infections

Phenylketonuria is a metabolic disorder that is associated with MR due to the inheritance of a recessive gene from each parent.

Prenatal causes

Deficiency of iodine in the mother's diet during pregnancy will result in mental retardation in the child. When mother's abuse alcohol it will produce fetal alcohol syndrome in the new born, a cluster of very serious problems they include cognitive, deficiencies maternal diseases like rubella, syphilis, toxo-plasmosis etc. during pregnancy can cause mental retardation.

Birth related causes include lack of oxygen during or after delivery can cause brain damage and retardation in a baby. Premature birth, birth injuries and abnormal delivery also have increased risk of brain damage. As for postnatal causes, head injuries, poisons, excessive exposure to X ray and excessive use of drugs can lead to mental retardation. e.g. Meningitis and encephalitis in childhood caused by certain infections can lead to mental retardation.

Socio psychological factors

Lack of adequate emotional and parental care in early childhood can result in a retarded rate of development. Severe environmental deprivation – physical, cultural, emotional and intellectual during infancy and childhood results in retardation of the child's intellectual development, every when his potential at birth is normal. School maladjustment also tends to retard the development of the child.

Common health problems associated with mental retardation

The common health problems associated with mental retardation include behaviour problems, convulsions, sensory impairments, etc. Let us take up these one by one.

In regard to behaviour problems, symptoms like restlessness (continuously moving around; unable to sit in one place), poor concentration, impulsiveness, temper tantrums, irritability and crying are common. Other disturbing behaviours, like aggression, self-injurious behaviour (such as head banging) and repetitive rocking may also be seen. When such behaviour is severe and persistent, it can become a major source of stress for families. Therefore, attention should be paid to reduce such behaviour while providing treatment and care.

About one-fourth of children with mental retardation may suffer from convulsions, which may involve the body, or single jerks leading to a fall.

Children also suffer from difficulties in seeing and hearing. This may be seen on about 5% of the cases. Sometimes these problems can be resolved by using hearing aids or glasses, or undergoing surgery for cataract. Other developmental disabilities, such as cerebral palsy, speech problems and autism, can occur along with mental retardation. Persons with many disabilities, or multiple disabilities, pose a big challenge in terms of providing care.

Self Assessment Questions

1) Disability refers to..

2) Mental retardation is defined as ....

3) Name the types of mental retardation according to American Association on Mental Retardation.

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4) The educationists classified mental retardation into.

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5) Mention prenatal causes of mental retardation.

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6) Elucidate the various causes of mental retardation post natal and at time of birth.

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7) What are the common health problems associated with mental retardation?

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2.3 PREVENTION OF MENTAL RETARDATION

Prevention is better than cure. The preventive measures have to be adopted for the Control of occurrence of mental retardation. Mental retardation can be prevented by taking precautions of prenatal, natal and postnatal causative factors. Some of the preventive measures are:

Genetic Counseling and Voluntary birth control: Chromosomal aberrations and faulty genes in parents can be identified through various blood tests and parents may be made aware and counseled about the risk and the problems they will have to face in raising a mentally retarded child.

Proper care of the mother and the child: This is essential for the prevention of mental retardation. All health measures and proper care should be taken for the prevention of physical damage inform of injuries prior to birth, at the time of birth or immediately following birth.

Provision of normal and stimulation environment after birth: Unfavorable social-cultural environment and psychological deprivations like rejection, frustration, maternal deprivation, defective family environment etc. especially in early childhood can cause or perpetuate mental retardation. Parents have to be educated for the prevention of such consequences. The children should be provided a normal stimulating environment for the proper growth and development of their innate capabilities.

Provision of information and education: To the public about nutritious balanced diet pollution control. Safety measures and control of infectious diseases, through awareness progress can be effective in prevention and controlling mental retardation. Other prevention strategies include the following:

Prevention can be primary, secondary or tertiary. Primary prevention refers to reduction or elimination of mental retardation in the community. This takes care of the health status of the community as a whole and provides specific protection against certain conditions. If the cause is known the same can be attended to thereby reducing the possibility of mental retardation.

Some of the simpler methods of primary prevention of mental retardation are the following:

Improve the nutritional status of the community thereby reduce the risk factors for mental retardation.

Universal iodisation salt to prevent iodine deficiency disorders.

Providing to mothers folic acid tablets to reduce the occurrence of neural tube defects.

Universal immunisation of children with BCG, Polio, DPT and MMR to prevent disorders that may cause damage to the brain.

Avoiding pregnancy before 21 and after 35 years to avoid complications during pregnancy and labour.

Spacing pregnancies so that the mother can replenish her nutritional requirements before the next pregnancy.

Detection and care of high risk pregnancies and screening women for syphilis and other such diseases and treating the same immediately.

Avoiding exposure to chemicals, drugs, alcohol etc.

Prompt treatment for diarrhea and brain infections in childhood to reduce the brain damage.

Provide enriching and stimulating envrionement to children for proper intellectual growth and development.

Health education about the nature, causes and prevention of mental retardation, especially during the formative years, can lead to healthy practices during pregnancy and child-rearing.

In addition there are certain technology based methods which includes prenatal diagnosis and screening, neonatal screening, neotatal intensive care, and genetic counselling.

In the prenatal diagnosis and screening , one can abort the embryo if found to have structural and Functional abnormalities. In the neonatal screening, where mental retardation of a certain type for which medicine and treatment are available, must be treated immediately. For example, phenylketunuria, galactosemia and hypothyroidism can be tested for and treated and thus mental retardation can be prevented. In regard to the neonatal intensive care, one can provide such specialised and technology intensive care that mental retardation can be prevented. However as these are very expensive, these are nit generally taken up.

As regards genetic counselling, it involves professional counselling to parents and help them make informed decisions about having the next child especially the first one is mentally retarded. Recently, there have been rapid advances in the field of genetics. A new set of techniques for the detection of genetic and other disorders called molecular genetics has evolved in the last decade. Though costly, the techniques are likely to become inexpensive and become applicable for wider use in future. One example is the possibility of detecting the presence of Downs syndrome by doing a blood test on the mother during early pregnancy. Such tests perhaps would become common in future. The WHO has suggested the following at each level to prevent mental retardation. This is reproduced in the table below:

Level	Approach	Interventions
Primary Prevention (preventing the occurrence retardation)	Health promotion	Health education, especially for adolescent girls
		Improvement of nutritional status in community Optimum health care facilities
		Improvements in pre, peri and postnatal care
	Specific protection	Universal iodisation of salt
		Rubella immunisation for women before pregnancy
		Folic acid administration in early pregnancy
		Genetic counselling

		Prenatal screening for congenital malformation and genetic disorders
		Detection and care for high-risk pregnancies
		Prevention of damage because of Rh incompatibility
		Universal immunisation for children
Se condary Prevention (halting disease progression)	Early diagnosis and treatment	Neonatal screening for treatable disorders
		Intervention with "at risk" babies
		Early detection and intervention of developmental delay
Tertiary Prevention (preventing comlications and maximisation of functions)	Disability limitation and rehabilitation	Stimulation, training and education, and vocational opportunities
		Mainstreaming / integration
		Support for families
		Parental self-help groups

2.3.1 Education and Vocational Training

Special education programmes are selected for mentally retarded children. This consists of a combination of regular classroom exercises and special education approaches. The special education may be optional and it must be remembered that special education programmes for mentally retarded help them learn the basic selfcare skills. They can also be taught social skills that enable them to interact more easily with people in school and community settings.

Most of districts and towns in India have special educational programmes for mental retardation starting from preschool years.

Training in language can be useful in helping the child to communicate more effectively.

Behavioural training methods also help effectively in teaching selfcare skills.

Vocational training in semi skilled or unskilled jobs can ensure some independent life through employment for educable mentally retarded.

They are trained in acquiring self help skills like independent eating, toileting, dressing etc. and in unskilled jobs.

The educational programmes for the custodial mentally retarded (severe and profoundly mentally retarded) who cannot be educated nor trained, custodial treatment is the only option. The emphasis here is on teaching self help skills and protection from health and wealth hazards.

2.3.2 Rehabilitation and Management

Whatever preventive measures are adopted mental retardation cannot be completely eliminated and we have to plan the treatment and rehabilitation measures for mentally retarded. Although there is no cure for mental retardation in the sense no medical care or training can transform mentally retarded into a normal individual, by adopting appropriate educational rehabilitation measures the functional levels of these individuals can be improved to maximize their personal and social effectiveness.

Rehabilitation is concerned with assisting individuals with disabilities in achieving optimal psychological, social and physical functioning by providing comprehensive intervention programme which is given as special education services in the form of supportive educational and vocational training in order to make the individual with disabilities lead an independent life with confidence and courage.

There are 1000 special schools for children with mental retardation in our country, Community based rehabilitation services should be available to all sections of the society.

Community involvement and participation is a must to bring about positive changes in social awareness attitudes and beliefs about mental retardation.

Parental counseling can help parents gain emotional support, guidance and assistance is needed to rear and train the mental retardation child. Individual or group psycho therapy can be useful in providing remedial measures for mentally retarded.

Self Assessment Questions

1) What are the various ways to prevent mental retardation?

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2) Write the various strategies at the primary prevention level.

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3) Elucidate the WHO measures for reducing mental retardation in the community.

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4) What is educational and vocational training given to MR.?

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5) What kind of rehabilitation programme do we organise for MR.?

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2.4 LEARNING DISABILITY (LD)

Mental retardation represents one end of the intelligence spectrum and the genius, represent the other end. Falling between these two extremes are children with learning ability.

Both mental retardation and learning disabilities come under cognitive disabilities. The learning disability was coined by Dr. Samuel Kirk (1963). In recent years learning disability is called as specific learning disability.

2.4.1 Definition

Learning Disability is an umbrella term which encompasses a variety of specific kinds of learning problems. Children with learning disability experience difficulty in learning and using certain skills namely reading, writing, listening, reasoning and arthematics. Usually learning disability is not identified until they enter schools. A child with learning disability has difficulty mastering one or more academic subjects, has normal intelligence and is not suffering from any sensory impairment or inadequate instructions (Lyon, 1996). Learning disability is an invisible disability. The child usually appears normal in every aspect except that his learning difficulties limits his progress in school.

2.4.2 Types of Learning Disabilities

Learning disability is categorised either by the type of information processing that is affected or by the specific difficulties caused by a processing deficit. These include input, integration, storage and output.

People with learning disabilities have difficulty taking organising and or acting or information the brain receives through the senses. The difficulty has to do with understanding or using written or spoken language. The problems are based on brain structure and function a case of poor wiring in one or more areas of the brain. Thus the deficit in any area of the information processing can manifest a variety of specific learning disabilities which are manifested as:

Dyslexia

Reading disability including difficulty with accurate word recognition, word decoding and reading comprehension and oral reading skills.

Dysgraphia

Writing disability, inability to write properly, illegible hand writing.

Dysphasia

Speech and language disorders.

Dyscalculia

Mathematics disability, difficulty in learning mathematical concepts and organising numbers in addition, subtraction, multiplication, division.

Dyspraxia

Difficulty with motor skills, non verbal learning disability, motor clumsiness and poor visual spatial skills.

Dysnomia

In inability to retrieve or recall appropriate words for oral or return language. There may be other difficulties that co-occur with learning disabilities like difficulty with memory, social skills and executive functions like organisation skills and time management.

2.4.3 Causes of Learning Disability

The causes of learning disabilities can be classified broadly in to educational, environmental psychological and physiological factors. The biological, psychological and socio cultural factors have a cumulative effect on learning disabled with children.

Educational factors

Learning disability may be caused by in adequate, inappropriate teaching, unskilled and inefficiently trained teachers, too high or too low teachers' expectations towards children and inappropriate materials and curriculum.

Psychological factors

These may be poor perception and lack of conceptualisation, unhealthy classroom climate and lack of scholastic motivation.

Environmental factors

Unstimulating environment at home develops emotional and language deprivation. Language plays a crucial role in child's environment, in his thinking as well as in learning other skills. Language deprivation and diversity complicate learning disability.

Physiological factors

Brain injury, damaged central nervous system, genetic factors and prenatal and postnatal problems also lead to learning disabilities. Maternal health, diet, life style and postnatal factors like head injury, nutritional defects are potential causes

of learning disability. Maturational lag and neurological disturbances can also be a factors that lead to learning disability.

2.4.4 Characteristics of Learning Disability

The most common characteristics of children with learning disability are:

- Hyperactivity
- Perceptual motor impairments
- Emotional liability (frequent shifts in emotional mood)
- General co-ordination deficits
- Attention disorders (short attention span distractibility, perseverance)
- Impulsivity
- Specific academic problems (reading, writing, arithmetic, spelling)
- Speech and hearing disorders
- Irregularities in EEG (electro encephalography).

Self Assessment Questions

1) What is learning disability?

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2) Mention the type of learning disabilities.

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3) What are causes of learning disability?

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4) Give the salient characteristics of learning disabled children.

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2.4.5 Diagnosis Identification/Assessment of Learning Disability

Parents realise the presence of a learning disability long before the problems are seen in school. Learning disability is often identified by school psychologists, clinical psychologists and neuropsychologists through a combination of intelligence testing, academic achievement testing. Classroom performance, social interaction and aptitude. Other areas of assessment include perception, cognition, memory, attention and language abilities. The resulting information is used to determine whether a child is achieving at his / her potential.

2.4.6 Impact of Learning Disability

The Psychological effects of learning disability vary from person to person, but for the learning disabled individuals these effects include:

- Frustration due to repeated failure in school, workplace on in social situations
- Low self esteem due to failure, humiliation from others
- Stress when pressurized to try harder by others who do not reason for difficulties
- Depression if they see no way out from the learning deficit and the emotions it engenders

2.4.7 Intervention

There are many educational interventions for the prevention of learning disability. These include mastery model direct instruction and special education. Ability training and skill training through direct instruction in the classroom and resource room and peer tutoring are provided to teach the needed academic skills, social skills and learning strategies to the children. Cognitive training through modeling and self instructional techniques are used to decrease impulsivity and increase reflectivity of learning disabled children. Early remediation can help reduce learning disability. A multi sensory approach and technological approach may also provided for remedial instruction of learning disabled child.

2.4.8 Role of Parents

Parents can formally asset in educational instruction of learning disability. They should be provided proper information and trained, so that they can act as parent tutors. Informed parents with regular communication and support from professionals can improve environmental conditions for their children and help in the development of basic skills in children. Their feedback, cooperation and reinforcement can bring together teachers, professionals and society in the combined effort forgather habilitation and rehabilitation of children with learning disability.

Self Assessment Questions

1) Describe the characteristic features of learning disability.

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2) What are the various types of learning disability. Describe.

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3) What psychological tests are used for assessing learning disability?

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4) What are the educational interventions used for learning disability?.

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5) What is the impact of learning disability?

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2.5 LET US SUM UP

In this unit you have studied about disability, cognitive disability and two types of cognitive disabilities namely mental retardation and learning disabilities.

Mental retardation is an invisible intellectual disability a sub average intellectual functioning and deficits in adaptive skills areas such as selfcare, home living communication, social and self skills, self direction, health and safety, functional academics, community use, leisure and work.The classification of mental retardation based on different criteria into different categories as given by different professionals. Also the salient characteristics of each category of mental retardation.

Two major causes of Mental Retardation namely the organic or biological causes and socio psychological causes.

Educational and vocational training as well as the rehabilitation provided for the management of mental retardated individual as there is no cure for Mental Retardation.

In the second section you studied about learning disability,

The causes, characteristics and types of learning disability.

The educational, psychological, environmental and physiological factors as causes of learning disability.

The salient characteristics of learning disability children.

The types of learning disabilities such as dyslexia, dysgraphia, dyscalculia, dysphasia, dyspraxia and dysnomia.

The impact of learning disability on children and educational intervention that can be given to them.

The role of the parents in helping a learning disability child has also been studied.

2.6 UNIT END QUESTIONS

1) Explain the classification and causes of Mental Retardation.
2) Discuss the educational and vocational programmes for the rehabilitation of mentally retarded individual.
3) What is learning disability? Explain the various types of learning disabilities?
4) How will you identify and educate a learning disabled child?

2.7 GLOSSARY

Disability : is limitation lack of ability to person activities which are considered normal form individual.

Down's syndrome : A mental retardation which occurs due to chromosomal abnormality in the 21st pair of the autosomes.

Dyslexia : is learning disability that leads to difficulty in learning to read.

Learning disability : is a disorder that leads to difficulty in acquiring language and academic skills.

Mental retardation : An intellectual disability characterised by sub average intellectual functioning and deficient adaptive behaviour before 18 years of age.

2.8 SUGGESTED READINGS

Bryan Tanis. H and Bryan James. H (1985) *Understanding Learning Disabilities* California, Mayfield Publishing Company.

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UNIT 3 EXCEPTIONAL CHILD IN SCHOOL

Structure

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3.2 Definition of Exceptional Child

3.3 Types of Exceptional Children

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3.18 Glossary

3.19 Suggested Readings and References

3.0 INTRODUCTION

In a democratic country like ours, every child has a right to education. No child should be deprived of education appropriate to him/her irrespective of him/her being abled or differently abled. The school system should welcome all children to meet their varied needs. There are individual differences among children due to different degrees of maturity or growth. Most children fall in the average or normal group in terms of growth and development but there are some children who are markedly different in certain ways from the general or average population of children. These children are called Exceptional children or children with special needs. In this unit we shall first discuss about an exceptional child, types of exceptional children and the various educational programmes for them. This will be followed by special educational programmes offered to these children based on the type of their exceptionality. Lastly the concepts of integration and inclusion in the education of these children with special needs will be discussed. This unit then will have a section discussing the exceptional child in the school and hiow he or she should be handled etc..

3.1 OBJECTIVES

After you have completed this unit, you will be able to:

- Define Exceptional Children;
- Describe Exceptional Children;
- Elucidate the Types of Exceptional Children;
- Explain the educational programmes in the School for exceptional children;
- Define mental retardation;
- Elucidate Special Educational Programmes offered to the mentally retarded children;
- Analyse the Integration of the learning disabled into the main stream; and
- Explain the new reforms of inclusion in their education.

3.2 DEFINITION OF EXCEPTIONAL CHILD

An exceptional child is one who deviates physically, intellectually, emotionally or socially, from the normal or average child so markedly that he cannot receive maximum benefit from the regular school programme and requires modification in the school practices and programmes or requires special educational services or supplementary instruction and services to enable him/her to develop to their maximum capacity. Such a child begins to show signs of exceptionality from birth or during the developmental stages as the child races ahead of others or lags behind in terms of growth and development in various dimensions, viz., Physical, Mental, Emotional, Social and Moral to such an extent that he or she exhibits problems and maladjustments in academics, the school setting itself, in behaviour and in terms of adjustment problems with other children. An exceptional child has some needs like those of the normal child and like his peer group children, and does have some different needs pertinent to the child's own particular type of exceptionality. Since the child has some special needs, he / she is also referred to as a child with special needs.

3.3 TYPES OF EXCEPTIONAL CHILDREN

All children exhibit differences from one another in terms of their physical attributes (e.g., some are shorter, some are stronger) and learning abilities (e.g., some learn quickly and are able to remember and use what they have learned in new situations. Others need repeated practice and have difficulty maintaining and generalising newly acquired knowledge and skills. These differences among most children are relatively smaller thereby enabling these children to benefit from the general education program.

The physical attributes and/or learning abilities of some children, however in regard to those children called **exceptional children** differ to quite an extent from the norm (either below or above) that they require an individualised program of special education and related services to fully benefit from education.

The term exceptional child, includes all those children who experience difficulties in learning as well as those whose performance is so superior that modifications in curriculum, teaching methodology and instructions are necessary to help them fulfill their potential.

Thus, exceptional children is an inclusive term that refers to children with learning and/or behaviour problems, children with physical disabilities or sensory impairments, and children who are intellectually gifted or have a special talent. The term students with disabilities is more restrictive than exceptional children because it does not include gifted and talented children. Learning the definitions of several related terms will help you better understand the concept of exceptionality.

Although the terms impairment, disability, and handicap are sometimes used interchangeably, they are not synonymous.

Impairment refers to the loss or reduced function of a particular body part or organ (e.g., a missing limb). A disability exists when an impairment limits a person's ability to perform certain tasks (e.g., walk, see, add a row of numbers) in the same way that most persons do. A person with a disability is not considered handicapped, unless or otherwise the disability leads to educational, personal, social, vocational, or other problems. For example, if a child who has lost a leg learns to use a prosthetic limb and thus functions in and out of school without problems, she is not handicapped, at least in terms of her functioning in the physical environment.

Handicap refers to a problem or a disadvantage that a person with a disability or an impairment encounters when interacting with the environment. A disability may pose a handicap in one environment but not in another. The child with a prosthetic limb may be handicapped (i.e., disadvantaged) when competing against nondisabled peers on the basketball court but may experience no handicap in the classroom. Individuals with disabilities also experience handicaps that have nothing to do with their disabilities but are the result of negative attitudes and the inappropriate behaviour of others who needlessly restrict their access and ability to participate fully in school, work, or community activities.

The word handicapped is thought to come from a game that involved a "cap in the hand," and it has the contemporary meaning of assigning extra weight (a

handicap) to better performers to "level" a playing field and enhance wagering (Treanor, 1993). Unfortunately, the word conjures up the negative image of a person with disabilities begging in the street. In most instances today, the term preferred for use is 'the person with disabilities' rather than using the term 'handicapped'.

At risk refers to children who, although not currently identified as having a disability, are considered to have a greater than usual chance of developing one. The term is often applied to infants and preschoolers who, because of conditions surrounding their births or home environments, may be expected to experience developmental problems at a later time. The term is also used to refer to students who are experiencing learning problems in the regular classroom and are therefore at risk of school failure or of being identified for special education services.

Some exceptional children share certain physical characteristics and/or patterns of learning and behaviour. These characteristics fall into the following categories of exceptionality:

- Mental retardation (developmental disabilities)
- Learning disabilities
- Emotional and behavioural disorders
- Autism
- Communication (speech and language) disorders
- Hearing impairments
- Visual impairments
- Physical and health impairments
- Traumatic brain injury
- Multiple disabilities
- Giftedness and special talents

As stated previously, all children differ from one another in individual characteristics along a continuum. Exceptional children differ markedly from the normal children that they require an individually designed program of instruction. In other words, special education is required if they are to benefit fully from education.

It is a mistake to think that there are two distinct kinds of children, that is, those who are exceptional and those who are regular. Exceptional children are more like other children than they are different. Nevertheless, an exceptional child does differ in important ways from his peers without disabilities. And whether and how we recognise and respond to those differences will have a major impact on the child's success in school and beyond. Keep these critical points in mind as you read and learn about the exceptional children described in this text and the special education programmes designed to help them.

The term 'Exceptional' is in reality an umbrella like term which encompasses many different groups of children and with different degrees of ability within each group. The following are the types of exceptional or deviant groups of children.

- Gifted, creative group

- Physically or neurologically handicapped or orthopedically and health handicapped.
- Sensory (visual and hearing) handicapped
- Speech handicapped.
- Emotionally handicapped.
- Socially handicapped or (Disadvantaged)
- Learning disabled.
- Slow learners or academically backward.
- Mentally handicapped.

Among the exceptional children, the intellectually exceptional children encompass two large groups each of which has different characteristics. At one extreme are children who are characterised by high mental ability, that is children who are intellectually superior and at other extreme are children who are referred to as slow learners and mentally handicapped or mentally deficient.

Children whose IQ score is 130 and above are referred as highly abled or gifted. On the other hand there are children whose IQ is below average (80-90) called as slow learners.

The *mentally retarded* are those whose IQ score is 70 and less.

Let us now consider in detail all the different categories of exceptional children.

3.4 GIFTED, CREATIVE CHILD

A gifted child does not necessarily possess a very high intelligence quotient. An exceptional talent in art, music, dance and creative writing also are included in giftedness. Such a child's cognitive abilities place him in the upper 3-5% of the population. A gifted child engages in convergent thinking, while a creative child is associated with divergent thinking. The gifted and creative children have special educational needs because of their exceptional abilities. The gifted and creative child requires opportunities for self expression, challenging and complex curriculum, teachers who can foster talent and peers who can stimulates their interest (Feldhusen, 1996).

3.4.1 Causes of Giftedness

Giftedness is biologically determined although some psychologists' emphasise on the child's Socio Economic Status to be associated with his/her IQ, Heredity sets the intellectual potential of an individual and the environment determines how much of it is realised.

Special educational programmes like enrichment (extra opportunities) acceleration and pullout approach (withdrawal for school classes for special training) are needed to realise his potential for personal fulfillment and social contribution.

3.5 SLOW LEARNER OR BACKWARD CHILD

The backward child is also called as a slow learner. The child is unable to cope with routine work normally expected of his/her age group. The rate of learning is the basis for identifying slow learners. He finds it difficult to keep pace with the normal child in his school work.

3.5.1 Characteristics of Slow Learners

The characteristics of slow learners are as given below:

- They have limited cognitive capacity.
- For them rational thinking is impossible.
- They have the capacity for rote learning and can retain in memory what ever is learnt only with lot of practice and revision in comparison with the normal child.
- They have poor memory.
- They are distractive and lack concentration in class room.
- They have an Inability to express through language. The slow learner has cognitive problems, language related problems, auditory perceptual problems, visual-motor problems and social emotional problem.

3.5.2 Causes of Slow Learning

Learning disabled children can be classified into educational, environmental factors, psychological and physiological factors.

Educational factors: Learning disabilities can be caused by inadequate, inappropriate teaching, unskilled and inefficient trained teachers, too high or low teacher's expectations towards children and inappropriate materials and curriculum.

Psychological factors: The factors that will cause learning disability under this will include perception and lack of conceptualisation, unhealthy classroom climate and lack of scholastic motivation.

Environmental factors: The causative factors under this will include unstimulating environment at home, language deprivation in the environment etc. Language plays a crucial role in the child's environment.

Physiological factors: These include brain injury, damaged central nervous system, genetic factors and prenatal postnatal problems which all may lead to learning disabilities.

3.5.3 Educational Programmes for Slow Learners

These measures include the following:

- Elastic curriculum.
- Remedial instruction.
- Healthy environment.
- Motivation.
- Individual attention.
- Special methods of teaching
- Simple methods of instruction based on concrete experiences to be used.
- Verbal instructions should be limited.
- Audio visual aids to be used.
- Project method of teaching can be helpful
- Homework and maintenance of progress card to be used.

3.6 MENTALLY RETARDED CHILDREN

A child is said to be mentally retarded when he has sub average intellectual functioning with deficits in adaptive skill areas like self care, communication, home living and community use, social and self skills, self direction, health and safety, functional academics, leisure and work. Sometimes the child seems to be normal with vision, hearing and limbs intact, but he does not behave appropriately to his age which leads to confusion and misconceptions about his disability.

3.6.1 Psychological Classification of Mental Retardation

The American Association on Mental Retardation (AAMR) have classified mental retardation (MR) into levels based on the IQ level as (1) mild (50-70), moderate (35-40) severe (20-40) and profound (below 20).

3.6.2 Educational Classification

The educationist, classify mental retardation according to the functional ability of the individual such as (a) Educable mentally retarded (b) Trainable mentally retarded and (c) Custodial mentally retarded (Cipani, 1991). The levels, along with IQ score range associated with each level are shown in the chart.

AAMR IQ Level Educators

Categorisation of intelliegence in MR	The IQ scores
Profound	10-20
Severe	20-30
Moderate	30-40
Mild	40-50
Custodial	50-60
Trainable	60-70
Educable	70-80

The most severe forms of Mental retardation are relatively uncommon. Profound, severe and moderate retardation together makeup only 10% of all cases. Children with profound and severe retardation usually have so few skills that they must be supervised constantly. Consequently, they typically live in institutions where they can be taught self help skills such as dressing, feeding and toileting (Reid, Wilson and Faw, 1991).

Children with moderate retardation may develop intellectual skills of non retarded 7 or 8 year old. With this level of functioning, they sometimes find employment working on simple tasks under close supervision. They do not live independently but receive care from relatives or in institutions (Editorial Board, 1996). They cannot benefit from classroom but have the potential to learn self care, adjust in home and economic usefulness in home, sheltered workshop or an institution. Special school setting is required for this type of children.

The remaining 90% of individuals with mental retardation are classified as mildly or educable mentally retarded. These individuals go to school and can master many academic skills, but at an older age than a non retarded child. Individuals

with mild mental retardation can lead independent lives. Many people with mild retardation work and some also marry. Comprehensive training programs that focus on vocational and social skills help individuals with mild mental retardation to become somewhat productive citizens and satisfied human beings (Baumeister and Baumeister, 1995)

3.6.3 Causes for Mental Retardation

There are many causative factors that are associated with mental retardation. These can be classified in three stages, Prenatal, Perinatal and Postnatal can result in mental retardation.

1) **Prenatal stage:**In this one comes across many types of disorders given below.

a) *Chromosomal disorders*

Any abnormality either in the structure or in the number of chromosomes can result in mental retardation. Major type of mental retardation is chromosomal disorder known as Down's syndrome. In this condition, at the time of conception, a piece of chromosome 21 becomes attached to another chromosome, often number 14, during cell division. If the resulting sperm or ovum receives a chromosome 14 (or another chromosome), with a piece of chromosome 21 attached and retains the chromosome 21 that lost a section due to translocation, then the reproductive cells contain the normal or balanced amount of chromosome 21. It is "autosomal" or "other"; it is simply an error in the translation process of Chromosome 21 (three copies instead of two).

Other abnormalities associated with MR include fragile X syndrome, where the tip of X chromosome breaks off and Trisomy 13 and Trisomy 18 caused by the presence of three chromosomes instead of two chromosomes.

b) *Genetic disorder*

Defect in the genes transmitted from the parents to the offspring can result in mental retardation. Even if the defect is not with the parents, the offspring may acquire some conditions with mental retardation. Metabolic disorder associated with MR is Phenylketonuria that is due to the inheritance of two recessive genes one from each parent.

c) *Infections*

During pregnancy if the woman gets afflicted by rubella (German measles), or herpes, especially during the first three months of pregnancy, can damage the developing brain of the fetus.

d) *Maternal diseases*

If the woman suffers from diseases like syphilis, etc., then the offspring may develop mental retardation. Also Deficiency and excesses of iodine in the mother's diet can result in conditions like cretinism and defect in central nervous system leading to MR.

e) *Exposure to X-rays*

During early months of pregnancy, if the mother uses harmful drugs especially in the treatment of cancer and some epileptic drugs and hormones, these can damage the growing fetus.

2) **Perinatal stage**

Premature birth (Born between 28 week to 34 weeks), low birth weight (Less than 2 kgs), Anoxia (Lack of Oxygen) immediately after birth affect the brain leading to MR. forceps delivery, birth injuries have increased risk of brain damage.

3) **Postnatal stage**

Malnutrition in the child during the first two years, poisoning infections such as meningitis or encephalitis (Brain fever) and repeated fits in the child and head injury can lead to MR.

3.6.4 Characteristics of Mental Retardation Child

Early childhood deprivation like lack of adequate mothering and parental care results in a retarded rate of development. The severe environmental deprivation in the form of physical, emotional, cultural and intellectual poverty during infancy and childhood results in the retardation of the child's intellectual development even when his potential at birth is normal school maladjustment tends to retard the development of the child.

3.7 VISUALLY HANDICAPPED CHILD

This child can be educated in the regular class room along with normal children. The written communication system for this child is through a sense of touch, the touch system is known as *Braille*. The blind child makes use of other senses, the ear and sense of touch for learning through compensatory skills such as Braille reading and writing. However, special training is required for the child to move about independently in the environment. The blind child can benefit from instruction along with the sighted children. Thereby gaining the same social attitudes, some information and develop the same level of confidence. A blind child is first a child and a 'blind' child later and so he has to be treated in the same way as any other child with the same standards of performance and the same level of expectations as a normal child. A resource teacher is required for consultation of blind child.

3.7.1 Causes of Visual Impairment

The causes of Visual Impairment can be classified as (i) ocular and (ii) general injuries.

Ocular causes: These are due to Congenital and Developmental disorders, like eyes do not develop, eye ball abnormally small, atrophy of the optic nerve, rapid involuntary movement of the eyeball, iris fails to develop and visual acuity becomes poor.

Eye disorders: Albinism Retinoblastoma (Malignant tumor), congenital cataract, all these cause visual impairment.

Eye diseases: Trachoma-contagious diseases of conjunctiva and cornea, conjunctivitis of the new born are also some of the important causes for visual impairment.

General Diseases: Sphilis and Gonorrhea are common causes of blindness. Deficiency in vitamin A, vitamin B_1 B_2, C and D are associated with impaired

visual functioning. Injuries and accidents and chemical disturbances like burns, tobacco, alcohol dyes cause visual impairment.

A multi sensory approach use A+ and use of Braille are used in the education of such a child.

3.8 HEARING IMPAIRED CHILD

A child with hearing handicap is given auditory training and use of hearing aids. Several aural oral techniques are used for language and communication. The curriculum is the same as it is for the normal child. This child's learning can be integrated in the regular school. The most significant defect is in his/her pronunciation and difficulty in understanding of abstract concepts. A resource teacher is required for his/her speech development.

3.8.1 Causes of Hearing Loss

Besides organic causes, hearing loss is associated with neurological transmission of sound that results from damage to the cochlea or to the auditory nerve due to genetic and or environmental factors.

Genetic cause

Hearing impairment can be due to a dominant gene and recessive gene transmission.

Maternal diseases and infection

If at the time of pregnancy the woman suffers from diseases like rubella, mumps, diabetes, liver diseases and influenza, these may affect the infant's hearing capacity. Overdose of drugs like Quinine, LSD and such other psychoactive drugs, also malnutrition, brain fever, brain tumor etc., may adversely affect the child's hearing capacity.

During birth

Lack of oxygen, forceps delivery, premature birth, use of anesthetic agents in delivery cause hearing problems.

Post birth

Ear discharge is an important cause of hearing loss. Other causes may be middle ear infection, typhoid, infections in nasal cavities, meningitis and whooping cough.

Remedial measures include visual presentation with oral instructions and multi sensory approach which are all used for the education of the deaf child.

3.9 SPEECH AND LANGUAGE HANDICAPPED CHILD

In certain cases, children show speech disorders in terms of stammering, stuttering etc. Some children may have other kinds of speech disorders too. However, these children can benefit from the regular class room teaching as they have other senses in tact. With regular and proper speech therapy these children can also get over their speech defects considerably and be at par with normal children. .

3.9.1 Causes of Speech and Language Disorders

Speech disorders are due to combinations of causes such as hereditary predispositions, neurological impairments, physical abnormalities of speech mechanisms, delayed development and cultural or environmental influences.

Language disorders can be due to brain damage, mental retardation, sensory and perceptual impairment or environmental deprivation.

Self Assessment Questions

Identify the particular disability in the following:

1) A child finds it difficult to keep pace with the normal child in his school work.

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2) A child has an IQ score of 50

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3) A child has average intelligence but is unable to achieve the skill in reading markedly.

....

....

....

....

4) A child who deviates from normal children in certain dimension of growth and development is called .... child

5) A touch system used by the blind is called ....

3.10 PHYSICALLY, ORTHOPAEDICALLY AND HEALTH HANDICAPPED CHILD

The physically handicapped child can be educated in the normal school by making adjustments in the sitting arrangements, like taking a seat on the side rather than in the middle of the class room and changing the physical structure of the class room which has ramps. The same teaching methods and same curriculum is used for teaching a physically handicapped child.

3.10.1 Causes of Physical, Orthopedic and Health Handicapped

The causes are many and varied as presented below:

- Brain damage, brain fever and brain anoxia lead to physical disability.

- Rh incompatibility intoxication,
- Viral infection suffered by the expectant mother also cause physical disability.
- Prolonged labour,
- Lead poisoning,
- Accidents may cause damage to the brain leading to neurological disorders.
- Polio,
- Burns and injuries are significant causes as per NSSO 1991 for Indian society.
- Health problems: some children have health problems that interfere with their education such as heart diseases tuberculosis, asthma, epilepsy, migraine and diabetes.

In certain cases, a child with health problems like epilepsy may be present in the regular class room. The child can study well but has a social stigma and low self esteem.

Remedial measures include the teacher helping such children and reducing the stigma by makig other children understand the child's problem. The teacher also needs to take precautionary measures during convulsions that the child suffers. Fear should be eliminated and the place where the event is occurring should be cleared of all congestion and the child should be helped to breathe properly aftert the convulsions are over.

3.11 EMOTIONALLY DISTURBED CHILD

The emotionally disturbed child is one whose reactions to life situations are unrewarding to the child itself and unacceptable to peers and other members of the society. This child has an inability to learn, has inability to establish interpersonal relations with others, and often shows inappropriate behaviours or feelings which are very undesirable and not approved by people or society. Under normal circumstances where other children behave normally, these children tend to show unhappiness, depression and fear of personal and school problems. These affect their academic performance.

3.11.1 Causes of Emotional Disturbance

These can be categorised into Psychoanalytic environmental and School related factors.

The Psychoanalytic causes are: Anxiety, trauma distrust of adults due to traumatic experiences, frustrations and rejection. For example, maternal deprivation due to death of the mother.

Environmental causes

This includes mental illness like schizophrenia, maternal malnutrition, anoxia, head injury, separation from parents, parental conflicts, divorce, physical and psychological abuse or neglect.

School related causes

This could be low/high expectations from the student in consistent behaviour management, meaningless assignments and reinforcement of inappropriate behaviour.

These children slow behaviours like inattentiveness, nervous reactions, failure in school and jealousy.

Emotionally disturbed

The child has negative self concept, lacks feeling of self work, conformity to demands, setting of realistic goals, ability to handle anxiety and is very withdrawn.

Educational provision for Emotionally disturbed

Teaching emotionally disturbed child is a challenge. The emphasis should be on structuring classroom atmosphere (it should be least restrictive for the child) use selected reading materials, group interactions between pupil and teacher and among peers, directed group activity, supporting self directed activities and recording positive behaviours. In addition techniques like behaviour modification, modeling counter conditioning, deconditioning and desensitisation and non-directive counseling should be used.

3.12 LEARNING DISABLED CHILD

This disability has got the maximum attention in the recent years children have normal intelligence but they have difficulty mastering basic skills like reading, writing, arithmetic, listening and oral language. There are four stages of learning input, integration, memory and output. Learning disability can occur in any of four stages.

Types of disabilities are (a) Dyslexia (Reading problem) (b) Dysgraphia (Writing problem) (c) Dyscalculia (Mathematics problem) (d) Learning disabilities in language

These are being explained below:

Learning Disabilities in Reading, Dyslexia

Types of Reading Disabilities: There are two types of learning disabilities in reading. One is in basic reading skills and involves the foundational skills required to understand the relationship between letters, sounds, and the words they represent. The second one is the reading comprehension disabilities which involves complex thinking skills such as understanding words, phrases and larger meanings of passages.

Dysgraphia or Learning Disabilities in Writing

Learning disabilities in basic writing skills include neurologically based difficulty with producing written words and letters. Expressive writing disabilities may involve comprehending and organising written thoughts on paper. These can be in terms of Learning Disabilities in Basic Writing Skills, Expressive Writing Disabilities.

Learning Disabilities in Math Discalculia

If the child struggles with math calculation or problem solving, one can suspect a type of learning disability. This learning disabilities could be in basic math, applied math skills, and other disorders such as dyscalculia. Learning Disability (LD) in Basic Math Skills.

Learning Disabilities in Language and communication

There are several types of learning disabilities in language. Students with language based learning disabilities may have difficulty with understanding or producing spoken language, or both. Receptive language disorder is a type of learning disability affecting the ability to understand spoken, and sometimes written, language.

3.12.1 Causes of Learning Disabilities

The causes can be classified into educational, environmental, psychological and physiological factors. Let us take each of these and see what they are.

Educational factors: Learning disabilities can be caused by inadequate, inappropriate teaching, unskilled and inefficient trained teachers, too high or low teachers' expectations towards children and inappropriate materials and curriculum.

Psychological factors: Learning disabilities can be caused by misperception and lack of conceptualisation, unhealthy classroom climate and lack of scholastic motivation.

Environmental factors: Unstimulating environment at home, develops language deprivation, language plays a crucial role in the child's environment.

Physiological factors Brain injury, damaged central nervous system, genetic factors and prenatal, postnatal problems also lead to learning disabilities.

3.12.2 Remedial Measures

In the regular class room the learning disability child can be provided:

1) individualised instruction
2) programmed instruction and
3) open class room at the elementary level.

A skill based approach is the most effective educational treatment for learning disability. The instructions and activities have to be carefully selected by the teacher, provide lot of practice to ensure skill mastery and show the child how to apply the skills that is learned. If the school can, a resource room to give the added instructional hours could be arranged.

3.13 SOCIALLY DISADVANTAGED CHILD

Socially disadvantaged child is one who is from socially and economically backward section of the community, who cannot profit from school because of deprivation of one sort or another. Such children show cumulative academic deficits, high dropout rate and progressive decline in intellectual functioning.

3.13.1 Causes of Social Disadvantage

Some of the major causes are unstimulating environment, lack of verbal interaction with adults, poor sensory experience, poverty, low social status, malnutrition and broken homes. Most of these causes are due to socio cultural disadvantage.

Such a child has characteristics like backwardness, frustration, aggression, delinquency, inferiority complex, alienation and lack of motivation.

3.13.2 Remedial Measures

The curriculum should to be specific and related to the needs and real life experiences. Emphasis should be on learning manual skills, life skills and technical efficiency. Interest in learning has to be, created by the teacher, effort should be towards developing self confidence, self respect and a sense of cultural identity.

3.14 SPECIAL EDUCATION

An exceptional child has some special and unusual needs which can be met only through special education as part and parcel of the general education. This would involve.

- Specially designed instruction.
- Special curriculum.
- Specific facilities.
- Special services.

3.14.1 Special Instructions

An exceptional child may require special materials, teaching techniques, equipment or facilities as for example, the visually handicapped children may require reading materials in large print or Braille. The Hearing impaired require learning aids/ or instructions in sign equipment. The emotionally disturbed may need smaller and more highly structured classes, while the and gifted and / or talented children may require access to varied types of materials and require the guidance of work professionals.

3.14.2 Special Curriculum

For different areas of exceptionality such as mental retardation, giftedness, deafness, blindness, orthopedically handicapped, cerebral palsy and social and emotional problems a special curriculum is designed for children.

Educationally backward children, handicapped and gifted need specific facilities for their optimal development. Special teaching facilities required to meet, the personal and social needs of the exceptional children.

The superior children should be provided with opportunity to work according to their talent. In an average class a bright child feels neglected and demotivated with little endeavour, he comes out of exceptionality. He can keep a position in the class with minimum effort.

3.14.3 Other Types of Facilities

Some facilities like special building features, study materials and equipment may be required for some types of exceptional children. The special education can be imparted in the regular classroom, special classroom or in combination of both. Special classes are necessary for backward children because they require specific teaching methods.

3.14.4 Special Services

These may be required for some exceptional children. *For e.g*: Orthopaedically handicapped children require physical therapy, occupational therapy and to be kept under constant medical supervision. The blind and deaf children may need periodic examination of their vision and hearing abilities. Some exceptional children need periodic examination of their progress in learning as a result of intervention.

In a regular class with different categories of children such as handicapped (physically and mentally) gifted (bright and superior) and normal children, the teacher would have problem to devise a method of instruction which is suitable for all.

Special education will help not only these exceptional children, but will also be conducive for regular class teachers.

3.15 CONCEPT OF INTEGRATION AND INCLUSION

Education for the exceptional children is undergoing major changes. The most fascinating feature of the modern Indian educational scenario is the integration of the children with special needs into the mainstream. The focus is on how to fit the exceptional child into the regular education programme. The integration of regular education and special education is limited to non academic activities for a part of the day. This leads to independence and integration of these children into the society. Also the children who are normal develop a realistic attitude and sensitivity to these children.

Since 1994 UNESCO world conference on Special Educational Needs (Salamanca) a reform *'inclusive education'* has emerged in the education of exceptional children. In inclusive setting the focus is on developing supportive classrooms and schools that fit, nurture and meet the educational and social needs of exceptional child in least restrictive and most effective environment by focusing on quality of schooling. When schools would modify their operations to include, all students it ensures acceptance and respect for differences. Despite differences we all have equal rights, when an exceptional child has free access to any school, it would promote positive attitudes improvement in academic and social skills and preparation for community living.

Self Assessment Questions

1) A special class is required to teach through specific methods for .... children.
2) Specific education is helpful for both .... and .... in the regular class.
3) ....children require smaller and highly structured classes.
4) .... children require physical therapy.
5) .... children require instructions in sign equipment.
6) Integration of special education and regular education is called .... setting has supportive classroom and schools that meet the needs of all children.

3.16 LET US SUM UP

In this unit we have discussed the following key points:

An exceptional child is one who deviates physically mentally, emotionally and socially from the normal children to such a marked extent that the child cannot benefit from the school instruction and requires modification in the school practices or special education programmes or supplementary instruction in order to develop to the child's maximum capacity.

Different categories of exceptional children such as gifted, backward, mentally retarded, physically and health handicapped, emotionally disturbed, learning disabled, speech handicapped and socially disadvantaged have been considered and discussed.

Educational programmes offered for these children include the following:

Special educational programmes consisting of specific curriculum, special instruction, specific facilities and special services for the exceptional children.

The introduction of integration and inclusive education as emerging concepts in the education for the exceptional children.

3.17 UNIT END QUESTIONS

1) Explain the types of exceptional children.
2) Who Are the gifted and the creative children? Describe their characteristics
3) Describe slow learners and backward children. Put forward a special educational programme for them
4) Describe the mentally retarded children. Desribe the causes thereof.
5) Explain about sensory handicapped.
6) What are the programmes provided for education of orthopedically and sensory handicapped children?
7) Explain the advantages of integration and inclusion approaches in the education of exceptional children.

3.18 GLOSSARY

Braille : Braille is a touch system used by the blind for reading and writing.

Exceptional child : Exceptional child is a child who has special needs according to his exceptionality and who cannot profit from school instruction but require modification in instructional programmes for the development of maximum capacity.

Inclusive education : Inclusive education welcomes all children into the classroom to meet the educational and other needs. Every exceptional child has access to free education in least restrictive and effective environment by focusing on quality of schooling.

Mainstreaming : Mainstreaming is on educational practice education are integrated for exceptional children but is limited to non academic activities for a part of the day. The normal age peers are educated and integrated with exceptional children in physical proximity but does not focus on quality of education.

Special education : Special education is a specially designed educational programme for the exceptional children to meet their special needs.

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UNIT 4 ASSESSMENT OF CHILDREN IN SCHOOLS FOR VARIOUS BEHAVIOUR PROBLEMS

Structure

4.0 Introduction
4.1 Objectives
4.2 Definition of a Behaviour Problem
4.3 Criteria of Problem Behaviour
4.4 Types of Behaviour Problems
  4.4.1 Uneven Development
  4.4.2 Arrested (or Regressional) Development
  4.4.3 Defective Development (Enduring Disabilities)
  4.4.4 Behaviour Problems in Children
4.5 Behavioural Assessment
  4.5.1 Behaviour Analysis and Assessment
4.6 The Method of Functional Behavioural Assessment
  4.6.1 Techniques for Conducting Functional Behavioural Assessment
  4.6.2 Behaviour Intervention Plan
  4.6.3 Possible Alternative Assessment Strategies
4.7 Assessment Techniques
  4.7.1 Interviews And Record Reviews
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4.8 Check Lists and Self Report Techniques
4.9 Let Us Sum Up
4.10 Unit End Questions
4.11 Glossary
4.12 Suggested Readings and References

4.0 INTRODUCTION

In this unit we will learn about what behaviour problem is, the type of behaviour problems commonly seen in children and their assessment in the school setting. Also the various techniques employed in assessment process will be discussed. The child is an important human resource of the nation. It needs to be nurtured with care and protected so that it will be able to develop to its maximum capacity. Childhood is a crucial period of growth and development that needs to be filled with joy and learning. When the course of development is interrupted by psychological problems, the child is often deprived of experiences that are important for psychological growth. In this unit we shall introduce you to the behaviour problems commonly seen in children. This will be followed by the behavioural assessment using various methods and techniques and the likely intervention to deal with them. All this will enable you to understand how to identify the causes of the behaviour problems and why the child behaves the

way he does. You will also learn to how to identify the interventions to deal with the problem behaviours.

4.1 OBJECTIVES

After learning all this you will be able to:

- Identify the different behaviour problems;
- Explain the causes and the context in which these behaviours occur;
- Describe a functional behavioural assessment;
- Analyse the appropriateness of various assessment techniques to collect information; and
- Elucidate the likely intervention plan to deal with the problems.

4.2 DEFINITION OF A BEHAVIOUR PROBLEM

A problem behaviour is a hindrance that disrupts the continuity of processes within the individual or in a group. As such any behaviour that disrupts the teaching, learning processes or that which disturbs the individual and group interaction or which disrupts the individual's ability to function adequately will constitute a behaviour problem. A behaviour becomes a problem when it goes to an extreme, when it persists and develops and results in maladjustments of the individual. For example, if a teacher comes across a boy in the class, who shows aggression on a certain day, it will not be regarded as a problem, but if this behaviour is repeated day in and day out, then it would indicate a chronic disturbances in the child, like deeper underlying tensions. But a serious single disturbance such as a serious temper tantrum or a serious lie may constitute a behaviour problem in the psychological sense of the term.

Another angle from which certain behaviour can be regarded as a problem is the socio-cultural norms of the group to which the child belongs. All the members of the group are expected to conform to certain norms or standard. The behaviour of an individual has to be acceptable by the group. As such repeated non-conformance to the group standards will lead to a behaviour problem which involves social objection or concern from people may be parents, teachers, associates or neighbours. Thus a behaviour problem is viewed as a discrepancy between the behaviour of a child and the demands-placed on him by his associates. If parents, teachers and companions do not expect a child to steal, stealing will be regarded by them as a behaviour problem, but stealing is not a problem if the social setup to which the child belongs, encourages stealing and other antisocial behaviour. The first view stresses on the individual and the forces within him whereas the second view brings out the importance of the forces outside the individual, the demands of people or society in the form of norms and value systems.

A behaviour problem is the resultant of both these forces. It is the outcome of the interaction of forces within the individual, his motives, wishes and desires, and those coming from his environment resulting in an inability to withstand a serious shock or prolonged strain or in maladjustments or attempts at making faulty adjustments.

4.3 CRITERIA OF PROBLEM BEHAVIOUR

Before labeling a behaviour as 'problem behaviour', it should always be considered against various criteria:

Adaptive behaviour criteria: In order to label a behaviour as adaptive, it should be age, sex and culturally appropriate.

Age-epoch: Wetting the bed is only a developmental milestone up to the age of the 1.5 yrs, but it is definitely abnormal after the age of 5 years. This is true of other habits like thumb-sucking or even stuttering.

Social and cultural background of the problem behaviour: Absence from school or not going to school may not even be recognised as abnormal by parents of some slum dwelling children.

Time and magnitude: certain behaviours occurring once or twice may not be regarded as problem behaviour. This criteria includes.

The frequency: Children may talk in sleep or even get up from sleep once in a few months or so. But they have to be recognised as "problems" only when they do it once in few days.

Intensity of symptom: An anger that boils up to violent, destructive behaviour or fainting spell is definitely abnormal.

4.4 TYPES OF BEHAVIOUR PROBLEMS

For further understanding and evaluating the problems of children some basic facts also need to be kept in mind and a behaviour could be checked against these. Remember that child's problems are usually transient by nature. This is so because, the child is essentially a growing organism with no fixed points of growth. Most of the limits of growth are reached at a much later date and thus they have great potentialities for overcoming their initial setback.

The principle of multiple causality and multiple effect: In school years, many factors like arrival of a new sibling, defective vision, fear of a class teacher etc., may all end up in one problem, namely, absence from school. Again one psychological factor like intense 'parental quarrelling' at home may be expressed in numerous forms of behaviour problems, e.g. nail biting, headache, quarrelsomeness at school and bed-wetting.

The pace of growth and development in skeletal, locomotor, social, emotional and intellectual field do not run exactly parallel. Limit of physical growth is usually reached in about 25 years with spurts in the first year, between 4th and 6th year and again between 12th and 18th year. Intellect grows rapidly during initial 4 to 5 years and then slowly to reach the peak between 16 and 18 years. Emotional growth is rapid in the first 5 years and then at the onset of adolescence and again around 25 years of age. But emotional maturity is achieved very slowly around 35 years of age., A child of four years may show skeletal growth of a four year old, social development of a three year old child. The important point to note is, how closely the growth levels approximate with chronological age level and in how many fields the growth profiles remain scattered.

Growth and development is usually not a smooth and continuous process. Rather, it exhibits a wave like pattern. There are cyclical rhythms of unrest and disequilibrium followed by periods of quiet consolidation. The sequences of these changes have been summarised by Ilg and Bates Ames (1980) as follows:

2 years	5 years	10 years	Smooth Consolidation
2.5 years	5.5 years	11 years	Breaking up
3 years	6.5 years	12 years	Rounded, balanced
3.5 years	7 years	13 years	Inwardised
4.5 years	9 years	15 years	Inwardised, Outwardised, Troubled
5 years	10 years	16 years	Smooth consolidated

A child may mistakenly be labeled as problematic if the child has been observed during one of these "unsettling cycles". There are individual variations in the ages mentioned above but all observant parents can easily notice the phenomenon of cyclical changes in their children.

The different pace of various developments, accident, injuries and illnesses as well as emotional development can lead to three types of situations.

- Uneven development
- Arrested development (temporary lag) and
- Defective development (enduring disability)

4.4.1 Uneven Development

A child of nine years, may be alright in his physical development but intellectually he may be like a eleven year old, but socially may be like a seven year old child and emotionally may be have emotionally like a six year old. This wide scatter may be particularly evident during one of the "unsettling cycles" and may also be caused by a variety of reasons. One need not panic unduly. Given enough time, encouragement and programmed opportunities for learning, the child may catch up with the average growth levels by twelve years of age, provided of course the intellectual growth of the child does not suffer.

4.4.2 Arrested (or Regressional) Development

After an accident, illness or emotional deprivation (even an imagined deprivation of love) a child often tends to slow down or even slip back in all aspects of intellectual, social and emotional responses. For example, the arrival of a new born or a change of school may cause relapse of bed wetting or stuttering. These situational reactions are indeed transient and with a little patient emotional support they overcome the problem within a few weeks or months.

4.4.3 Defective Development (Enduring Disabilities)

Brain damage due to head injury, infection of the brain or even genetic defect (like Mongolism or Tay Sach's disease) may leave permanent defects in the quality and quantity of development. These defects usually affect a large spectrum of cognitive functions.

Some problems are rooted in the child's maturational processes and some others, in their interactional processes (not always contributed by the child itself.). John

Bowlby, described five types of instinctual impulses in the infants which need be satisfied by the mother for a healthy growth. Sucking, clinging and following these three are physically directed to mother, while crying and smiling responses are intended to induce reactions in the mother. Unfortunately over these latter two reactions, the child has little control. If either of these two sets of responses is not satisfied, the child develops tension (Primary Anxiety). John Bowlby has also shown convincingly that sudden deprivation of maternal love within the first five years of life (loss or separation of parent) may permanently alter the child's emotional responsiveness to other human beings.

The child's language development and capacities for abstraction are somewhat limited and its ability to find substitute gratifications being very circumscribed, the child often expresses its problems as a physical complaint. For instanced if the child had not completed the school homework, the child may complain of tummy ache in the morning before going to school. This is called 'Somatisation' of psychological conflicts and tensions.

Many a times child exhibiting behaviours like bedwetting, stomachache, tension headache, breathing difficulty is rushed to a doctor for checking the physical symptom but which may be due to or a result of psychological factors like anxiety, tension, parental quarrel.

4.4.4 Behaviour Problems in Children

In the school setting children exhibit several behaviour problems. Some of the common ones are:

Temper tantrums: These are characterised by behaviours, such as shouting, screaming at the top of his voice, crying, throwing things, kicking with legs, stamping the foot on the floor when angry.

Aggressive reactions: are characterised by hostile disobedience, quarrelsome, physical and verbal aggressiveness, vengefulness and destructiveness. Hostile teasing other children is common.

Phobias or fears: fears when irrational and intense are called phobias like fear of strangers, school phobia, phobia of high places, spiders, dogs.

Depression: in children is characterised by behaviours such as withdrawal, crying, avoidness of eye contact, physical complaints, poor appetite and aggressive behaviour. In some cases suicide tendencies.

Oppositional Defiant behaviour: The child with this behaviour problem, frequently loses temper, argues with adults, is defiant towards authority figures refuses to comply with requests or rules, annoys others and blames others for its own mistakes and problems.

Attention Deficit Hyperactivity Disorder (ADHD): is characterised by in attention, hyperactivity and impulsivity.

Attention problem: This is characterised by the child's difficulty to keep attention focussed on tasks and thus this lack of attention interferes with the child's learning. The child is also not able to give attention to the tasks so that the assignments could be completed on time both at school and at home. Lack of attention also

leads to the failure to listen to instructions given by the teacher at school or pay attention to details.

Hyperactive behaviour: is overactive impulsive behaviour.

Withdrawing, Recessive Reaction: This is characterised by exclusiveness, detachment, sensitivity, shyness, timidity and a general inability to form close interpersonal relationships.

Over anxious reaction: This is characterised by chronic anxiety, excessive and unrealistic fears, exaggerated autonomic responses. He is self conscious, immature and lacks self confidence, conforming inhibited, dutiful, approval seeking and apprehensive in new situations and unfamiliar surroundings.

Stealing: Taking away things that belongs to others.

Lying: Saying things which are not true.

Disruptive behaviour: which interferes or creates obstacles or hinders others from performing tasks or activity.

Runaway reaction: is characterised by the child escaping from threatening situations by running away from home or school a day or more without permission. He feels rejected, inadequate and is friendless. He is immature and timid.

Group delinquent reaction: children with this problem have acquired values, behaviour and skills of a delinquent group or gang to whom they are loyal and with whom they characteristically steal, skip school and stay out late at night. Amongst these children, shop lifting is also common.

Acting out behaviour: In this the child tries to seek attention or approval from others by misbehaviour in the classroom.

It is common for children to violate or break rules or misbehave. But some display patterns of negativity hostility and defiance that are frequent, intense and disruptive than the norms. They are considered to have behaviour problems. Most of these problems emerge in preschool and elementary school years.

These problems lead to difficulty for the child in adjustment, makes the child inadequate, unhappy and uncomfortable. These behaviour problems have to be corrected by detecting the typical problems ahead in advance. If these problems are left untreated, they are likely to become more serious and chronic disorders as the child passes into adulthood.

To overcome these problems, one of the remedial measures is behaviour therapy which has been demonstrated time and again to be of value and quite effective in treating these problems. Before behaviour therapy begins, there must be a behavioural assessment. This assessment focuses on the causes of the behaviour and is highly specific. It assumes that the person is best understood and described by what he/she does in a particular situation. Also it is intervention oriented which necessitates the use of a variety of assessment procedures like interview, observation etc. for collecting information from multiple sources about the behaviour problems. The treatment strategies are individually tailored to different problems in different individuals.

Self Assessment Questions

1) A behaviour becomes a problem when it is ...., ..., ...

2) The factors lead to a behaviour problem are ....

3) Name five common behaviour problems of children.

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4.5 BEHAVIOURAL ASSESSMENT

In the early application of behaviour therapy in managing behaviour problems, assessment received little attention. Since 1970's the importance of assessment has become increasingly recognised. There are three major functions of assessment procedures in behaviour therapy, firstly assessment techniques help in defining the child's problem through a functional analysis of the problem behaviour. Such an analysis will fully specify the treatment objective such as overcoming a phobia or obsessive thoughts and include a description of the stimuli that elicit the target behaviour and the situations in which such behaviours occurs and the nature, magnitude and frequency of the particular behaviour. The second way in which assessment procedures can guide is in selecting the appropriate treatment. Thirdly assessment helps to assess the behaviour change that results from the treatment. Such assessment include techniques for monitoring change in order to permit the evaluation of treatment effectiveness and introducing alternative procedures and terminal measures to attain a satisfactory status and to plan for follow up procedures as needed.

4.5.1 Behaviour Analysis and Assessment

The term behaviour modification refers to a set of psycho therapeutic procedures based on the learning theory and designed to change inappropriate behaviour to more personally and socially appropriate behaviour. The inappropriate behaviour may be excesses, deficits or other inadequacies of actions that are correctable through behavioural techniques such as systematic desensitisation, counter conditioning and extinction. Much maladaptive behaviour like fears or phobias, overeating, anxiety, non assertiveness can be tackled with behaviour therapy.

i) *Behaviour Analysis:* To understand the problem behaviour we need to identify its antecedents, causes including both history, social learning and the current environment and the results or consequences of this behaviour. A fundamental principle of behaviour modification, based on operant learning, is that behaviour is controlled by its consequences. In designing a programme, to correct the problem behaviour, we need to identify not only the conditions that precede and trigger the behaviour but also the reinforcing consequences that sustain it. Using this approach the process of behaviour modification is preceded by a 'functional analysis' of the problem behaviour. The analysis

consists of A-B-C, sequence in which A stands for the antecedent conditions, B-the problem behaviour and C the consequences of this behaviour. B is modified by controlling A and altering C. The antecedents and consequences of the target behaviour may be overt objectively observable conditions or covert mental events reported by the person, whose behaviour is to be modified.

ii) *Behaviour Assessment:* This has multiple functions like identifying the target behaviour, alternative behaviours and causal variable, designing intervention strategies and revaluating target and causal behaviours (Haynes and Heiby, 2004). Various techniques are employed including observations and interviews in addition to check lists, rating scales and questionnaires completed by a person who is acquainted with the concerned child.

iii) *Observation method:* This is another assessment method, and is used in behaviour analysis by noting the frequency and duration of the target behaviour and the particular contingencies (antecedents and consequences) of their occurrence. Behaviour observations are recorded by the teacher or parent of the child.

To give an example, The number of times the child hits other children in 1hour, 2 hours etc.

iv) *Self monitoring:* This is perhaps the easiest and the most economical way to determine how frequently and under what conditions, a particular target behaviour occurs. Recording of the occurrence of the target behaviour, the time and place at which it occurs, the circumstances under which it occurs etc., can be to an extent done by the child if old enough and is able to understand what is required. Sometimes self monitoring can result in reducing the problematic behaviour.

v) *Behavioural interviewing:* Another method which is a part of assessment is a type of clinical interviewing in which the focus is on obtaining information to plan a program of behaviour modification. This entails objectively describing the problem behaviour as well as the antecedent condition and reinforcing consequences to the child (interviewee). After obtaining the necessary information, a programme of behaviour modification is developed and the child is asked to adhere to it.

Self Assessment Questions

1) In behaviour analysis, explain the terms A-B-C.

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2) What kind of problems do you feel are more appropriate for behavioural assessment?

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3) What are the various methods of assessment?

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4) Explain behavioural analysis and assessment.

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5) What is self monitoring?

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4.6 THE METHOD OF FUNCTIONAL BEHAVIOURAL ASSESSMENT

A functional behavioural assessment has to be conducted to identify the underlying causes of behaviour. One of the first steps is to define the problem behaviour so as to identify the same.

Thus the first step in the process is to define the problem behaviour in concrete terms. An example of concrete descriptions of problem behaviours aregiven below in the table.

Problem Behaviour	Concrete Definition
Sita is aggressive.	Sita hits other students during recess when she does not get her way.
Ram is hyperactive.	Ram leaves his assigned area without permission. Ram completes only a small portion of his independent work. Ram blurts out answers without raising his hand.

The child's behaviour has to be carefully observed in different situations and during different types of activities and interviews are conduct with other school staff and care givers to pinpoint the specific characteristics of the behaviour.

After defining the problem functional behavioural assessment is conducted to determine the functions of behaviour.

4.6.1 Techniques for Conducting Functional Behavioural Assessment

i) **Indirect Assessment:** This technique uses structured interviews with students, teachers and other adults dealing with the child to yield information about the setting in which

a) the behaviour occurs,

b) where it does not occur,

c) who is present when the behaviour occurs,

d) what activities or interactions took place prior to the behaviour

e) what happened after the behaviour

f) what can be the acceptable behaviour to replace this behaviour.

Interview with the child is useful in identifying how the child perceives the situation and what caused the child to react in the way it behaviour did things.

ii) **Direct assessment:** This involves observing and recording antecedent and consequence events behaviour using A-B-C approach.

iii) **Data Analysis:** The next step is to compare and analyse information collected to determine whether or not there are any patterns associated with the behaviour. To give an example, Sita gets what she wants by hitting other children. This is a typical pattern which gives the child not only what se wants but also makes her feel great about it and all these reinforces her behaviour of hitting other children to get what she wants.

However in certain cases the pattern may not be so clearly visible or observable, in such cases, other assessment methods for assessing behaviour have to be identified by reviewing and revising the functional behaviour assessment plan.

iv) **Hypothesis stated:** Based on the information obtained from analysis, hypotheses or what is called the tentative solutions have to be formulated regarding the functions of the behaviours in question. This hypothesis

predicts the conditions under which the behaviour is most and least likely to occur (antecedents) as well as the consequences that maintain the behaviour. For instance if a teacher's report is that 'Reena calls out during class instruction' a functional behavioural assessment might reveal that the function of the behaviour is to gain attention (verbal approval of classmates), avoid instruction or seek excitement or both, in order to gain attention and avoid less interest subject. Only when the relevance of the behaviour is known, can the function of the behaviour be verified and one can work out an individual behaviour intervention plan.

Manipulation of the various environmental conditions is done to verify the hypothesis regarding the function of the behaviour. In the above example, the teacher may make provision in the environment that Reena gets peer attention she seeks as a consequence of appropriate behaviours. If this manipulation changes Reena's behaviour, the hypothesis is proved correct. But if Reena's behaviour remains unchanged despite the environmental manipulation, a new hypothesis needs to be formulated using data collected during the functional behaviour assessment.

4.6.2 Behaviour Intervention Plan

After collecting data on the child's problem behaviour and after developing a hypothesis of the likely function of behaviour, a behaviour intervention plan for the child is developed. Intervention plan should not be based on one assessment alone or on data collected from only one observer. When designing behaviour intervention plan, one has to consider the following to address the disruptive behaviour:

1) Manipulate the antecedents and / or the consequences of the behaviour.
2) Teach more acceptable behaviours that serve the same function as the in appropriate behaviour.
3) Implement changes in the curriculum and instructional strategies and
4) Modify the physical environment.

4.6.3 Possible Alternative Assessment Strategies

Multiple sources and methods are used for this functional behavioural assessment, as a single source may not give accurate information because the functions of a problem behaviour vary according to the circumstance. When considering the problem behaviour we need also to know whether the problem is due to skill deficit. The child who lacks the skills to perform the expected tasks may exhibit behaviour that helps the child to avoid or escape those tasks or the problem may be due to performance deficit. (Non performance is rewarded or performance of the task is not sufficiently rewarded).

Based on the type of deficit that is linked to the problem behaviour an assessment plan has to be devised which will intimately lead to more effective behaviour intervention plan. The intervention plan should emphasise on the skills, the child needs to behave appropriately in providing motivation to conform to the required standards and not on controlling behaviour.

Thus functional behaviour assessment is an approach that incorporates a variety of techniques and strategies to diagnose the causes biological, social, emotional and environmental factors that imitate and sustain the behaviour. It helps and to

identify likely interventions to deal with the problems behaviours knowing why the child misbehaviours based on functional behavioural assessment in extremely useful in addressing a wide range of problems.

4.7 ASSESSMENT TECHNIQUES

There are varieties of techniques to be considered, when doing functional behavioural assessment. No single assessment is perfect. The major assessment procedures that can be used for behavioural problem, include interviews, record reviews, observation methods, check lists and rating scales. The choice of the procedure depends on the nature of the problem, characteristics which the child exhibits and the environment in which the client (child) must operate and the facilities available at the school. In most cases a combination of several assessment procedures is desirable.

4.7.1 Interviews and Record Reviews

These help to define the problem and provide a historical content for the problem. The record reviews describe incidental or behaviours observed in the particular child, parent or teacher in concrete narrative terms. These types of recording gives insight about the cause and effect by detailing what occurred before the problem behaviour took place, the behaviour itself and the consequences or events that occurred after the behaviour.

Both interviews and record reviews are used early in the assessment process because these procedures focus and inform the assessment process. However, assessors can use these procedures throughout the assessment process to refine and test their definition and hypotheses about the student's problem.

Also in behavioural consultation procedures, interviews are used to define the problem, analyse, the causes of the problem, select intervention and evaluate the intervention outcomes.

4.7.2 Observation Methods

Observation is used commonly as a part of the diagnostic assessment. Assessors use observation method to redefine their definition of the problem, generate and test hypotheses about why the problem exists, develop intervention within the classroom and evaluate the effects of an intervention.

Observation can be informal (indirect) or formal (direct). Informal or indirect observation is conducted in a naturalistic situation by the teacher. It provides narrative, qualitative records of the data for understanding a problem. The assessor can evaluate the child's behaviour in the context in which the behaviour occurs, helps to compare his behaviour to that of his peers (that determine what typical for that classroom) and detect environmental factors that might contribute to the behaviour problem.

The formal or direct observation is behavioural observation for recording the frequency, intensity and duration of the target behaviours. Multiple observation strategies should be used to record multiple aspects of multiple behaviours simultaneously. Formal observation helps to monitor change over time and circumstances and focuses on factors relevant to take problem at hand. These observations are done in multiple sessions to have stability over time.

Both the formal and informal observation methods should be used to identify the problem, develops hypotheses, suggest intervention and monitor the child's responses to classroom changes.

Both observation method and interviewing are used in behaviour analysis and in designing behaviour modification programmes.

4.8 CHECK LISTS AND SELF REPORT TECHNIQUES

School based psychological assessment also gathers information directly from the informants in the assessment process. In addition to interviews, the assessors use checklists to get the parent and the teacher perspectives on the child's problems. Self reports of behaviour are also used from students to help them monitor and identify the problem. Checklists are designed to identify behaviour problems in children. A checklist requires the observer to note whether a particular characteristic is present or absent.

A rating scale requires the observer to note the degree to which a characteristic is present or how often the behaviour occurs.

Child behaviour checklist – Teacher's Report form (Achenbach and Edelbrock 1986) is completed by the teacher. It provides a picture of problem behaviours and adaptive behaviours of children in the school settings.

Revised Behaviour Problem Checklist (RBPC) - can be used to screen behaviour disorders in school and to measure behaviour change associated with psychological intervention. It identifies conduct disorders, aggression and attention problems, immaturity anxiety, withdrawal; motor tension excess etc.

Other Checklists

Connors Rating Scale (1997) gives specific information for hyperactivity. Checklists developed by March (1997) for anxiety, Reynolds (1987) for depressions Murell and Walters (1998) for internalising disorders like aggression. Checklists are most useful for differential diagnosis because they tell us the degree of a typical behaviour the child has, with respect to the age or grade level peers. For example, severe emotional disturbance and mental retardation.

Peer nomination: Peer nomination instrument is one form of checklist or rating system that is unique to the schools. The students are asked to respond to items like who in your classroom is most likely to fight with others or who would you like to work with to identify maladaptive and prosocial behaviours. These are generally reliable and stable over time.

Self Report by the client comprises a diversity of techniques such as interviews, self monitoring records of the target behaviours and associated conditions by the client and checklists and inventories. Self report inventories are used for preliminary screening, identification and for monitoring target behaviours.

Other instruments like objective *rating scales* can be completed by multiple informants.

Behaviour Rating Scale (Reynolds and Kamhaus (1992) for teachers can be used to record direct observations of classroom behaviours.

The **Social Skills Rating system by Gresham and Elliott (1990)** for parents and teachers to evaluate problem behaviours of students in educational and family settings.

It provides linkage of assessment result with planning of intervention strategies. The use of self report and checklist instruments in schools help to screen programs for prevention and early intervention. E.g. Reynolds Adolescent Depression scale in the school setting can help the psychologist to intervene prior to the onset of various symptoms.

Psychological assessments in schools prefer more objective approaches to assess behaviour problems than to use projective techniques. However, a projective test like Draw a person test developed by Naglieri, Mc Neish and Bardos (1991) may be used as a screening test for children suspected of behaviour problems and emotional disturbances.

Self Assessment Questions

1) What is functional behavioural assessment?

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2) What is direct and indirect observation?

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3) Name two checklists they can be used for assessing children problem behaviour.

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4.9 LET US SUM UP

In this unit we have learnt about the following:

The behaviour problem is any behaviour which is disruptive persistent and intense and against the norms of the group to which the child belongs and makes the child inadequate unhappy, discomfort able and leads to difficulty in adjustment.

Some common behaviour problems observed in children such as temper tantrums aggressiveness, fears, or phobias, disruptive behaviour, attention problem, hyperactive, impulsiveness, withdrawal behaviour, acting out behaviour, oppositional defiant behaviour, lying, stealing, running away, depression and gang delinquent behaviour etc.

These problems are assessed through functional behavioural assessment before behaviour therapy is given.

Functional behavioural assessment involves behaviour analysis and behaviour assessment. Behaviour analysis consists of identifying the antecedent conditions and the consequences of the target problem behaviour using an A-B-C approach. Both observation and interviewing are used in behaviour analysis and in designing behaviour modification program.

Behavioural assessment is done through various techniques like observation methods. Self monitoring and behavioural interviewing.

The different assessments techniques such as interviews and record reviews, observation methods, checklists and self report techniques that can be used in school based assessment for various behaviour problems in children.

4.10 UNIT END QUESTIONS

1) What is Behaviour Problem?
2) Explain some common behave problems seen in elementary school children.
3) Explain the procedure for conducting a Behavioural Assessment.
4) Describe the different techniques that are employed in the Assessment process.
5) Differentiate between Behaviour Analysis and Behaviour Assessment.

4.11 GLOSSARY

Assessment : is an intensive study of an individual by gathering information from multiple sources interpreting the results and making suggestions and recommendations about the case and persistent.

Phobia : Is an persistant irrational fear of a specific object, activity or situation.

Counter Conditioning : A procedure that replaces an anxiety response to a stimulus with a pleasure or relaxation response.

Behaviour Therapy : A method of treatment for specific problem that uses the principles of learning theory.

Extinction : A process in which a conditioned response is reduced to its preconditioned level. Previously reinforced responses are no longer reinforced.

Systematic desensitisation : A behaviour therapy technique in which the patient while in the relaxed state, imagines anxiety provoking stimuli or presented with the actual stimuli, progressing from the least to the most feared situations. The patient learns to remain relaxed- a response that should carry over to real life situations.

Functional behavioural assessment : It is an approach that uses a variety of techniques and strategies to diagnose the causes of the problem behaviour and identify the likely intervention to deal with the behaviour problem.

4.12 SUGGESTED READINGS AND REFERENCES

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UNIT 1 CLASSIFICATION OF DISORDERS IN CHILDREN IN SCHOOLS

Structure

1.0 Introduction

1.1 Objectives

1.2 Problem Behaviours in School Children

- 1.2.1 Definition and Meaning of Problem Behaviour
- 1.2.2 Definition of Problem Behaviour
- 1.2.3 Conducting a Functional Behavioural Assessment
- 1.2.4 Identifying the Problem Behaviour
- 1.2.5 Possible Alternative Assessment Strategies
- 1.2.6 Problem Behaviour Linked to a Skill Deficit
- 1.2.7 Techniques for Conducting the Functional Behavioural Assessment

1.3 Different Types of Behaviour Problems

1.4 Classification of Disorders in Children as per the Standard Classification System

- 1.4.1 Attention Deficit Hyperactivity Disorder
- 1.4.2 Etiology of ADHD
- 1.4.3 Autism
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- 1.4.10 Mixed Receptive Expressive Language Disorder
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- 1.4.12 Pervasive Developmental Disorder
- 1.4.13 Reactive Attachment Disorder
- 1.4.14 Rett Syndrome
- 1.4.15 Selective Mutism
- 1.4.16 Separation Anxiety Disorder
- 1.4.17 Stuttering

1.5 Let Us Sum Up

1.6 Unit End Questions

1.7 Suggested Readings

1.0 INTRODUCTION

This unit deals with problem behaviours in school children. It starts with definition and meaning of problem behaviours and conducting a functional behavioural assessment to ascertain the problem behaviour. T also presents the alternative assessment strategies. The problem behaviour linked to skill deficit is then taken up and discusses the techniques for conducting functional behavioural assessment. The unit then presents the different types of problem behaviours manifested in children which includes ADHD, Asperger syndrome, ODD etc.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define the psychological disorders of school children;
- Differentiate one psychological disorder from another;
- describe each of these childhood behaviour disorders;
- classify the disorders of childhood; and
- Analyse and present the causes of the various disorders.

1.2 PROBLEM BEHAVIOURS IN SCHOOL CHILDREN

1.2.1 Definition and Meaning of Problem Behaviour

Many children who go to the school are expelled by the school authorities as they are found to be out of control and highly indisciplined. This could be due to the behaviour problems that they exhibit. This has attracted the attention of parents, educational as well as correctional institutions, because in the present day it appears that incidences of such problems are on the increase and many students exhibit serious psychological problems at later stages of their lives.

Many of these children are put on medication to control these behaviours. This has also raised serious debates due to the risks involved in it. Therefore, the present unit focuses on the understanding of these problem behaviours.

It is well known that many children behave badly from time to time, exhibiting occasional temper tantrums, aggression and defiance of authority. In the adolescent years many of them show good amount of rebelliousness and in most cases these are considered as a normal part of growing up.

Therefore, it is indeed a difficult task to label particular behaviour as 'problematic' or call them as 'disorders' as the behaviours of children change quite dramatically as they keep growing into adolescence and into adulthood. Also there are certain age level at which certain problems become conspicuous but as children grow up these problems invariably disappears.

However, for practical reasons we need to define them. A behaviour may be considered problematic for various reasons. This could be because of the fact that its occurrence is strikingly different in terms of frequency or duration from what is seen in other children of the same age group. When the behaviour occurs with very high frequency or duration it is called an 'excessive' behaviour and when occurs at very low rate, called deficit behviour. Some behaviours are as such so inappropriate or peculiar for the situation that they look abnormal.

Such behaviours are called 'behaviours with 'inappropriate stimulus controls'. This means that the behaviour is triggered by stimuli which are not appropriate. A problematic behaviour is always interpreted as normal or abnormal with reference to the context of the socio-cultural, setting in which it occurs, the developmental age of the child.

For diagnostic purpose, such behaviour is considered to be problematic if persists for a long period of time (e.g. lasts for 6 months or more) and severe enough to disrupt life at home school or in the community. Apart from such social distress, problem behaviours may be reflected in personal distress to the child himself affecting his/her emotions, development and socialisation. Therefore, study of problematic behaviour of children deserves legitimate scientific attention.

1.2.2 Definition of Problem Behaviour

i) Problem behaviour is troublesome, risk taking, or disruptive behaviour that is more extreme than occasional errors in judgment and requires professional intervention to avoid legal difficulties.

ii) Problem behaviour is also termed as Behaviour problem, behavioural problem, behaviour problems.

iii) Problem behaviour is often associated with adolescence but may manifest in the very young or in adults. Delinquency, drug use, academic failure, risky sexual behaviour, violence, property damage, vandalism and disregard of the rights of others are all problem behaviours. Because of changes within the brain and social issues that contribute to lack of control, problem behaviour rises dramatically in early adolescence. The rate of problem behaviour tends to fall after age 23 years.

There is no universally accepted definition of Behaviour Problem. Professional groups and experts have felt free to construct individual working definitions to fit their own professional purposes.

There is general agreement that Behaviour Problem refers to the following:

- Behaviour that goes to an extreme: behaviour that is not slightly different from the usual.
- A problem that is chronic: one that does not quickly disappear.
- Behaviour that is unacceptable because of social or cultural expectations.

Different types of definitions of problem behaviour are available and these include the following:

Operational definition of problem behaviour: An operational definition describes the behaviour in terms of what is observed and seen. It is an explicit definition that two or more disinterested observers would be able to identify. Academic goals should also be operationally defined in that one defines the academic behaviour the child should exhibit. Objectivity, clarity and completeness are important for operational definition. Any problem behaviour has to be clearly spelt out in terms of the number of times it occurs, and whether it is measurable and if so in terms of which measuring instrument etc. For instance, temper tantrum as a behaviour problem can be operationally defined in terms of the time at which it occurs, the number of times it occurs and the typical manner in which it occurs and how intense it is and when and how does it stop.

Professional definition of problem behaviour: Professional definition of problem behaviour takes into account the many behaviours that need to be intervened with which are causing problems to the individual as well as to others

around. Thus in terms of professional definition, the Problem behaviour is troublesome, risk taking, or disruptive behaviour that is more extreme than occasional errors in judgment and requires professional intervention to avoid legal difficulties. Such a definition of problem behaviour is often associated with adolescence but may manifest in the very young or in adults. Delinquency, drug use, academic failure, risky sexual behaviour, violence, property damage, vandalism and disregard of the rights of others are all problem behaviours.

Administrative definition of problem behaviour: Before a functional behavioural assessment can be implemented, it is necessary to pinpoint the behaviour causing learning or discipline problems, and to define that behaviour in concrete terms that are easy to communicate and simple to measure and record. If descriptions of behaviours are vague (e.g., poor attitude), it is difficult to determine appropriate interventions. Examples of concrete descriptions of problem behaviours are what exactly the individual does and what behaviour he manifests which needs administrative interventions.

Having defined the problem behaviour let us see how these behaviour problems could be assessed before any intervention could be worked out for the same.

Self Assessment Questions

1) What is a problem behaviour?

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2) What is ICD-10?

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3) Classify the problem behaviours found during childhood.

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1.2.3 Conducting a Functional Behavioural Assessment

(**Source:** Prepared by the Center for Effective Collaboration and Practice, USA.)

Identifying the underlying causes of behaviour may take many forms; and, while the Amendments to IDEA advise a functional behavioural assessment approach (which could determine specific *contributors* to behaviour), they do not require or suggest specific techniques or strategies to use when assessing that behaviour. While there are a variety of techniques available to conduct a functional behavioural assessment, the first step in the process is to define the behaviour in concrete terms. In the following section we will discuss techniques to define behaviour.

1.2.4 Identifying the Problem Behaviour

Before a functional behavioural assessment can be implemented, it is necessary to pinpoint the behaviour causing learning or discipline problems, and to define that behaviour in concrete terms that are easy to communicate and simple to measure and record. If descriptions of behaviours are vague (e.g., poor attitude), it is difficult to determine appropriate interventions. Examples of concrete descriptions of problem behaviours are:

Problem Behaviour	Concrete Definition
Trish is aggressive.	Trish hits other students during recess when she does not get her way.
Carlos is disruptive.	Carlos makes irrelevant and inappropriate comments during class discussion.
Jan is hyperactive.	Jan leaves her assigned area without permission.
	Jan completes only small portions of her independent work.
	Jan blurts out answers without raising her hand.

It may be necessary to carefully and objectively observe the student's behaviour in different settings and during different types of activities, and to conduct interviews with other school staff and caregivers, in order to pinpoint the specific characteristics of the behaviour.

Once the problem behaviour has been defined concretely, the team can begin to devise a plan for conducting a functional behavioural assessment to determine functions of the behaviour. The following discussion can be used to guide teams in choosing the most effective techniques to determine the likely causes of behaviour.

1.2.5 Possible Alternative Assessment Strategies

The use of a variety of assessment techniques will lead teams to better understand student behaviour. Each technique can, in effect, bring the team closer to developing a workable intervention plan.

A well developed assessment plan and a properly executed functional behavioural assessment should identify the contextual factors that contribute to behaviour.

Determining the specific contextual factors for a behaviour is accomplished by collecting information on the various conditions under which a student is most and least likely to be a successful learner. That information, collected both indirectly and directly, allows school personnel to predict the circumstances under which the problem behaviour is likely and not likely to occur.

Multiple sources and methods are used for this kind of assessment, as a single source of information generally does not produce sufficiently accurate information, especially if the problem behaviour serves several functions that vary according to circumstance (e.g., making inappropriate comments during lectures may serve to get peer attention in some instances, while in other situations it may serve to avoid the possibility of being called on by the teacher).

It is important to understand, though, that contextual factors are more than the sum of observable behaviours, and include certain *affective* and *cognitive* behaviours, as well. In other words, the trigger, or antecedent for the behaviour, may not be something that anyone else can directly observe, and, therefore, must be identified using indirect measures. For instance, if the student acts out when given a worksheet, it may not be the worksheet that caused the acting-out, but the fact that the student does not know what is required and thus anticipates failure or ridicule. Information of this type may be gleaned through a discussion with the student.

Since problem behaviour stems from a variety of causes, it is best to examine the behaviour from as many different angles as possible. Teams, for instance, should consider what the "pay-off" for engaging in either inappropriate or appropriate behaviour is, or what the student "escapes," "avoids," or "gets" by engaging in the behaviour. This process should identify workable techniques for developing and conducting functional behavioural assessments and developing behaviour interventions. When considering problem behaviours, teams might ask the following questions.

1.2.6 Problem Behaviour Linked to a Skill Deficit

Is there evidence to suggest that the student does not know how to perform the skill and, therefore cannot? Students who lack the skills to perform expected tasks may exhibit behaviours that help them avoid or escape those tasks. If the team suspects that the student cannot perform the skills, *or has a skill deficit,* they could devise a functional behavioural assessment plan to determine the answers to further questions, such as the following:

Does the student understand the behavioural expectations for the situation?

Does the student realise tht he or she is engaging in unacceptable behaviour or has that behaviour has become a habit?

Can the student control that behaviour?

Does the student have skills necessary to perform expected new behaviours?

Sometimes it may be that the student can perform a skill, but, for some reason, does not use it consistently (e.g., in particular settings). This situation is often referred to as performance deficit. Students who can, but do not perform certain tasks may be experiencing consequences that affect their performance (e.g., their non-performance is rewarded by peer or teacher attention, or performance of the

task is not sufficiently rewarding). If the team suspects that the problem is a result of a *performance deficit*, it may be helpful to devise an assessment plan that addresses questions such as the following:

Clapping and shouting and cheering a person loudly etc., are appropriate in the sports field but not in the classroom. Does the student realise this and understand?

Would the student like to engage in appropriate behaviour?

Is the problem behaviour associated with social and environmental factors?

Addressing such questions will assist in determining the necessary components of the assessment plan, and ultimately will lead to more effective behaviour intervention plans. Some techniques that could be considered when developing a functional behavioural assessment plan are discussed in the following section.

1.2.7 Techniques for Conducting the Functional Behavioural Assessment

There are two techniques of assessment; one is indirect assessment and the other direct assessment.

Indirect or informant assessment: This relies heavily upon the use of structured interviews with students, teachers, and other adults who have direct responsibility for the students concerned. Individuals should structure the interview so that it yields information regarding the questions discussed in the previous section. Interviews with the student may be useful in identifying how he or she perceived the situation and what caused her or him to react or act in the way they did.

Also commercially available student questionnaires, motivational scales, and checklists can also be used to structure indirect assessments of behaviour. The district's school psychologist or other qualified personnel can be a valuable source of information regarding the feasibility of using these instruments.

Direct assessment: This involves observing and recording situational factors surrounding a problem behaviour (e.g., *antecedent* and *consequent* events). An evaluator may observe the behaviour in the setting that it is likely to occur, and record data using an Antecedent-Behaviour-Consequence (ABC) approach.

The observer also may choose to use a *matrix* or *scatter plot* to chart the relationship between specific instructional variables and student responses. Regardless of the tool, observations that occur consistently across time and situations, and that reflect both quantitative and qualitative measures of the behaviour in question, are recommended.

Data analysis: Once the professional or the counsellor is satisfied that enough data have been collected, the next step is to compare and analyse the information. This analysis will help to determine whether or not there are any patterns associated with the behaviour (e.g., whenever Kanika does not get her way, she reacts by hitting someone).

If patterns cannot be determined, the team should review and revise (as necessary) the functional behavioural assessment plan to identify other methods for assessing behaviour.

Hypothesis statement: Drawing upon information that emerges from the analysis, school personnel can establish a hypothesis regarding the function of the behaviours in question. This hypothesis predicts the general conditions under which the behaviour is most and least likely to occur (antecedents), as well as the probable consequences that serve to maintain it. For instance, should a teacher report that Kanika calls out during instruction, a functional behavioural assessment might reveal the function of the behaviour is to gain attention or avoid instruction or seek excitement or both to gain attention and avoid a low interest subject.

Only when the relevance of the behaviour is known it is possible to speculate the true function of the behaviour and establish an individual behaviour intervention plan.

Many products are available commercially to help the counsellor assess behaviours in order to determine their function.

During school age children exhibit a number of behaviour problems. Some of these problems are so severe that they affect their families and those who are in close acquaintance such as neighbors or peers.

Childhood behaviour problems are different from those of adult problems in terms of their manifestation as well as etiology. Therefore diagnosis and treatment of children with mental and emotional disturbances is necessarily different from that used with adults.

The child lives through critical phases of development, which influence her behaviour. Schooling is one of the major event in child's life. Children enter to schools at 3-4 years of age. With progress of schooling, they are required to spend increasingly more amount of time in learning environment that requires acquisition of new sets of academic and social skills. Most children learn to accommodate themselves well to this changing nature of skill demand, but some of these children find it difficult to do so. Further, much problematic behaviour which go unnoticed, even tolerated in home-setting, become more conspicuous in the school environment due to competition and frequent evaluation. Some of the commonly occurring problematic behaviours are attention deficit hyperactive disorder, learning disability, bullying and delinquent behaviour.

Critical information about the child's behaviour from the significant others who are in close contact with the child, such as parents, teachers and peers.

Self Assessment Questions

1) What is functional assessment?

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2) What are the techniques of assessment?

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1.3 DIFFERENT TYPES OF BEHAVIOUR PROBLEMS

There are wide range of problem behaviours seen in children. However, the main categories of problems/ disorders used by professionals are developmental (which involve delays in development as feeding, including anorexia nervosa, bulimia, elimination, such as bowel or bladder problems, intellectual, social, educational adaptation such as learning disabilities, hyperkinesis such as overactivity, impulsivity, attention deficits); conduct (disruptive behaviour, disobedience, stealing, defiance, fire-setting, aggression, anti-social behaviour, etc.); emotion (anxiety states, phobias, depression); habit (tics, sleeping problems); post-traumatic stress and adjustment (e.g. difficulty chronic fatigue syndrome etc.); psychotic (schizophrenia, manic depressive disorder) etc.

While diagnosing these behaviour disorders, the stage of development, severity, complexity, persistence are taken into consideration. The effects of such problematic behaviours on other spheres of life are also important to understand. Many of these disorders may cause secondary handicaps in children. While identifying such problem behaviours one should also look into the possible 'stressors' in the environment that may enhance the risk of maintaining as well as worsening the behaviours and the protective factors that may help in ameliorating such problems.

Thus children exhibit a wide range of behaviour problems. Earlier, these problems used to be broadly described as either neuroses or psychoses. Neuroses refer to relatively milder forms of mental disorders whereas psychoses refer to rather severe ones. Neuroses included disorders of habit, affect and conduct. Some of them are described as anxiety disorders, phobic disorders, obsessive compulsive disorders and so on, whereas, psychoses affect their perception, thinking, or belief systems. One may have hallucinations (a disorder of perception: e.g. hearing voices when none is speaking) and delusions (disorders of belief: i. e false beliefs that cannot be changed by reason, for instance the delusion that someone is trying to poison him/her). The psychotic disorders included schizophrenia, delusional disorder, affective disorders etc.

Sometimes mental disorders are also classified broadly as organic and functional on the basis of their etiology, depending whether they have biological bases or have psychosocial or environmental causes. However, making such clear distinction between the two is often difficult in case of many mental disorders.

Now, the term 'neurosis' is rarely used for its dubious connotations. Diagnoses of mental disorders are focused on behavioural, affective and motor symptoms instead of their causes. Based on this, child behaviour problems may be classified under two broad groups: (i) internalising problems and (ii) externalising problems.

While internalising problems may be severely disturbing to the individual himself/ herself who suffers from it, externalising problems are those which can be extremely disturbing for others. There are several classification systems available for classification of specific childhood disorders. Out of which, the most widely used ones are: (1) International Classification of Disease (ICD) and (2) Diagnostic and Statistical Manual (DSM).

ICD has been recognised as a diagnostic system which is used all over the world. Its revised editions are published from time to time. The last revised edition was ICD-10 (WHO).

In the subsequent section, we shall discuss some of the most common childhood behaviour disorders

1.4 CLASSIFICATION OF DISORDERS IN CHILDREN AS PER THE STANDARD CLASSIFICATION SYSTEM

1.4.1 Attention Deficit Hyperactive Disorder (ADHD)

Attention Deficit Hyperactive Disorder (ADHD) is one of the most frequently occurring childhood behaviour disorders. This is characterised by inattentiveness (i. e short attention span), over activity, and distractibility. Most children up to the age of 3 or 4 years show remarkable levels of restlessness. However, it declines with age. As they grow older, become more stable.

Therefore, while considering a child to be 'hyperactive' one must carefully contrast him/her with other children of the same age group. There are different symptoms of this disorder, such as:

1) ADHD: Primarily Inattentive
2) ADHD: Primarily Hyperactive Impulsive Type,
3) ADHD: Combined Type

These classifications are made on the basis of predominance of the types of symptoms. Children of inattentive subtypes have difficulty in sustaining their attention. They have poor attention to details and distractibility. Their activities are often disorganised. They are often forgetful and leave many activities incomplete, make many silly mistakes in school work.

Due to poor attention, they fail to comprehend long instructions, even avoid activities that require sustained attention. Common extraneous stimuli such as noise in the classroom, or sound of the vehicles at a distance easily distract them. The hyperactive/impulsive type of children have problem in staying seated, fidgety, engage in excessive movement, enjoy loud play, always on the go, highly talkative, act before thinking, have difficulty in turn-taking etc.

Also, ADHD is often associated with many other psychological problems like specific learning disabilities, conduct disorder, depression, anxiety, and even sleep disorders. The third type of ADHD i.e combined type is characterised by combination of symptoms of both of the above.

A few years back investigators suspected this condition to be due to brain damage as certain types of brain diseases cause hyperactivity (and therefore) it is considered as a 'soft' neurological sign, suggestive of brain damage or brain dysfunction.

Since most children exhibit attention deficit and hyperactivity during childhood, careful assessment is required for diagnosis. Further, all children with hyperactivity do not exhibit the same kinds of problems although many are common among them. For example, most of them often fidget with hand or feet, fail to sit at one place, report difficulty in concentrating or actually found to be unable to concentrate. Smaller distraction from the environment disturbs them.

They often answer questions before it is completed and fail to complete the tasks given to them, as they switch over from one task to the other. It causes tremendous management problem in the classroom as well as in home setting. Excessive talk, interrupting others activities are some of the commonly associated problems with ADHD.

1.4.2 Etiology of ADHD

ADHD is a highly heritable disorder. However, it can also be acquired, and some individuals have a combination of genetic and acquired ADHD. At the present time, it is not possible to distinguish between these two types of ADHD. They both look the same, and both usually respond to treatment with the same psychostimulant medication.

Genetics of ADHD

ADHD is, in most cases, of familial origin. Parents with ADHD have a better than 50% chance of having a child with ADHD, and about 25% of children with ADHD have parents who meet the formal diagnostic criteria for ADHD. Twin studies have placed the heritability of ADHD in the range of 80%. In a longitudinal twin study examining the size of genetic and environmental effects on ADHD behaviours based on maternal report at the ages of 3, 7, 10, and 12 years, the estimate of heritability was nearly 75% at each age. The genetic factors explained 76% and 92% of the covariance between hyperactivity and inattention. This provides another line of support for the observation that behaviours related to ADHD (inattention to a greater extent than hyperactivity) do not improve with maturation.

ADHD can be considered a disorder of neurotransmitter function, with particular focus on the neurotransmitters dopamine and norepinephrine. There has been extensive research conducted that demonstrates that dopamine is critical in the regulation of learning, as well as maintaining trained or conditioned responses and motivated (goal-directed) behaviours. Dopamine also plays an important role in working memory, the ability to "keep something in mind" for a brief period of time. Thus, dopamine can modulate neuronal activity related to motor activity that is guided by external cues and is goal directed Norepinephrine (noradrenaline) is involved in maintaining alertness and attention. Psychostimulant

medications that increase the amount of central dopamine and norepinephrine are typically the most effective way to treat ADHD.

Genetic studies of ADHD have focused on genes involved in the regulation of neurotransmitter function, mainly related to dopamine, although some studies have also examined the role of norepinephrine and other neurotransmitters. Many different processes are involved in neurotransmission. It is unlikely that a single gene will be linked to ADHD.

ADHD might be due to the interaction of several different genes involved in the function of several different neurotransmitters.

Acquired Brain Lesions and ADHD

The behaviours associated with ADHD can also arise from environmental factors that disrupt normal brain growth, before, during, and after birth. Such insults give rise to behaviours that are indistinguishable from the behaviours seen in ADHD of genetic origin. It is not unusual to see individuals who have both a genetic and an acquired form.

Multiple pre- and perinatal factors can result in ADHD. One such factor is fetal alcohol syndrome, which results in significant inattention, impulsivity, and hyperactivity in the child. Exposure of the fetus to alcohol is associated with a reduction in the volume of the prefrontal and temporal cortices—the brain areas involved in regulation of attention and control of impulsivity. Maternal smoking has been linked with ADHD. Even though women with ADHD are at increased risk of becoming smokers and the child's ADHD might be genetic, exposure of the fetus to cigarette smoking confers an increased risk. One study found a fourfold higher risk of ADHD in the offspring of smokers, even after controlling for maternal ADHD. Metabolic disorders of the mother (e.g, diabetes, phenylketonuria) can also result in an ADHD-like picture in the infant

The dopamine system is exquisitely sensitive to hypoxia, particularly in the fetus or infant. Thus, any events pre- or postnatally that disrupt the flow of blood or oxygen to the brain might set the stage for later ADHD behaviours. This observation is supported both by laboratory studies and a study of ex-premature infants who had documented cerebral ischemia at birth and were re-examined in early adolescence.

Iron deficiency is associated with disruption of the dopamine system and more extensive neurodevelopmental problems. It is rarely a cause of ADHD because most children in the United States receive diets with adequate iron.

Injury to the medial temporal lobe during early development is also associated with ADHD-like behaviours later in development, possibly because of the disruption of dopamine regulation in the dorsolateral prefrontal cortex. This has been shown in nonhuman primates and children with temporal lobe cysts.

Hyperbilirubinemia (jaundice) in the newborn period can evolve into an ADHD-like picture later in childhood. In the past, before effective treatments were developed, neonatal hyperbilirubinenia resulted in severe and irreversible damage to the basal ganglia (specifically the globus pallidus and subthalamic nucleus). (Bilirubin is a mitochondrial poison and affects calcium homeostasis, resulting in neuronal death.) However, it has become apparent that even moderate levels

of bilirubin in otherwise healthy infants might not be as benign as previously believed.

Any injury to the brain that affects the prefrontal-subcortical circuits can result in an ADHD-like picture. Traumatic injury often involves damage to the tips of the frontal lobes or shearing of white-matter tracts and often results in ADHD-like behaviours. In one study comparing monozygotic twins who were discordant for ADHD, caudate lesions were observed in the twin with ADHD. Similarly, children who have suffered strokes, particularly those involving subcortical areas in the prefrontal-subcortical circuits, not infrequently manifest ADHD-like behaviours. In one study, nearly half of the children developed ADHD following stroke, and there was a strong correlation between lesions of the putamen and ADHD symptomatology. Meningitis and encephalitis are also associated with ADHD-like behaviours. Autoimmune disorders have also been implicated in triggering ADHD-like symptoms in susceptible patients. Pediatric autoimmune neuropsychiatric disorder associated with streptococcus (PANDAS) is linked to Tourette syndrome, obsessive-compulsive disorder, and ADHD. Lyme disease has also been associated with a number of neuropsychiatric symptoms, including those of ADHD.

The role that environmental factors play in ADHD should not be minimised. Early deprivation can result in ADHD symptoms in later childhood (increased rates of attention deficit and hyperactivity have been observed in children who were raised in institutions). These children also have a somewhat different set of associated psychiatric disorders than children with genetic ADHD and have disturbed attachment. Children who grow up in chaotic environments often have difficulty regulating attention, impulsivity, and emotionality. The risk of ADHD is proportional to the number of adverse factors (e.g., poverty, maternal psychopathology, paternal criminality) that are present.

1.4.3 Autism

This manifest in early infancy with the infants shying away from parent's touch, not responding to parents call etc. They also show inappropriate gaze behaviour. The child may show developmental delays in milestones.

1.4.4 Asperger's Disorder

This is a separate autistic spectrum disorder which does not meet criteria for other pervasive developmental disorders or schizophrenia. Features of Asperger's disorder includes severe and sustained impairment in social interaction, repetitive patterns of behaviour, interests and activities and significant impairment in social, occupational and other important areas of functioning.

1.4.5 Childhood Disintegrative Disorder

Up to two years of age children have normal development. They then become impaired in social, communication, restricted receptive language or stereotyped movements. Though the age of onset is later, in the most severe cases these children resemble autistic children. CDD is also known as Heller's disorder.

1.4.6 Feeding and Eating Disorders

There are 3 feeding and eating disorders of infancy or early childhood.

i) Pica

ii) Rumination disorder

iii) Feeding disorder of infancy and childhood.

1.4.7 Conduct Disorder

In this disorder the individual violates social norms and rights of others. Those with conduct disorder are most of the time in trouble with parents or teachers of peers. Conduct disorder may lead to adult anti social personality disorder.

Disorder of conduct is seen in 2-16 per cent of school going children. This is considered as a set of externalising negativistic behaviours in children, much more serious disorder than the other forms of childhood disorders as it violates the basic rights of others and also the societal norms expected from a child of his/her age. This is a repetitive and persistent pattern of behaviour, characterised by aggression, destruction of property, theft and serious violation of rules. These children are often reported to be bullying and threatening other children, engage in frequent fights and carry weapons. Cruelty to people or animals, destruction property is some of the other behaviours seen in children with conduct disorder. Some of them stay out side till late in the nights. Some of them run away from home for 1-2 days.

In International Classification of Diseases conduct disorders are described as "repetitive and persistent pattern of antisocial and aggressive or defiant conduct. Such behaviour when at its most extreme for the individual, should amount to major violations of age-appropriate social expectations, and therefore more severe than ordinary child's mischief or adolescent rebelliousness" (p.163, ICD-10, WHO, 1988). It classifies conduct disorders into the following major groups: (a) Conduct disorder confined to family context, (b) Unsocialised Conduct Disorder and (c) Socialised Conduct Disorder (d) Oppositional Defiant Disorder, and (e) Others .

The first group of conduct disorders are confined to family and immediate neighbourhood only. This may cause severely disturbed parent-child relationship. The second group of conduct problems are manifested in isolation. In this case, the child is usually poorly integrated to his/her peer group, rather rejected and used to be unpopular. The behaviours include bullying, excessive fighting, violent assault, resistance to authority and so on. Whereas, the third group i.e socialised conduct disorders include defiant and disruptive behaviours in peer groups. The child is usually well integrated to his/her peer groups. The fourth group of conduct problems occur in children who are below the age of 9-10 years. The disorder is characterised by presence of markedly defiant, disobedient, provocative behaviour and by absence of more severe or aggressive acts that violate the law or rights of others.

In the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV) conduct disorder behaviours are classified into four main groups such as: (a) aggressive conduct that causes or threatens physical harm to other people or animals, (b) non- aggressive conduct that causes property loss or damage, (c) deceitfulness or theft, and (d) serious violations of rules.

The major constellation problems with a child with conduct disorders include: (1) physical and verbal aggressiveness, (2) disruptiveness, (3) irresponsibility, (4) non-compliance and (5) poor interpersonal relationship.

1.4.8 Dyslexia

This is a specific learning disability that is neurological in origin. It is characterised by difficulties with accurate and / or fluent word recognition and by poor spelling and decoding abilities.

Learning disabilities and Learning disorders

Specific learning disabilities are diagnosed particularly when children are engaged in academic activity in schools. This is a disorder that involves one or more of the basic psychological processes which are required in understanding or using language, spoken or written, which disorder. This may be manifested in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations (IDEA, 2004). Even having average or above average intelligence, these children perform poorly in academic tasks such as reading, writing and arithmetic.

Learning disability is believed to be present if there is substantial difference between expected and actual performance based on intelligence, ruling out other contributing factors such as poor learning-teaching environment, second language etc. For diagnosis of specific learning disability the person should not only have at least appropriate intelligence for learning the subject of instruction, should have adequate opportunity of appropriate instruction and should not have socio-cultural constraints that may affect. These are the necessary conditions for the identification of children with this problem.

Here, substantial difference between means the difference between level of intelligence and academic performance is technically more than 2 standard deviations on a standardised test of academic achievement, measuring these academic skills.

Now this disability is identified by using measures called response to intervention (RTI). That is, not by using standardised measures alone but by examining their response to intervention in specific areas of disability and provision of special services for them.. However, the regulations prevalent in given state or regional authority determine the school practices in diagnosis.

In a multi-cultural and multilingual background like ours, one need to be careful about the diagnosis, as we do not have standardised tests of reading, writing and arithmetic designed for assessing academic achievement at different grade levels. Hence, the assessment is largely curriculum-based. While doing such assessment the influence of age of enrolment in school, instructional environment at school and support in home-setting require careful consideration. Under circumstances, when it is difficult to ascertain these, the term ‘learning difficulties’ more appropriate to use for underachievement in reading, writing and arithmetic.

This occurs in three major categories, viz., reading, mathematics and written expression. Reading problems generally occur before the age of 7 years of age. This is followed by problems with spelling and written language expression by the age of 8 years. Mathematical learning disorders often are not detected until

after rote memorisation has ended and application of more abstract skills is necessary.

1.4.9 Mental Retardation

This is based on both IQ and deficits in functioning. It is not a single, simple syndrome but rather a state of impairment. By definition, to have the label mental retardation, the person must have an IQ below 70 and impairments in adaptive functioning in atleast two of the following areas: communication, self care, home living, social interpersonal skills, use of community resources, self direction, work. Leisure, health and safety. Onset must be before the age of 18 years. There are 4 levels of mental retardation, viz., mild, moderate, severe and profound.

1.4.10 Mixed Receptive Expressive Language Disorder

In this children have difficulty in understanding and expressing language. The disorder may be acquired or developmental.

1.4.11 Oppositional Defiant Disorder

In this children ignore or dedy adults' requests and rules. They may be passive finding ways to annoy others, or active, verbally saying 'No'. They blame others for their mistakes and difficulties. When asked why they are so defiant, they may say that they are only acting against unreasonable rules.

1.4.12 Pervasive Developmental Disorder

This indicates a severe, pervasive impairment in social interaction or communication skills, or the presence of stereotyped behaviour, interests and activities. The criteria for a specific pervasive developmental disorder, schizophrenia and schizotypal and avoidant personality disorders are not met. This diagnosis generally has a better outcome than does autistic disorder.

1.4.13 Reactive Attachment Disorder

This is characterised by the breakdown of social ability of a child. RAD is associated with the failure of the child to bond with a caretaker in infancy or early childhood. This can be caused by child neglect, or child being hospitalised for medical problems.

1.4.14 Rett Syndrome

This is a disorder that is exclusive to females. For the first 6 months of life the development is normal. Then they begin to exhibit many of the symptoms of autism such as stereotypes movements, poor social interaction and communication. Children with Rett syndrome also have problems with both expressive and receptive language, psychomotor retardation and poorly coordinated gait and or trunk movements.

1.4.15 Selective Mutism

This is a disorder in which children may talk at home but due to severe anxiety are unable to speak in social situations. Their anxiety may affect their ability to communicate in other ways as well. To make a diagnosis of selective mutism, the person must have had the communication problem at least for one month period.

1.4.16 Separation Anxiety Disorder

This is a disorder that affects children who are afraid to be separqated from the main caretakers in their lives. When separated they are constantly afraid that something horrible will happen to either themselves or to their primary caretaker. When the subject separating is brought up the child with separation anxiety disorder begins to present with somatic symptoms ranging from headaches to nausea, committing and anxiety.

1.4.17 Stuttering

This is a disturbance in the fluency and time patterning of speech that is inappropriate for the patient's age. Stuttering may contain sound repetitions, prolongations, interjections, pauses in words, word substitutions to avoid blocking and audible or silent blocking.

The DSM is another important tool that clinicians use to diagnose psychological and behavioural disorders. The DSM IV-TR (4th edition, text revision), was published in 2000 is the latest available classification category. It provides comprehensive diagnostic criteria, which is based on the best available clinical and research literature findings regarding mental illness. In DSM individuals are assessed across five separate "axes" (dimensions) in order to develop a more complete understanding of their functioning. This is termed as Multi Axial diagnosis.

Self Assessment Questions

1) Describe the main characteristics of ADHD.

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2) What are the different types of conduct disorders?

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3) How would you identify children with specific learning disability?

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4) Discuss the various disorders of childhood in detail

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5) What is mental retardation?

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6) What are the causes of ADHD?

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1.5 LET US SUM UP

School aged children exhibit a wide range of behaviour problems. Particularly, when they enter to the school environment, they are exposed to a new world of learning and experience new challenges. Some of them fail to adjust with it and as a consequence, develop behaviour problems. However, some problems could be unconnected with school and may occur for other reasons connected with genetic predisposition, upbringing in home setting, parent-child relationship and so on.

A behaviour is considered to be problematic when it causes distress to the individual concerned or to the people around him/her in the community. Usually such behaviours are inappropriate for the situation, stage of development or occurs with inappropriate frequency duration or severity.

The major behaviour problems may be classified as developmental disorders, emotional disorders, psychotic, habit disorders, post-traumatic stress disorders, adjustment disorders, psychosomatic disorders psychotic disorder and so on.

These disorders need to be diagnosed at the early stage. Various diagnostic systems are available for diagnosis, such as International Classification of Disease (ICD) and Diagnostic Statistical Manual (DSM). Three major disorders that occur during school age are Attention Deficit Disorder (ADHD), Specific Learning Disability

(SLD) and Conduct Disorder. ADHD is characterised by three major symptoms (1) inattention, (2) motor restlessness (3) impulsivity. SLD is characterised by substantially poor academic performance in reading, writing or arithmetic considering the child's intellectual capacity. Technically speaking, the academic performance of the child in any of these specific subjects is below second standard deviation of the mean academic performance. Conduct disorder is characterised by either repetitive aggressive behaviour, destruction of property, theft or violation of rules. There are several types of conduct disorders such as (a) Conduct disorder confined to family context, (b) Unsocialised Conduct Disorder and (c) Socialised Conduct Disorder (d) Oppositional Defiant Disorder, and (e) Others. No matter whatever is the behaviour problem, it requires early identification.

1.6 UNIT END QUESTIONS

1) What are the symptoms of ADHD? Elucidate the causative factors.
2) Differentiate between the two classification systems namely ICD 10 and DSM IV TR.
3) What are the various types of childhood disorders? Give details.
4) Discuss the different learning disabilities in children.

1.7 SUGGESTED READINGS

Phares, V. (2003). *Understanding Abnormal Child Psychology,* John Wiley & Sons Inc. NJ.

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UNIT 2 THE ETIOLOGY OF PROBLEM BEHAVIOUR IN CHILDREN

Structure

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2.2 Etiological Factors of Abnormality

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2.2.2 Major Brain Structures

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2.7.2 Special Learning Disability

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2.8 Let Us Sum Up

2.9 Unit End Questions

2.10 Suggested Readings

2.0 INTRODUCTION

In this unit we will be dealing with various causative factors in regard to the many behavioural problems and childhood disorders. We first explain what etiology is and define the concepts. Then we present the etiological factors contributing to behavioural disorders. This would include the biological factors

with interaction of genes with the environment. In this context we also present how neurological factors also affect and cause behavioural problems in children. In this context some of the major brain structures will be discussed which if adversely affected or damaged cause behavioural problems in children. Then we take up the psychological factors contributing to behavioural problems. In this we present human nature and temperament, traits, and how learning and cognition and the sense of self and self esteem cause such behavioural disorders. Life span development is also discussed and it is pointed out as to how any damage or deficiency or injury caused during the different developmental periods may cause behavioural disorders in children. Relationship factors including attachment factor is discussed as a causative factor contributing to problem behaviours. System theory is also presented in regard to the above problem behaviours. Developmental psychopathology is also taken up and the three different models in this regard are discussed as causing the problem behaviours. Otgher important theories such as the psychodynamic, behavioural, cognitive etc. theories are also presented to explain behavioural disorders. Finally the etiology of some of the specific disorders such as ADHD etc. is discussed in detail.

2.1 OBJECTIVES

After going through this unit, you will be able to:

- Define etiological factors in problem behaviours in children;
- Describe the various factors that cause problem behaviours;
- Expalin the psychological factors contributing to problem behaviour;
- Describe systems theory as a cuase for problem behaviour;
- Elucidate the developmental psychopathology;
- Describe the various models that are used to explain problem behaviours;
- Analyse the other causative factors including psychodynamic in causing problem behaviours; and
- Elucidate the causative factors related to specific problem behaviours.

2.2 ETIOLOGICAL FACTORS OF ABNORMALITY

There are different models of Psychology and each model represents its own unique interpretation of the etiology and treatment of abnormal behaviour. These models include biomedical, psychoanalytical, humanistic, behavioural, and cognitive models or approaches to understanding the etiology of abnormal behaviour. All these models combine together in Bio-Psycho social approach or multidimensional integrative approach. The biological factors focus on genetics, the interaction of genes and environment. This model also focuses on neuron, brain and spinal cord. Let us deal with this model first.

2.2.1 Biological Factors: Genes and Its Interaction with Environment

The study of neuro-anatomy and neurophysiology is the study neuroscience. The Neuron Billions of tiny nerve cells, called the neurons form the basic building blocks of the brain. Each neuron has four major anatomic components:

- the soma, or cell body,
- the dendrites,
- the axon, and
- the axon terminal.

The *dendrites* branch out from the soma.

They serve the primary function of receiving messages from other cells.

The *axon* is the trunk of the neuron.

Messages are transmitted down the axon toward other cells with which a given neuron communicates.

Scientists have found that disruptions in the functioning of various neurotransmitters or oversupply or undersupply of neurotransmitters are the causes for mental disorders.

2.2.2 Major Brain Structures

Neuroanatomists divide the brain into three subdivisions:

- the hindbrain
- the midbrain
- the forebrain.

The hindbrain

Basic bodily functions are regulated by the structures of the hindbrain, which include the

- medulla,
- pons, and
- cerebellum.

The medulla controls various bodily functions involved in sustaining life, including heart rate, blood pressure, and respiration. The pons serves various functions in regulating stages of sleep. The cerebellum serves as a control center in helping to coordinate physical movements.

The Midbrain

The midbrain also is involved in the control of some motor activities, especially those related to fighting and sex.

The Forebrain

The forebrain evolved more recently than the hindbrain and midbrain and, therefore, is the site of most sensory, emotional, and cognitive processes. These higher mental processes of the forebrain are linked with the midbrain and hindbrain by the limbic system.

The Limbic System

The limbic system is made up of a variety of different brain structures that are central to the regulation of emotion and basic learning processes.

The Spinal cord

The Spinal cord is along bundle of neurons that carries messages to and from the body to the brain that is responsible for a very fast, life saving reflexes.

Damage to any of these areas or part of these areas would cause mental disorders or abnormalities.

Self Assessment Questions

1) Discuss the etiological factors of abnormality.

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2) Elucidate the biological factors and gene interaction wit environmental causing behaviour problems in children.

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3) Explain the major brain structures that are associated with disorders.

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2.3 PSYCHOLOGICAL FACTORS OF ABNORMALITY

2.3.1 Human Nature and Temperament

John Bowlby's attachment theory has been of great influence in the field of children's growth and development as well as abnormality. He was of the view that humans need to form close relationships and the major tenet of Bowlby's theory was that children form attachments early in life, that is they form special and selective bonds with their caregivers. Bowlby based his approach, known as *attachment theory,* on the findings based on studies of animal behaviour.

Research has shown that the effects of insecure or anxious attachments or uncertain parent child relationships leads to the development of abnormal behaviour.

One of the most important areas of research on individual differences in personality is the study of temperament, characteristic styles of relating to the world. Individual differences in temperament may play a role in a number of psychological disorders, especially personality disorders and child behaviour problems. Emotions that is internal feeling states, are essential to human experience and to our understanding of mental disorders.

2.3.2 Learning and Cognition

Emotions, motivations, and temperamental styles can be modified, at least to some degree, by learning. Cognitive theories like Albert Ellis's REBT and Beck's Depression theory suggests that distorted perceptions of reality cause people to become depressed. A successful treatment based on this theory encourages depressed people to be more scientific and realistic in evaluating conclusions about themselves.

2.3.3 The Sense of Self

Maslow's theory of needs gives importance to the self and self actualisation. Self-esteem, that is, valuing one's abilities, is another important and much discussed aspect of our sense of self. Evidence indicates that high self esteem is more of a product of success while low self esteem may result from psychological problems.

2.3.4 Life Span Development

Life span developmental psychopathologists want to understand how different periods of development influence, how stress and other factors have an impact on mental disorders. Eric Erickson (1982) suggested that we go through eight major crises during our life and each crisis is influenced by biological maturation, social factors and the developmental stages we are passing through. Erickson believed that humans grow and change even beyond 65 years of age. During older adulthood, we look back and view our lives as rewarding or as disappointing. Erickson's developmental theory and Freud's psychosexual developmental theories of normal and abnormal behaviour are important. While Freud's theory visualises 5 stages of development, Erikson's theory visualises 8 stages of development. These are presented in the table below.

Theory	**Developmental stages**	**Period of growth**
Freud's psychosexual theory	Five	1st year to 12 years
Erik Erikson's developmental theory	Eight	1st year to 65 years and beyond.

Development or how people grow and change, is of basic importance to normal and abnormal psychology. One of the important aspects of development is that the human development can be considered in terms of stages through which an individual passes through. This is common to all humans and any deficiency or inability to pass through the stages of development indicates abnormality. All

stages of development have certain normal and abnormal behaviours and these are part of growing up. However, where a particular behaviour which is not in accordance with the norms or expectations, gets stuck or becomes the main pattern of behaviour and does not change, indicates abnormality.

2.3.5 Relationships and Psychopathology

Abnormal behaviour is also caused by defective relationships or abnormal relationships. Much evidence links abnormal behaviour with distressed or conflicted relationships, still it often is impossible to determine if troubled relationships actually cause abnormal behaviour. To give an example it is well known that an individual enjoys a large number of social relationships and in any of these relationships abnormality can develop, as in the case of marital relationship. The conflicts between the couple may lead to divorce, separation etc. and may cause not only disturbance to the couple but also to the children and other closely related family members.

2.3.6 Gender and Gender Roles

Every individual plays many a role in his or her life. Each role is more or less clearly defined such as parental role, role of children, relatives and so on. There are male and female roles even though the distinction between some of these roles has been considerably minimised. Gender and gender roles, expectations regarding the appropriate behaviour of males or females, do and can dramatically affect social relationships and social interaction. Where a person is not in line with the expected roles and is unable to accomplish what is expected of him or her, then such a behaviour is indicative of abnormality. Gender roles may influence the development, expression, or consequences of psychopathology.

2.3.7 Prejudice and Poverty

An increased risk for psychological disorders is associated with prejudice and poverty, the conditions of poverty affect a large number of people in many ways. Broad social values also influence the nature and development of abnormal behaviour. The broad practices, beliefs, and values of our society play a role in defining abnormal behaviour and in shaping the scientific enterprise that attempts to uncover the roots of psychopathology.

Self Assessment Questions

1) Discuss human nature and temperament as psychological factors contributing to problem behaviours.

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2) How do learning and cognition explain problem behaviour in children.

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3) How are self esteem and sense of self related to behaviour problems?

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4) Delineate lifespan developmental factors as contributing to problem behaviour.

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5) Discuss relationship, gender and gender roles in terms of behavioural disorders in children.

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2.4 SYSTEMS THEORY

Systems theory is an approach to integrating evidence on different contributions to abnormal behaviour. One can think of systems theory as similar to the bio psychosocial model or the multidimensional integrative approach, but systems theory also embraces several key concepts that deserve some elaboration. These concepts include (i) Holism (ii) Reductionism and (iii) causality . Let us consider in detail these three concepts below.

Holism: A central principle of systems theory is holism, the idea that the whole is more than the sum of its parts. A human being is more than the sum of a

nervous system, an organ system, a circulatory system, and so on. We can appreciate the principle of holism if we contrast it with its scientific counterpoint, reductionism.

Reductionism: Reductionism attempts to understand problems by focusing on smaller and smaller units, viewing the smallest possible unit as the true or ultimate cause. One approach is not right, while the others are wrong. The lenses are just different, and each has value for different purposes.

Causality: The cause of any one case of abnormal behaviour occasionally can be located in one area of biological, psychological, or social functioning. More commonly, however, understanding the causes of psychological problems involves a multitude of causal influences, not in one single area of biological or psychological or social. The cause of any one case of abnormal behaviour occasionally can be located in one area of biological, psychological, or social functioning.

2.5 DEVELOPMENTAL PSYCHOPATHOLOGY

Developmental psychopathology is a new approach to abnormal psychology that emphasises the importance of developmental norms which include age graded averages so as to determine what constitutes abnormal behaviour.

Developmental psychopathology can be defined in a variety of ways, all having to do with development on the one hand and the resulting set of maladaptive behaviours on the other. Developmental psychopathology focuses on and integrates these two areas, looking at maladaptive processes themselves as well. Underlying much of the study of developmental psychopathology is the principle of predictability. The prediction of maladaptive behaviour has been viewed not only as possible, but also as an important feature in the study of psychopathology.

With this added feature, we now have a more complete definition of Developmental psychopathology which states that it is the study and prediction of maladaptive behaviours and processes across time.

As we can see, the definition of developmental psychopathology involves the merger of two fields of study, that of development and that of psychopathology. Although there is much interest in the etiology of psychopathology, until recently, there has been little research on the development of maladjustment.

In part, this was due to the now discredited idea that some adult psychopathologies could not occur in childhood and to the misconception that the adult forms of pathology are the same as those for children. The introduction of a developmental perspective allows for the understanding that the same underlying psychopathology in children and in adults may be seen in very different behaviours. Thus, a developmental perspective is necessary in order to understand psychopathology.

2.5.1 Models of Developmental Psychopathology

Three models, a trait model, a contextual or environmental model, and an interactional model reflect the various views in regard to development and, therefore, to the etiology of psychopathology. Because attachment theory remains

central to normal and maladaptive development, it is used as an example. Unfortunately, by describing sharp distinctions, we may draw too tight an image and, as such, may make them caricatures. Nevertheless, it is important to consider them in this fashion in order to observe their strengths and weaknesses and how they are related to developmental psychopathology.

2.5.2 Trait or Status Model

The trait or status model is characterised by its simplicity, and is of the view that a trait the child has at one point in time is likely to predict a trait at a later point in time. This model is not interactive and does not provide for the effects of the environment. In fact, in the most extreme form, the environment is thought to play no role either in effecting its display or in transforming its characteristics. A particular trait may interact with the environment, but the trait is not changed by that interaction.

Traits are not easily open to transformation. They can refer to processes, coping skills, attributes, or tendencies to respond in certain ways. Traits can be innate features, such as temperament or particular genetic codes, or can be acquired through learning or through interactive processes with the environment. However, once a trait is acquired, it remains relatively unaffected by subsequent interactions. The trait model is most useful in many instances, for example, when considering potential genetic or biological causes of subsequent psychopathology.

A child who is born with a certain gene or a set of genes is likely to display psychopathology at some later time. This model characterises some of the research in the genetics of mental illness. Here, the environment, or its interaction with the genes, plays little role in the potential outcome. For example, the work on heritability of schizophrenia supports the use of such a model, as does the lack or presence of certain chemicals on depression.

In each of these cases, the trait model argues that presence of particular genes is likely to affect a particular type of psychopathology. Although a trait model is appealing in its simplicity, there are number of problems with it, as for example, not all people who possess a trait at one point in time are likely to show subsequent psychopathology or the same type of psychopathology. That all children of schizophrenic parents do not themselves become schizophrenic, or that not all monozygotic twins show concordance for schizophrenia, and thus suggest other variables to be considered.

This model also is useful when considering traits that are not genetically or biologically based, but based on very early experiences. For example, the attachment model as proposed by John Bowlby and Mary Ainsworth holds that the child’s early relationship with its mother, in the first year of life, creates a trait (secure or insecure attachment) which will determine the child’s adjustment throughout his or her life. The security of attachment that the child shows at the end of the first year of life is the result of the early interaction between the mother and the child. Once the attachment is established, it acts as a trait affecting the child’s subsequent behaviour.

The trait model is widely used in the study of developmental psychopathology. For example take the concept of the vulnerable or invulnerable child. A vulnerable child is defined as one who has some characteristic (trait), acquired early, which

makes the child vulnerable to psychopathology, even if they show no ongoing problems. However when the child goes through a stress which he or she cannot cope, this trait is expressed.

As Alan Sroufe has said, 'even when the child changes rather markedly, the shadows underlying that of the earlier adaptation remains (the insecure attachment) and in times of stress, the prototype itself may become clear and the child manifests that trait.

On the other hand, the invulnerable child, even when stressed, is less likely to show pathology. Such a model of invulnerability has been used by Norman Garmezy and Michael Rutter (1983) to explain why children raised in highly stressful environments do not all show psychopathology. In the attachment literature, a secure child is more likely to be invulnerable to subsequent stress, whereas an insecure child is more vulnerable to stress.

The trait notion leaves little room for the impact of environment on subsequent developmental growth or dysfunction. Environments play a role in children's development in the opening year of life and continue to do so throughout the life span.

2.5.3 The Environmental Model

The prototypic environmental model holds that exogenous factors influence development. Two of the many problems in using this model are our difficulty in defining what environments are, and the failure to consider the impact of environments throughout the life span. In fact, the strongest form of the environmental or contextual model argues for the proposition that adaptation to current environment, throughout the life course, is a major influence in our socio-emotional life. As environments change, so too does the individual. This dynamic and changing view of environments and adaptation is in strong contrast to the earlier models.

In the simplest model, behaviour is primarily a function of the environmental forces acting on the organism at any point in time. In such a model, a child does behaviour x but not behaviour y, because behaviour x is positively rewarded by his or her parents and y is punished. Notice that, in this model, environmental forces act continuously on the organism, and the behaviour emitted is a direct function of this action.

Much of our behaviour is controlled by an indirect form of environmental pressure. For example, a young child is present when the mother scolds the older sibling for writing on the walls. The younger child, although not directly punished, learns that writing on walls will be punished. Indirect forms of reward and punishment have received little attention, but exert as much environmental influences as direct forms.

There are many other types of environmental pressures. For example, we see an advertisement for a product that will make us fair and beautiful. We purchase such a product in the hopes that we are going to become fair and beautiful. We can reward or punish ourselves by our knowledge of what is correct or incorrect according to the environmental standards that we learn. Poor environmental effects, such as an overdeveloped sense of standards, can lead to high shame and, through it, to other forms of psychopathology.

Because other people make up one important aspect of our environment, the work on the structures of the social environment is particularly relevant, and an attempt has been made to expand the numbers of potentially important people in the child's environment beyond the mother. Sociologists and some psychologists, such as Urie Bronfenbrenner, Michael Lewis, and Judy Dunn have argued that other persons, including fathers, siblings, grandparents, and peers, clearly have importance in shaping the child's life. For the most part, mothers and, to some extent, families, have received the most attention in regard to shaping the child's personality and behaviour.

The role of environments in the developmental process has been underplayed because most investigators seek to find the structure and change within the organism itself. Likewise, in the study of psychopathology, even though we recognise that environments can cause disturbance and abnormal behaviour, we prefer to treat the person to increase coping skills or to alter specific behaviours rather than change the environment. Yet we can imagine the difficulties that are raised when we attempt to alter specific maladaptive behaviours in environments in which such behaviours are adaptive.

The thrust of development resides in the organism rather than in the environment, in large part, raises many problems. At cultural levels, we assume that violence and its cure must be met in the individual, a trait model rather than in the structure of the environment. The murder rate using handguns in the USA is many times higher than in any other Western society. We seek responsibility in the nature of the individual (e.g., XYY males, or the genetics of antisocial behaviour), when the alternative of environmental structure is available. In this case, murders may be due more to the culture's nonpunishment of persons or nonrestriction of handguns. The solution to the high murder rate in the USA might be the elimination, through punishment, of the possession of weapons. Thus, we either conclude that Americans are by nature more violent than Europeans or that other Western societies do not allow handguns and therefore have lower murder rates.

Other forms of maladaptive behavioural development have a similar problem. Depressed women are assumed to cause concurrent as well as subsequent depression in children. What is not considered is the fact that depressed mothers are also likely to be depressed.

Some of the important queries in this regard are:

What role does the mother's depression in the child's subsequent condition?

What would happen to the child if the mother was depressed?

These questions suggest that one way to observe the effect of the environment on the child's subsequent behaviour is to observe those situations in which the environment changes.

The environmental model is thus characterised by the view that the constraints, changes, and consistencies in children's psychopathology rest not so much with intrinsic structures located in the child as it is located in the nature, structure, and environment of the child.

2.5.4 The Interactional or Transformational Model

Interactional models vary. Michael Lewis (1990) prefers to call them 'interactional', while Sameroff (1975) calls them transactional. All these models have in common the role of both child and environment in determining the course of development. In these models, the nature of the environment and the traits of the child are needed to explain concurrent as well as subsequent behaviour and adjustment.

Maladaptive behaviour may be misnamed because the behaviour may be adaptive to a maladaptive environment. The stability and change in the child need to be viewed as a function of both factors and, as such, the task of any interactive model is to draw us to the study of both features.

In our attachment example, the infant who is securely attached, as a function of the responsive environment in the first year, will show competence at a later age as a function of the earlier events as well as the nature of the environment at that later age.

One of the central issues of the developmental theories that are interactive in nature is the question of transformation.

Two models of concurrent behaviour as a function of traits and environment can be drawn.

i) In the first, both trait and environment interact and produce a new set of behaviours. However, neither the traits nor the environment are altered by the interaction. From a developmental perspective, this is an additive model because new behaviours are derived from old behaviours and their interaction with the environment, but these new behaviours are added to the repertoire of the set of old behaviours. This model is very useful for explaining such diverse psychopatho-logical phenomena as regression and vulnerability. In its most general form, it has been called by Richard Lerner (1986), the goodness-of-fit model.

ii) In the second model, both trait and environment interact, producing a new set of behaviours which transform themselves. From a developmental perspective, this is a transformational model because the old behaviours give rise to new behaviours and the environment itself is altered by the exchange. The variety of interactional or transactional models is considerable.

2.5.5 Future Directions

The understanding of these different models of development directly bear on the type of research on developmental psychopathology. It seems reasonable to assume that different forms of psychopathology have different developmental pathways, some fitting one or the other of these models.

Self Assessment Questions

1) What are the various models of developmental psychopathology?

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2) Elucidate the Trait and status model of problem behaviour.

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3) Discuss the environmental and transformational models in causing problem behaviours.

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2.6 OTHER IMPORTANT THEORIES THAT EXPLAIN BEHAVIOURAL DISORDERS / PROBLEM BEHAVIOURS IN CHILDREN

Theories are basically explanatory and analytical tools that help us to understand, explain, and make predictions about any given subject matter. There are many theories explaining the etiology of behaviour problems in children as well. Understanding of these theories helps us not only to analyse and explain these behaviours but also predict and treat them. Theories pertaining to problem behaviours may be broadly classified as biological, psychological and social. Some of the major theories have been discussed below:

2.6.1 Biological Theory

Biological theories focus mostly on genetic, neurological, or biochemical abnormalities in children that manifest in problem behaviour. Genes inherited from biological parents tend to play a significant role in emotional and behavioural problems in children. Many childhood behaviour problems are considered to have high genetic loading. ADHD, for example, is highly influenced by genetic factors (Eaves, et al., 1997), even conduct disorder is genetically linked with parental substance abuse and antisocial behaviour (Merikangas, Dierker, & Szatamari, 1998), fear and phobias are more genetically loaded for girls than boys (Lichenstei, & Annas, 2000). Even children's adjustment to parental divorce is influenced by genetics to some extent.

In order to explain genetic loading, various types of genetic researches are conducted to determine genotype and phenotype in a given problem behaviour. Genotype refers to a child's genetic make up whereas phenotype refers to the set of observable characteristics that are due to interaction of heredity and environment. Heritability of a disorder is indicated by a proportion of variation in a given trait (e.g. distractibility) that is genetic or inherited rather than

environmental. The heritability estimate is indicated by a proportion that ranges from 0 (no genetic influence) to 1.0 (perfect genetic correspondence). In order to understand the role of genetic loading, twin studies as well as adoption studies are conducted. The twin studies attempt to compare both, disygotic and monozygotic twins on a series of measures, whereas in adoption studies, twins or siblings are reared in different households. In both of these studies attempt is made to assess the differential contribution of genetic, non-shared environmental and shared environmental characteristics of a specific psychopathology.

Damage to the central nervous during formative years of life, and at the latter stage due to trauma, deficiencies in essential enzymes of the body, deregulation of neural activity in the brain, mental disorders may occur in children.

2.6.2 Psychodynamic Theory

Behaviour problems may occur due to psychological disturbance. Sigmund Freud explained that there are three regions of mind: conscious, subconscious and unconscious, out of which unconscious mind is the largest segment. It is considered as a reservoir of forbidden wishes and impulses which are not easily accessible. Special analytic methods are used to explore them. Subconscious mind is one about which an individual is presently not aware of but it is easily accessible if the individual wishes to do so, for instance the memory of the actions that have been performed in the immediate or recent past. Conscious mind includes the here-and-now day-to- day experiences of the individual about which, he or she is aware of. Primitive whishes such as sex and aggression contained in the unconscious mind constant seek immediate gratification.

This dynamic aspect of mind is called id. However, such immediate gratification may have dangerous consequences for the individual. Similarly, there is a diametrically opposing aspect of mind called superego that represents conscience and equally powerful. Therefore, it requires good amount of executive control and the controlling and organising element of mind is called The human child passes through different stages of psychological development which are termed as stages of ‘psychosexual development’ such as oral, anal, phallic, latency, and genital. At each of these stages the child obtains psychosexual gratification of certain characteristic needs. Either over satisfaction or under satisfaction cause this period to prolong, psychologically affecting the personality and behaviour of the child. This phenomenon is called fixation. It derails the natural course of psychosexual development. This is manifested in various forms of mental and behavioural disorders.

The Oral Stage occurs during the first year of life. The infant derives maximum pleasure from food and objects that stimulates the mouth (oral zone: lips and oral cavity) though sucking, chewing, biting, swallowing, drinking and so on. The fixation at this stage leads to development of certain characteristic disorders like anxiety disorders, over dependence on food, alcohol, cigarettes etc., and depression.

The Anal Stage that follows oral stage and continues till end of the second year of life is characterised by the pleasure that one derived from the anal region by its stimulation and control of defecation. Either poor or harsh toilet training may cause fixation. The fixation at this stage leads to formation of anal characters such as stinginess, extreme cleanliness, messiness, repetitive behaviours, in extreme cases obsessive-compulsive disorders.

The Phallic Stage occurs between 3 to 5 years of age. During this stage the child derives maximum pleasure for the genitals (phallus). He/she seem to sexually desire the opposite sex parent and tend to hate the same sex parent. This murderous hate for opposite sex parent and love for same sex parent leads to what is called Oedipus Complex in case of boys and Electra Complex in case of girls. As a consequence of fixation at this stage they develop irrational fear of various objects, animals and situation. The clinical manifestation of phobic disorders, simply called phobia.

The Latency Period starts at about five years of age and continues during the adolescence. During this stage there is little focus on sexual pleasure. Freud has not explained much about either the nature of fixation or the psychopathology associated with this stage.

The Genital Sage occurs during later part of adolescence and characterised by sexual desires and impulses. Again the genitals become the source of pleasure and it continues till adulthood. Fixation at this stage does not seem to be problematic.

For understanding problems of childhood emphasis is placed on the first three stages of psychosexual development. Psychoanalytic techniques such as free association or dream analysis are used for overcoming fixations.

2.6.3 Behavioural Theory

Behavioural approach is based on use of learning principles for explaining behavioural emotional disorders. It explains that most behaviours, whether normal or abnormal are learned. Children learn maladaptive behaviours either through association of their behaviour with certain new stimulus (classical conditioning), actual consequences of their own behaviour (operant conditioning) or by observing consequences behaviours performed by others (observational learning).

In an early classical conditioning experiment Watson explained how fear can be learned through conditioning. A 3 year old child Albert used as the subject. He was initially allowed to enjoy playing with a white rabbit for quite some time. The animal provoked absolutely no fear response. However, following that, while playing with the rabbit, a loud sound was produced by striking a iron rod. It elicited a startle reaction and the child started crying out of fear.

Following this experience, the child started avoiding not only white rabbits but also other furry objects, such as white beard other such objects. In the next phase of his experiment, he attempted to demonstrate how principles of learning can also be reduced through application of learning theory; the process is precisely called counter conditioning. In order to do so, instead of associating an aversive stimulus the rabbit was gradually brought closer to a tolerable distance and Albert was encouraged to play with it, simultaneously he was made comfortable by manual stimulation. After a few such trials the child became as comfortable as before, while playing with the animal and the acquired fear response got extinguished altogether. This was a classic experiment that demonstrated not only how fear could be acquired through classical conditioning but also gets generalised to similar objects and also unlearned by using learning principles. Operant conditioning explains behaviour as a consequence of reinforcement or punishment it produces its occurrence. Excessive behaviours occur due to their

positive consequences (reinforcement), whereas deficit behaviours are due to the punitive consequences.

According to observational learning theory, however, acquisition of behaviour does not always occur by direct involvement of the client but by observing others. That is, by observing the consequences a behaviour on the environment. For instance phobias (irrational fear) can be learned not always due to actual experience but also by watching others fearful responses to a given stimulus. Many mal adaptive behaviour are picked up by watching peers, parents and even teachers. Behaviour therapy, which is based on learning principles, is used effectively in treatment of many forms of mental disorders in children.

2.6.4 Cognitive Theory

Most cognitively oriented clinicians believe that mental disorders are due to faulty belief, poor self-concepts, faulty self-appraisal or self-attribution. The belief system seems to mediate abnormal behaviour and therefore much maladaptive behaviour is believed to be the result of specific cognitive appraisal about self and others. A wide range of cognitive therapies are suggested for treatment of mental disorders in children.

2.6.5 Other Theories

There are several other approaches which explain maladaptive behaviours in children. For example, attachment theorists explain that many behaviour disorders could be due to attachment problem with significant family members, particularly the parents. Deprivations of early attachment, poor parenting, and loss of parents at early stage of development may lead to withdrawn behaviour, depression and conduct disorders. It may even increase the vulnerability childhood schizophrenia. Fear toward same sex parent may be expressed in the form of various kinds of phobias. In the last half of the 20th century, child abuse and neglect came to be seen as significant factors in childhood disorders. Sometimes family problems such as marital conflicts between parents, family violence, alcohol abuse, and criminal behaviour in the family contribute to problematic behaviours in children. Parents' hostility, cruelty, neglect, overprotection of the child, or high expectations, cause a wide variety of behaviour disorders.

Treatment of child behaviour disorders requires accurate diagnosis, complete and thorough examination of genetic, constitutional, physical, psychological as well as familial factors contribute to the disturbance.

Self Assessment Questions

1) Discuss the biological and psychodynamic theories of problem behaviour.

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2) Explain behavioural disorders in terms of behaviour theories.

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3) How does cognitive theory explain behaviour disorders?

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4) What are the other theories that explain behaviour problems?

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2.7 ETIOLOGY OF SPECIFIC DISORDERS

2.7.1 Attention Deficit Hyperactivity Disorder (ADHD)

ADHD may be caused by many factors. Some are environmental and some are biological in nature. Both contribute to this disorder. Many theories have been proposed to explain this disorder. Some investigators report subtle differences in the structure and function of the brains of people with and without ADHD. For instance, some of them comparing the brains of boys with and without ADHD, found that the corpus callosum, that is the nerve fibers connecting the two hemispheres of the brain, contain less number of tissue in those with ADHD. Differences are also reported in the size of the caudate nuclei. This is found to be about 3 per cent larger in cases with ADHD group and the blood flow is relatively low in right caudate nucleus. Apart from anatomic differences as described above, some of them have reported functional deficits in brains of people with ADHD. For instance, poor metabolism or absorption of glucose in the prefrontal cortex could lead to its poor functioning of this area of the brain. The size and level of functioning of prefrontal cortex and basal ganglia play significant role in impulse control.

The chain of neurons in connecting the prefrontal cortex, the basal ganglia and the thalamus,is considered to be one of the main structures responsible for impulse inhibition. Failure in response inhibition is manifested as impulse control

difficulties in people with hyperactivity. Many of these problems could be due to delay in the normal growth and development of this inhibitory circuit.

High concentration of certain neurotransmitters such norepinephrine or metabolites of dopamine that plays important role in reward system of the brain may also cause hyperactivity. Dopamine is found to be in high concentration in cerebrospinal fluid of the hyperactive boys. Dysfunction of the ascending reticular activating system (ARAS) that screens and sends selected information to the brain may cause uncontrolled transmission of information to the higher centres of the brain leading to hyperactivity as well as, impulsivity.

Ritalin has been used a medicine for treatment of ADHD as it restores average levels of blood flow through the caudate nucleus. It also helps in reduction of dopamine levels in children with ADHD. Normally, the dopamine level decreases with age. From this perspective ADHD is seen as a developmental disorder.

The deficiencies in the regulation and maintenance of behaviour do have an impact on the social ecology of the child that includes social interaction in the family, school or in the community. When the controlling responses of the family or community members including neighbors, teachers or peers fail to bring much change in the child's behaviour, there is tendency to reject the child. As a result of which defiant and oppositional behaviour increases in the child leading to more severe problems of conduct or criminal behaviour at the later stages of life. Managed properly, conflicts with the above change agents remain minimal this may restrict its behavioural consequences.

2.7.2 Specific Learning Disability

Presence of a positive neurological birth history such as head injury, anoxia, central nervous system (CNS) infections, tumour, and epilepsy my result in specific learning disabilities. Other medical problems like chronic illnesses, side effects of certain and sensory deprivation may also have similar effects. Therefore, the child's over all medical status is a relevant concern.

Lesions in different areas of the brain may affect reading, writing, arithmetic. We have two hemispheres of the brain. Either due to premature shift of emphasis in activation from right hemisphere to left hemisphere of the brain, or even failure to do so, causes characteristic reading errors. The former type of reading errors is known as 'linguistic' (L-Type) learning disability, whereas, the later is known as 'perceptual' (P-Type) learning disability. Electroencephalographic studies indicate significant difference in brain activation during reading of learning disabled and non-learning disabled children.

However, learning disability is not an entirely organic disorder. The condition may arise from environmental factors as well. Cultural factors, childrearing practices and other psychosocial stressors such as reduced autonomy, isolation, family relationship, or attitude to academic achievement may affect acquisition of academic skills. Child's learning strategy itself may be an impediment in smooth learning in classroom environment. The academic skills acquired by the child also need to be reinforced and maintained by the teachers and family members.

Behaviourists believe that over critical and punitive attitude and lack of adequate reinforcement affect the academic performance. Information processing theorists, on the other hand focus on the child's capacity and style of processing information which received from the learning environment. Due to poor skills to handle this information the child fails to utilise it. This termed as failure to use 'executive' skills or 'meta-cognitive skills. Meta-cognition simply refers to the understanding and control of one's own cognitive processes such as attention, perception, memory and use of these skills when there is a task-demand to do so.Therefore, many therapists focus on these fundamental deficiencies to enhance the child's academic skills.

2.7.3 Conduct Disorder

There does not seem to be very strong biological theories to explain conduct disorders in children. However, there seem to be general agreement that the familt setting plays a significant role particularly in conduct disorders. The home-environment of a majority of such children are characterised by rejection, harsh punishment, inconsistent discipline and general frustration. The parents seem to have marital disharmony, sociopathic behaviour or are emotionally disturbed. The children imitate these behaviours without their awareness. Many of them are from crime prone areas, where a delinquent subculture exists. It influences the child's early socialisation. Thus modeling and social learning plays a significant role. Many of these children live in broken homes and are overtly rejected. Broken homes are characterised by single parent homes. This may happen due to absence of a parent caused by divorce or death of a parent. Some of these behaviours are outcomes of the impoverished environment and deprivation. Impoverished environment refers to the environment where the basic requirements of life are not fulfilled. Such an environment creates a sense of insecurity, mistrust and frustration. It results in conduct disorders, delinquency and psychopathic personality disorders..

Patterson and associate proposed a negative reinforcement hypothesis about conduct disorder. The explained that conduct problems such as aggressive destructive or disruptive behaviours are maintained as these behaviours are successful in reducing the chance of immediate punishment. For instance the nagging or frustrating behaviour of the parents or peer group is reduced significantly as the victim (child) engages in more destructive or aggressive acts. This is also called 'coercion hypothesis' model of conduct disorder (Patterson, 1976a). Initially, these behaviours occur at over level then become covert, from home setting it gets generalised to school or community setting.

2.8 LET US SUM UP

Etiology of such behaviour problems is essentially multi-factorial. The major approaches to the understanding of psychopathology are biological, psychodynamic, behavioural and cognitive. Biological causes include genetic predisposition or heritability, trauma, damage to the brain, deficiencies in essential enzymes of the body, or deregulation of neural activity in the brain, whereas, psychodynamic approach focuses on psychological conflicts and fixations a different stages of psychosexual development as cause of behavioural problems in children. Behavioural approach on the other hand, focuses on maladaptive learning. Classical conditioning, operant conditioning and observational learning

have been considered as the three prominent models of acquisition of maladaptive responding within the field of learning paradigm. In addition to maladaptive learning, the cognitive-behavioural theorists emphasise on cognitive elements such as self-concept, self-attribution, self-appraisal, beliefs and attitude as causes of psychopathology.

2.9 UNIT END QUESTIONS

1) Discuss the different etiological factors of abnormality.
2) What are the psychological factors of abnormality?
3) Discuss systems theory and its components.
4) Define developmental psychopathology and indicate the various models explaining the abnormal behaviour.
5) What are the other major theories of abnormality? Explain
6) Discuss the etiology of ADHD.
7) Discuss the etiology of special learning disabilities.
8) Discuss the etiology of conduct disorders.

2.10 SUGGESTED READINGS AND REFERENCES

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UNIT 3 COUNSELING FOR PROBLEM BEHAVIOUR

Structure

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3.1 Objectives
3.2 Counseling for Problem Behaviours
 3.2.1 Psychoanalytically-Oriented Counseling
 3.2.2 Family Therapy
 3.2.3 Child Guidance and Marriage Counseling
 3.2.4 Psychoanalytic Treatment for Children
3.3 Client Centered Counselling
 3.3.1 Play Therapy and Client Centered Counseling
3.4 Behavioural Counselling
 3.4.1 Behaviour Modification Counselling Technique
 3.4.2 Four Steps of Behaviour Modification
3.5 Counselling Children for Specific Disorders
 3.5.1 Attention Deficit Hyperactivity Disorder (ADHD)
 3.5.2 Specific Learning Disabilities
 3.5.3 Conduct Disorders
3.6 Referrals and Coaching
3.7 Let Us Sum Up
3.8 Unit End Questions
3.9 Suggested Readings and References

3.0 INTRODUCTION

This unit deals with counseling for problem behaviours. The various techniques of counseling are taken up and the theories of counseling are presented. These include psychoanalytically oriented counseling, the client centered counseling and the behavioural couselling. The psychoanalytical treatment of children is also discussed. The client centered counseling is considered and the play therapy and treatment of children with problem behaviour using this technique and play therapy are discussed. Then behaviour modification technique and its application in counseling are discussed in detail and the four steps of behaviour modification are delineated. This is followed by counseling children with specific problems such as the ADHD, specific learning disability and conduct disorders are discussed. Finally how the children need to be referred to other professionals as and when needed is put forward.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain the need of counseling for children with problem behaviour;
- Describe different types of counseling based on different theories;

- Describe play therapy in terms of client centered counseling;
- Elucidate the behaviour modification techniques as applied to counseling of problem behaviour;
- Analyse the different steps in behaviour modification;
- Describe treatment of children with specific problem behaviours; and
- Refer cases to appropriate professionals for intervention.

3.2 COUNSELLING FOR PROBLEM BEHAVIOURS

Problem behaviours of children can be dealt with by counseling of the index child, his family members, peer groups as well as teachers who have important role in management of such problems. Counseling refers to the guidance given by a trained individual to a client to overcome certain mental and behavioural problems. Initially an attempt is made to establish a working relationship with the client, so that he/she would feel free to express his/her problems. The counselor attempts to analyse the problems in a matter of fact manner, explaining the psychological deficiencies in the individual client. The counselor also suggests ways and means of overcoming these problems. In many cases intensive training programmes are conducted for the significant persons in the life of the client, so that a congenial environment can be created for developing appropriate skills. There are different approaches to counseling. For example: psychoanalytically oriented counseling, client-centered approach to counseling, and behavioural counseling and so on. Let us take up first the psychoanalytically oriented counseling.

3.2.1 Psychoanalytically-Oriented Counseling

One of the applications of psychoanalysis is in the field of children's problems. One can consider psychoanalysis with children in terms of certain age groups as for instance, (i) psychoanalysis of the child up to five years, (ii) psychoanalysis of the puberty child and the (iii) psychoanalysis of the teen-age child. Each of these stages, as we could expect, presents their own peculiarities and difficulties.

The development of psychoanalysis during the first decades of the last centuries, the increase of the number of the adherents to its techniques led to a sort of excessive appreciation of its virtues. Soon, psychoanalysis was thought to understand everything, and especially to interfere in every sphere of human life with an absolute authority.

Also in the field of education and pedagogy, the involvement of psychoanalysis generated specific works. Child's education is a living and direct process, which requires total, physical and spiritual participation and calls for an opening toward its problems, which is free from any preconceived ideas, even psychoanalytical. Psychoanalysis is useful for exploring the significance of the infantile behaviour. Of course that our experience with our own unconscious protects us against the counter transference, namely the temptation to project upon our own childhood experiences, our expectations, which were those of our parents, etc., on to children, but this experience results from own analysis, that is self analysis rather than from the analysis of someone else (even children).

If psychoanalysis has to be successful with children, we should give up the dogmatic ideas concerning education of the child in regard to what he or she should be or do etc. All the dictats to children, such as: "you should do this or that", must be filtered by the faculty of reasoning. In other words instead of saying do this or that, ask yourself why do we have to do this thing or that thing.

Next, we need genuine love for the child. Love has something magical about it, and perhaps it is the most reliable path to know the needs of children. If there is no love or compassion, our mind will try to fill this void of relationship with well known things, which are often erroneous.

3.2.2 Family Therapy

Therapy for children is incomplete if we do not take family into consideration. The practice of treating psychological problems in the context of the family did not actually begin until the mid 1950's. However, the developmental roots of family therapy were founded much earlier in social and theoretical changes and developments in the field of psychology. Family therapy evolved out of the reigning paradigm of psychoanalysis and the medical psychiatric model as patients' treatment needs seemed to go beyond the psychoanalytic workroom. Today more contemporary cultural influences such as managed health care etc., have favored the usually quicker approach of treating the entire family as opposed to each individual member.

The earliest approaches to psychotherapy prevalent in the 20th Century focused on individual therapy and the patient therapist relationship as the best way to treat psychological problems. Leading therapists such as Freud and Rogers believed that while family life does shape one's personality, the most influential and dominant forces controlling human behaviour were the internal, subjective beliefs that patients had about their families and thus the therapy would be most effective if conducted in isolation from the harmful influences of relatives. Therefore, patients were segregated from their families for therapy and treatment focused on their individual symptomatic behaviours.

The advent of family therapy ushered in a whole new way of understanding and explaining human behaviour. Family therapists proposed that psychological problems were developed and maintained in the social context of the family. This new contextual perspective relocated the responsibility for the problems and the focus of treatment from the internal world of the individual patient to the entire family.

Two of the most important concepts that influenced family therapy include:

a) The process and content of group discussions; and

b) Role theory.

Therapists recognised the need to understand not only the content of what the group members said but also the manner in which they communicated this. By focusing on the process of their discussions, therapists were able to help families improve the way they related to each other and thus enhance their own capacity to deal with the content of their problems.

The roles each family member played was also important and many times these roles were reversed to make the person understand what it is to be in that role

and how to react etc. To take an example, if one child is a troubled "rebel child," a sibling may take on the role of the "good child" to alleviate some of the stress in the family. This concept of role reciprocity is helpful to understanding family dynamics because of the complementary nature of roles. This breaks the individual's resistance to change.

Several other aspects of group dynamics contributed to the treatment approaches developed in family therapy, some of which are still used today. These included:

i) Acting out familial conflicts with the group instead of discussing them.

ii) Instructing individual group members to imagine that the group is their family of origin, with the intention of enabling group members to allow unresolved family and emotional issues to surface and be dealt with in a more objective setting.

All of these applications of group dynamics to family therapy involved shifting the focus of treatment from individuals to the group itself, and involved a growing understanding of themes and dynamics common to all members.

3.2.3 Child Guidance and Marriage Counselling

The child guidance movement was also highly influential in the history of family therapy. Child guidance clinics were established on the premise that psychological problems begin in childhood and early intervention is the best way to prevent the future occurrence of mental illness. At first, child guidance clinics treated children and parents separately; the family was viewed as an extension of the child. However, it became apparent that treating the child did not make the family's problems go away. Eventually, child guidance workers such as John Bowlby determined that a child's symptoms were usually a function of emotional distress in the family. Bowlby began the transition from individual to family therapy by facilitating communication between parents and children in conjoint interviews.

Professional marriage counseling is another area of clinical practice that contributed to the development of family therapy. The first institutes for marriage counseling were established in the early 1930's as clinicians recognised the advantages and efficiency of treating married couples in conjoint sessions. This growing appreciation for patterns of relationships in families led to numerous studies on marital conflict and dynamics and the effects on children's development.

Most modern types of counseling or psychotherapy have their roots in psychoanalytic theory. But unlike some forms of counseling that try to be helpful by giving advice and reassurance, psychoanalytic therapies attempt to help a person understand his or her own mind. Psychoanalytic treatment provides a relationship and a setting that allows the patient to observe and change ways of thinking, feeling, relating and behaving that may have been on "automatic pilot" or out of the patient's conscious control.

There are two types of psychoanalytic treatment: psychoanalysis and psychoanalytic psychotherapy. Both forms of treatment are characterised by an attitude of concern and respect for the patient's privacy and independence.

- In psychoanalysis, the patient meets with an analyst four or five times each week, typically lies on a couch and attempts to speak as freely as possible.

- In psychoanalytic psychotherapy, the patient and therapist meet from one to three times a week and usually sit face-to-face.

The decision to pursue either type of psychoanalytic treatment is reached between the analyst and patient based on a careful evaluation of the patient's needs. When indicated, both psychoanalysis and psychotherapy may be combined with medications that can relieve debilitating physical symptoms of depression and anxiety, while the patient and analyst work together to achieve deep and lasting psychological change.

Psychoanalysis and psychoanalytic psychotherapy are intensive therapeutic relationships that provide unique opportunities to explore and understand an individual's emotional life in depth. Insight and healing happen through a careful and empathic examination of the patient's thoughts, feelings, dreams and emerging relationship with the analyst.

Psychoanalysis is a deep, insight oriented form of psychotherapy in which patient and analyst work together to explore conscious and unconscious factors that create unhappiness in the form of painful symptoms, difficulties in work and relationships, or disturbances in self-esteem.

Psychoanalysis is the treatment of choice for many adults and children who suffer emotional pain, including those who feel derailed in their personal or educational development, hurt or disappointed in their relationships, or held back in their pursuit of creative and successful work.

Psychoanalysis is often helpful when attempts at self-help, talking to family or friends, or briefer, less intensive treatments have not been adequate. The sustained and personal collaboration with an analyst can ease depression and anxiety, restore self-esteem, relieve inner conflict and lead to a greater capacity for love, work and play.

3.2.4 Psychoanalytic Treatment for Children

Psychoanalytic treatment can be effective with children and adolescents who are experiencing difficulties. Psychological problems in young people often are expressed through problems in school, moodiness, irritability, fears, bad dreams, trouble separating from parents or difficulty concentrating. When these symptoms persist and seem to be interfering with the child's relationships or with success in school, a consultation with a child and adolescent analyst may be helpful.

During a consultation, the analyst meets with parents to thoroughly review their child's development and meets with the child or adolescent several times as well. While teenagers are usually able to talk about their troubles, younger children often express their thoughts and feelings through playing and drawing with the therapist.

Psychological testing and information from school may also be gathered to create a complete picture of the child's life.

When psychoanalysis or psychotherapy is recommended for a child or adolescent, parents are also involved in the treatment to provide information and to discuss how to help their child at home. The goal of treatment with young people is to relieve troubling symptoms and to remove psychological roadblocks that interfere

with normal development. The types of problems for which children and adolescents will seek psychoanalysis are the following:

1) Grief and loss
2) Emotional reactions to trauma or crises
3) Family transitions — divorce, remarriage, moving, new sibling
4) Concerns about separation and autonomy
5) School difficulties
6) Learning inhibitions
7) Difficulty concentrating
8) Oppositional behaviour
9) Poor self-esteem
10) Depression
11) Anxiety
12) Obsessions and compulsions
13) Phobias
14) Persistent sleep problems or nightmares
15) Harming the self or others
16) Relationship problems with peers, siblings or parents
17) Effects of sexual, physical or emotional abuse
18) Concerns related to adoption
19) Attachment disorders.

In psycho-analytically-oriented counseling, the focus is on catharsis, that is creating an atmosphere of trust in which, the client will feel free to express his feelings. The client is encouraged to talk to the counselor about anything that comes to his/her mind. This technique is called free association. In this context, the client may speak about his previous childhood experiences, which might have determining effect on his present behaviour problems. Sometimes play, drama, dance and other types of expressive methods are used as adjunct to this in order to facilitate catharsis. As the client keeps expressing his/her feelings, he/ she feels more comfortable and gets ready to do anything to overcome their psychological problems. A major objective of psychoanalytically oriented counseling is to help the clients to get rid of their fixations that prevent them from conflict resolution. Limitation of this form of counseling is that it is not problem focused and highly time-consuming. The counselor does not train the client in specific skills to overcome specific problems. There may be many problems in child's life that are not of unconscious origin.

Children may not be in a position or even capable of expressing their problems due to their not fully grown up or mature. They can however express themselves in drawing, painting and play. Play is one of the best mediums for children to express themselves. Whether it is psychoanalysis or client centered counseling or behavioural therapies, play is an important activity which facilitates children to become more expressive, uninhibited and free. They can give vent to their feelings both through activities and many play equipments and materials.

Self Assessment Questions

1) Discuss counseling for problem behaviour.

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2) What is meant by psychoanalytically oriented counseling?

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3) How important is family therapy in regard to counseling children?

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4) How do child guidance and marriage counselling contribute to counseling children with behaviour problems?

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3.3 CLIENT CENTERED COUNSELLING

3.3.1 Play Therapy and Client Centered Counseling

Play therapy refers to a method of psychotherapy with children in which a therapist uses a child's fantasies and the symbolic meanings of his or her play as a medium for understanding and communicating with the child.

The aim of play therapy is to decrease those behavioural and emotional difficulties that interfere significantly with a child's normal functioning. Inherent in this aim is:

1) Improved communication and understanding between the child and his parents.
2) Improved verbal expression,
3) Improved ability for self-observation,
4) Improved impulse control,
5) Improved and more adaptive ways of coping with anxiety and frustration, and
6) Improved capacity to trust and to relate to others.

In this type of treatment, the therapist uses an understanding of cognitive development and of the different stages of emotional development as well as the conflicts common to these stages when treating the child.

Play therapy is used to treat problems that are interfering with the child's normal development. These problems might have been extreme in degree and have been occurring for many months without any solution. Some of the problems for example could be temper tantrums, aggressive behaviour, non-medical problems with bowel or bladder control, difficulties with sleeping or having nightmares, and experiencing worries or fears.

Children communicate their thoughts and feelings through play more naturally than they do through verbal communication. As the child plays, the therapist begins to recognise themes and patterns or ways of using the materials that are important to the child. Over time, the clinician helps the child begin to make meaning out of the play.

At times, children in play therapy will also receive other types of treatment. For instance, youngsters who are unable to control their attention, impulses, tendency to react with violence, or who experience severe anxiety may take medication for these symptoms while participating in play therapy. Play therapy on the other hand would address the child's psychological symptoms.

Other situations of dual treatment include children with learning disorders . These youngsters may receive play therapy to alleviate feelings of low self-esteem, excessive worry, helplessness, and incompetency that are related to their learning problems in addition to receiving special type of tutoring for specific learning issues.

In play therapy, the clinician meets with the child alone for the majority of the sessions and arranges times to meet with parents separately or with the child, depending on the situation. The structure of the sessions is maintained in a consistent manner in order to provide a feeling of safety and stability for the child and parents. Sessions are scheduled for the same day and time each week and occur for the same duration. The frequency of sessions is typically one or two times per week, and meetings with parents occur about two times per month, with some variation. The session length will vary depending on the environment. For example, in private settings, sessions usually last 45 to 50 minutes while in hospitals and mental health clinics the duration is typically 30 minutes. The number of sessions and duration of treatment varies according to treatment objectives of the child.

During the initial meeting with parents, the therapist will want to learn as much as possible about the nature of the child's problems. Parents will be asked for information about the child's developmental, medical, social and school history, whether or not previous evaluations and interventions were attempted and the nature of results. Background information about parents is also important since it provides the therapist with a larger context from which to understand the child.

Sessions with parents are important opportunities to keep the therapist informed about the child's current functioning at home and at school and for the therapist to offer some insight and guidance to parents. At times, the clinician will provide suggestions about parenting techniques, about alternative ways to communicate with their child, and will also serve as a resource for information about child development.

Details of child sessions are not routinely discussed with parents. If the child's privacy is maintained, it promotes free expression of the child in the therapist's office and engenders a sense of trust in the therapist. Therapists will, instead, communicate to the parents their understanding of the child's psychological needs or conflicts.

For the purposes of explanation, treatment can be described as occurring in a series of initial, middle and final stages. The initial phase includes evaluation of the problem and teaching both child and parents about the process of therapy. The middle phase is the period in which the child has become familiar with the treatment process and comfortable with the therapist. The therapist is continuing to evaluate and learn about the child, but has a clearer sense of the youngster's issues and has developed, with the child, a means for the two to communicate. The final phase includes the process of ending treatment and saying goodbye to the therapist.

During the early sessions, the therapist talks with the child about the reason the youngster was brought in for treatment and explains that the therapist helps make children's problems go away. Youngsters often deny experiencing any problems. It is not necessary for them to acknowledge having any since they may be unable to do so due to normal cognitive and emotional factors or because they are simply not experiencing any problems. The child is informed about the nature of the sessions. Specifically, the child is informed that he or she can say or play or do anything desired while in the office as long as no one gets hurt, and that what is said and done in the office will be kept private unless the child is in danger of harming himself.

As the child plays, the therapist begins to recognise themes and patterns or ways of using the materials that are important to the child. Over time, the clinician helps the child begin to make meaning out of the play. This is important because the play reflects issues which are important to the child and typically relevant to their difficulties.

When the child's symptoms have subsided for a stable period of time and when functioning is adequate with peers and adults at home, in school, and in extracurricular activities, the focus of treatment will shift away from problems and onto the process of saying goodbye. This last stage is known as the termination phase of treatment and it is reflective of the ongoing change and loss that human

beings experience throughout their lives. Since this type of therapy relies heavily on the therapist's relationship with the child and also with parents, ending therapy will signify a change and a loss for all involved, but for the child in particular.

Client centered therapy is a form of counseling that was popularised by Carl Rogers. It focuses on recognising the potential of the individual client, It is assumed that every client has the innate potential to solve his/her own problems. This can be explored by giving unconditional positive regard to the client, which means, in spite of his/her problem behaviour he is accepted with full regard of a human being who can bring a change in his own behaviour.

This is made possible by the therapist being non-critical, non-evaluative and non-judgmental. The counselor acts a clean mirror to reflect back the solutions offered by the client to the client himself/herself. Therefore, a client-centered counselor does not give any specific advice or direction rather encourages the client to examine his/her own solutions, thereby shaping the client' problem solving skills, so that the solutions become congruent to himself/herself. The counselor acts as a facilitator. Hence, the method is also termed as non-directive approach. This method can also be used with the caregivers of children to help them in bringing out solutions to the problems of the child.

Person centered therapy, which is also known as client centered, non directive, or Rogerian therapy, is an approach to counseling and psychotherapy that places much of the responsibility for the treatment process on the client, with the therapist taking a nondirective role.

Two primary goals of person-centered therapy are increased self-esteem and greater openness to experience. Some of the related changes that this form of therapy seeks to foster in clients include closer agreement between the client's idealised and actual selves; better self-understanding; lower levels of defensiveness, guilt, and insecurity; more positive and comfortable relationships with others; and an increased capacity to experience and express feelings at the moment they occur.

Self Assessment Questions

1) What are the aims of play therapy?

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2) Discuss the role of the clinician in play therapy.

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3) What is client centered counseling?

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4) How is Client centered counseling used in children counseling?

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3.4 BEHAVIOURAL COUNSELING

3.4.1 Behaviour Modification Counseling Techniques

Behaviour is constantly being changed, stopped or adjusted. What is important is to apply the correct counseling techniques so the subject will perform the correct behaviour.

Counselling generally entails speaking with students, children or the subject who has behavioural issues to determine why they are acting as they do. Recommendations must take into account negative reinforcement. That is the behaviour the counselor wants to change, whether it is being rewarded and if so how and how often. To take an example a student who wants attention and acceptance from peers may act out in the class. If the counselor brings the student in front of the class and lectures about how wrong the behaviour was, he is reinforcing what was done and will very likely have increased acting out behaviour in the student all the more. Hence there is a need for an accurate analysis of the underlying reasons the person is acting out. Once this is know it would be possible to change that behaviour without reinforcing it.

3.4.2 Four Steps of Behaviour Modification

Effective behaviour modification counseling entails four steps: Defining, Designing, Reinforcing and Applying.

Defining means that the concerned deviant or undesirable behaviour has to be clearly defined. If a student is getting out of her seat to get supplies to share, it must be clarified that the getting out of the seat without permission is the problem, not that the student wants to share or is doing a favour for others.

Designing means an appropriate method must be designed to reward good behaviour and punish or repress bad behaviour. Students of different ages, and backgrounds will respond differently to various techniques. Sometimes group

punishment is effective, other times it only makes the majority of well behaved students frustrated.

Reinforce actually requires a reinforce and identifying the same. Subjects may respond well to treats, praise, or a point system where good behaviour is rewarded and negative behaviour has points taken away. Points must be given real value by allowing some sort of exchange or reward for a certain number of points. Some counselors do report success with younger students by just using points without rewards, based simply on the human need to do well. This reinforcer must be applied consistently and clearly to shape behaviour.

Prevention is the next step which is one of the most effective counseling techniques in behaviour modification. This helps in stopping negative behaviour from beginning. Details such as classroom seating plans, clear rules, modeling of pro-social behaviour, interpersonal skills training and anger management skills etc., are imparted to children which go a long way in preventing issues from arising.

Thus behaviour modification is a here and now approach. Problem behaviours are seen as consequences of poor contingencies of reinforcement and punishment. Therefore, a behaviourally oriented counselor attempts to re-engineer these contingencies by analysing the operational aspects of the problematic behaviour. The counsellor attempts to examine if problem behaviours are maintained by reinforcement available in the environment (such as encouragement, praise, attention etc.) and deficit problem behaviours are due to lack of adequate reinforcement or due to punishment (such as excessive criticism, scolding, ignoring etc.).

The counselor encourages the client to identify these consequences of behaviour in their natural environment so that these operating contingencies can be altered or replaced to strengthen good behaviour. Many problematic behaviours which are considered as problematic can be ignored to reduce their strength and probability of occurrence. The main role of the counselor is to help the clients, the care givers and significant others as to how to rearrange the defective contingencies that maintain problem behaviour.

There are many other forms of counseling which are focused on specific problems (e.g. anxiety, phobia, conduct problems, aggression etc.) and involving specific group of counselee (e.g. children themselves, their parents, teachers and so on).

Behavioural approach to counseling too has its own limitations as contingencies of reinforcement or punishment operating behind each problematic behaviour is not always identifiable and that all problems are not necessarily environmental. There are many behaviours which are controlled by internal processes that are unobservable, such as beliefs, attitudes, thoughts or nature of self-attribution.

Hence, some counselors attempt to understand these cognitive processes apart from the behavioural ones. This approach is broadly called cognitive-behavioural approach to counseling. Some counselors even prefer to have a combined approach having elements of all these approaches, termed as 'eclectic' approach.

Self Assessment Questions

1) Discuss in detail, behavioural counseling.

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2) What is behaviour modification?

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3) What are the four steps in behaviour modification?

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4) How is behaviour modification used in counseling children?

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3.5 COUNSELLING CHILDREN FOR SPECIFIC DISORDERS

3.5.1 Attention Deficit Hyperactivity Disorder (ADHD)

There are various treatment approaches to ADHD. However, prior to treatment, proper assessment is required to understand the nature and severity of this disorder. Different types of specific measures are obtained, such as behaviour rating scales, measures of vigilance and sustained attention, impulsivity, activity level and so on. Direct observation procedures are used for assessing the base rate of occurrence of behaviour of an ADHD child in natural setting. There are different

treatment approaches. Out of which pharmacological treatment and behaviour therapy are most prominent.

Treatment of ADHD requires multidisciplinary approach involving experts from various disciplines and the treatment should be multi-modal involving more than a single treatment approach. Psychopharmacological treatment involves use of pharmacological agents for treatment such as stimulants as well as depressants. Stimulants reduce ADHD by lowering the threshold of reinforcement in the nervous system. Other investigators explain ADHD as a consequence of decreased duration of sensitivity to reinforcement and that stimulants increase this duration. However, much lesser is known about the mechanism of action of the depressants.

In order to avoid the side effects of stimulants and depressants, non-pharmacological methods of treatment are preferred. Behaviour therapy is one of them. Behaviour therapy refers to application of principles of learning for changing maladaptive responding. It helps in teaching new skills to children with ADHD, as well as reducing their undesirable responding.

As their behaviour causes significant social distress, caregivers are taught to use principle of behaviour therapy to deal with these problems. Most responses of ADHD are characterised by poor stimulus control. This means, generally the stimuli that are supposed to hold attention and continue to sustain a behaviour for desired period of time fail to do so. This could be due to inconsistent disciplining, negative or punitive management of the disorder and due also to many other biological and environmental reasons. Behaviour therapists attempt to develop such a control by systematically associating reinforcement for appropriate responding and punishment in response to inappropriate responding. This is termed as 'contingency management'. There are a number of studies that indicate that this can immediately improve vigilance as well as impulse control in children with ADHD in laboratory setting. The degree of environmental stimulation greatly determines the level of hyperactivity as well as inattentiveness of these children. Studies have shown that increasing relevant inter task stimulation , novelty as well as reduction of complexity of the task may help in reducing hyperactivity. It is also noted that repeating instructions during the task improves their attention. However, what is most important is training the caregivers in such procedures.

Behaviour management technique is considered to be an essential part of ADHD treatment programme. Generally as mentioned earlier medications are given and in addition behaviour modification programme is used. These two in combination help children overcome the problem to an extent.

There are three basic categories behavioural training for children with ADHD and these are:

1) Parent training in effective child behaviour management methods.
2) Classroom behaviour modification techniques and academic interventions.
3) Special educational placement.

Behaviour management is most often used with younger children with ADHD, but it can be used in adolescents up to 18 years old and even adults. In children and adolescents, the two basic principles are:

- Modeling behaviour by encouraging good behaviour with healthy praise or rewards. This works best if the reward or praise immediately follows the positive behaviour.
- Negatively reinforcing bad behaviour by allowing appropriate consequences to occur naturally.

  For children up to 5 years of age, following behaviour modification technique could be tried out.

- Children must be provided a consistent routine and their environment and the days programme should be clearly structured.
- These children should be given clear boundaries and expectations and instructions and guidelines should be given right before the activity or situation.
- An appropriate reward system for good behaviour or for completing a certain number of positive behaviours must be worked out
- The child must be engaged in constructive and mind building activities, such as reading, games, and puzzles . In all these the counselor or the parents or care givers must themselves participate.
- Giving a child a time limit for chore completion is also useful, especially if a reward is given for finishing on time.

For children between ages of 6 years to 12 years, the behaviour modification technique to be used may be as follows:

- Clear instructions and explanations for tasks should be given throughout the day. If a task is complex or lengthy, break it down into steps that are more manageable, keeping in mind that as the child learns to manage their behaviour, the steps and tasks can become more complex.
- Appropriate reward for good behaviour and tasks completed should be clearly worked out and the children must be told about it.
- Setting up a specific consequence for a certain behaviour is probably the best method of providing consistency and fairness for the child.
- Communicate regularly with the child's teachers so that behaviour patterns can be dealt with before they become a major problem and before the teachers get overly frustrated with the situation.
- Always a good example should be set by the parents for the child. Children with ADHD need role models for behaviour more than other children, and the adults in their lives are very important.

For children who are in their teens behaviour modification can be as given below:

As the child matures, it is important to involve them in setting expectations, rewards, and consequences.

They have to be helped to improve their self esteem and reinforce the concept that they are ultimately the masters of their own behaviour and can create positive results with good behaviour.

Parents and teachers should communicate openly with the teenagers about the issues surrounding physical and sexual maturation.

Communicating on a regular basis with the teachers at school is very important.

The parents themselves should be predictable, reasonable in their behaviours and should be an asset for their children.

If parents find themselves becoming overwhelmed by the situation, they must consult a professional.

3.5.2 Specific Learning Disabilities

For conducting any scientific intervention, apart from the core areas like intelligence or specific areas of learning such as reading, writing, arithmetic, assessment is required to be carried out in many potential problem areas. Intellectual assessment is conducted by psychologists using standardised tests of intelligence. Such as Malin's Scale of Intelligence (MISIC), Wechsler's Intelligence Scale for Children (WISC) and other tests like Bhatia's Test of Intelligence. Academic performance in given area is conducted by using curriculum based tests. Many of them have limited understanding about the content areas as well as deficits in adopting proper strategies in learning e. g poor listening skills, note-taking abilities, and study habits. Difficulties may be found in spelling ability such as sound-symbol correspondence or ability to employ spelling knowledge while writing. Language disorders, memory impairments, motor coordination are some of the "soft neurological signs" often associated with learning disabilities.

Psychosocial problems such as poor task orientation, disruptive behaviour in the classroom, dependency, low self-esteem are some of the psychosocial problems that impairs their learning. Environmental influences such as socio-economic status, cultural values and child-management practices, misplaced blame, negativism and parental guilt may affect child's learning process. Therefore, special efforts made to look into these problems for improving learning abilities of such children. The major goal of remedial programme is to improve the academic skills of children with learning disabilities. In order to do so individualisation of remedial teaching is very essential. They require alternative teaching instruction as well as materials. Instructional programmes may be organised in small groups. Providing structure and direction to teaching, individualisation of instruction, promoting generalisation of learned tasks and transfer of knowledge, providing incentives contingent on better performance are some of the guiding principles behind teaching of the children with learning disabilities.

Some authors have tried to improve the self-monitoring skills of children with learning disabilities (Hallahan, Lloyd, Kosiewiex, Kauffman, & Graves, 1979) which enabled them to improve on-task behaviour. Self-monitoring programmes work best with children who are more aware of themselves. Phonological processing skills such as auditory blending or segmentation of spoken words are closely related to children's ability to read and spell (Wagner & Torgesen, 1987). Therefore, the intervention should focus on these skills. Some investigators have attempted to improve the children's learning strategies, The strategies include solving verbal math problems, study text book chapters, take tests, monitor errors

in their own performance etc., Deshler et al (1983) for instance suggested a learning strategy acronymed as 'SMART' (S:Set a goal, M: Make a plan, A: Attempt a plan, R: Review T: Try). Usually, the children with learning disabilities take a passive approach to learning (Torgesen, 1980). Purpose of these executive strategy training is to make them more active learners, so that they benefit best from the instructional environment. However, the entire intervention programme is tailored according to the need of the concerned child.

To plan out any intervention programme, assessment and evaluation of the need forsuch intervention are a must.

Firstly one must identify the inappropriate behaviour in concrete terms, naming it with verbs in the present tense. For example: "The student pushes other students when walking in line to and from activities outside of the classroom."

Assessment of behaviour both directly and indirectly must be carried out. In terms of direct observation, the student can be observed in different settings at different times as to when and under what circumstances the beahviour occurs. As for indirect assessment, interviewing students and other teachers .

All these behaviours must be documented especially in terms of specific actions prior to the onset of the behaviour, during the behaviour and as a consequence of the behaviour.

All observations and interviews should be considered when intervention is planned.

Find out if the student shows similar behaviour in similar or different settings under the same or different stimulus conditions.

Determine what the student avoids or gets as a result of the behaviour. Create an intervention plan addressing the specific skill or performance deficits that the student displays with the negative behaviour.

Make changes in the difficulty level of instruction and materials to address skill deficits.

Address performance deficits by making changes in the classroom setting and eliminating outside distractions. Try moving the student's seat to a quieter area of the classroom.

Offer explicit and intense instruction on appropriate ways to receive teacher or peer attention.

Evaluate the intervention system immediately. Keep anecdotal records of the student's behaviour or graph the occurrence or nonoccurrence of the behaviour to keep track of the effectiveness of the intervention.

3.5.3 Conduct Disorders

Intervention in conduct disorders require careful assessment of the child behaviour as well as his interaction within and outside family. In order to obtain information about the cause of such behaviours interviews, questionnaires and behavioural observations are conducted. Behavioural interviews are designed to understand

the parent-child interaction. Hence interviewing parents is important. The investigator requires to understand the stimulus events that cause conduct problems in the family.(e. g Symptom Checklist, Patterson, Reid, Jones, & Conger,1975) . Some rating scales are used with the children themselves such as Child Behaviour Checklist (CBCL: Achenbach, & Edelbrock, 1983). Behavioural observation of parent-child interaction during free-play situation and the parent-directs activities.

Behaviour therapy is reported to be one of the most effective programmes for managing children with conduct disorder. Major treatment programmes which are reported to be effective are family-based interventions, school-based interventions and skill training approaches. Family based approaches include parent training programmes in which they are trained as to how to handle conduct problems in home-setting.

Community-based residential programmes involve groups of families having children with conduct disorder. The treatment components involve multi-level point system by which reinforcement is provided for several behaviours of the child, self-government procedure, peer manager programme, social skill training academic tutoring, and home-based reinforcement system for monitoring school behaviour.

Home or community based programmes may not benefit the child who has such problems in school-setting. Therefore, school-based programmes are also required to improve effectiveness of the above programmes. Teachers' reinforcement for appropriate behaviour can reduce classroom disruptive behaviour (Becker, Madsen, Arnold & Thomas, 1967, Brown, & Elliot, 1965). The elements which are effective in classroom management include establishment of clear rules and direction, use of programmes instruction so that the child can progress at his own rate, providing positive and corrective feedback reprimand for the classroom disruptive behaviours that cannot be ignored and praise for appropriate classroom behaviour.

Special behavioural intervention programmes can be designed at individual level as well for covert conduct disorders which occur in isolation such as stealing, lying, fire setting. Substance abuse and so on.

Since some of the major characteristics of the child who has CD are: aggression (to people and animals), defiance, anti social, destructive behaviour, when documenting the child's behaviour make sure that the disorder was present at least for a period of 6 months. It is important to look for the following characteristics:

- Physical aggression to people and animals
- The child is defiant and doesn't obey rules/routines
- The child argues often with adults and peers
- The child seems to go out of his/her way to bully and harm others
- The child is often lacking accountability and blames others for inappropriate behaviours
- The child often seems angry, spiteful and vindictive and is physically cruel as well as destructive to property

- The child is non-compliant and difficult to control
- The child violates rules regularly and will destruct property, be involved in theft, start fights, and lacks respect for authority
- The child rarely shows concern for others
- There is also a tendency for this child to run away.

CD is by far one of the hardest disorders to treat, let alone cope with. There is no one way to treat cases of CD. Sometimes, medication is used to treat some of the symptoms, sometimes psycho therapy and or family therapy is used but more often than anything else, behaviour modification is used. As with all disorders, the earlier a form of consistent treatment is in place, the greater chance of success.

Given below are some of the better ways to handle CD children. A consistent approach has to be followed and consistent discipline is a must. Whenever the child behaves in the right direction, positive reinforcement should be ensured. One has to be fair but firm with them and most importantly they must be respected and they must respect the counselor.

- Develop consistent behaviour expectations.
- Communicate with parents so that strategies are consistent at home and school.
- Apply established consequences immediately, fairly and consistently.
- Establish a quiet cooling off area.
- Teach self talk to relieve stress and anxiety.
- Provide a positive and encouraging classroom environment.
- These children are often lacking confidence and have low self-esteem, promoting both will be beneficial.
- Give praise for appropriate behaviour and always provide timely feedback.
- Provide a ‘cooling down’ area/time out.
- Avoid confrontation and power struggles.

Successful treatment requires commitment and follow up on a regular basis from both parents and teachers. Expect setbacks from time to time but know that an ongoing consistent approach is in the best interest of the child. Remember, even though you put the best of strategies in place, the outcome may still be negative. However, if you turn the child with CD around, what an amazing, worthwhile experience!

3.6 REFERRALS AND COACHING

Behavioural and mental health problems when occur in milder form can be dealt by educating family members, teachers or caregivers, but when the problem is unmanageable it requires help of a professional counselor or even mental health professionals who are trained and authorised to deal with these problems. These professionals are clinical psychologists, psychiatrists, special educators, or psychiatric social workers. Coaching programmes can be organised by schools to develop specific skills in children to combat with mental health problems.

Routine screening and early identification of such problems in school or home setting can prevent serious problems of children, as prevention is always better than cure.

3.7 LET US SUM UP

Problem behaviours of children can be reduced effectively by counseling. Counseling is a process of guidance by a trained person that brings a change in the behaviour of a client. There are various types of counseling procedures. However those which are most meaningful for children exhibiting behaviour problems are psycho-dynamically-oriented counseling, client-centred counseling and behavioural counseling. Psycho-dynamically oriented counseling deals with the unconscious motivation of the child that causes the problem behaviour. Usually the unconscious wishes which are in conflict with the demand of day-to-day life are believed to cause problem behaviour. Therefore, the counselor attempts to reduce this conflict though the process of catharsis. Free association is one of the techniques to facilitate this process. It helps in bringing out the unconscious materials to the conscious, so that the individual becomes aware of it. It reduces the tension, and thereby also the problematic behaviour.

Client centred counsellor on the other hand provide unconditional positive regard to the client in order to make the best use of the child's potentials to solve client's own problems. He/sheThe counselor acts as a good listener and a clean mirror to reflect the ideas, suggestions as well as possible solution of the problem to the client so that the latter can choose the solution. In this manner the solution becomes more congruent and acceptable to the client, than if suggested by someone else.

Behavioural counselors on the other hand attempt to examine the environmental contingencies of reinforcement that maintain such problem behaviour and contingencies of punishment which fail to maintain good behaviour. They attempt to counsel the client to manipulate in such a manner that it can reduce the probability of occurrence of problematic behaviour.

However, each kind of problem behaviour need specific intervention. Therefore, at the outset, first of all they require careful assessment. Apart from pharmacological treatment attention deficit and hyperactivity disorder (ADHD) for instance can be managed by contingency management programme. Similarly, in case of specific learning disabilities (SLD) behavioural programmes may benefit the child in improving the self monitoring of spelling errors and similar errors. Teaching them strategies of learning such as 'SMART' can improve their performance. For children with conduct disorders also behavioural counseling or behaviour therapy has been found to be effective in conducting individualised, school as well as home based interventions. Self governance procedure, peer manager programme, social skills training are some of the important elements of behavioural training. In fact, behavioural counseling can be used effectively in reducing most behaviour problems of children.

On most occasions counseling is effective when performed by trained persons, such as clinical psychologists, psychiatrists, special educators or social workers. The parents, other significant family members, community members, and teachers should be aware of the counseling services available in the vicinity so that referral can be made at an early stage of detection of a problem behaviour.

3.8 UNIT END QUESTIONS

1) Discuss psychoanalytically oriented counseling for children.
2) What is meant by cklient centered counseling and how is it used for counseling children?
3) Discuss behavaioural counseling with suitable examples
4) Discuss counseling children for ADHD
5) What are the methods of counseling children with specific learning disabilities
6) What are the ways in which one could counsel children with conduct disorders?
7) Discuss referrals and coaching

3.9 SUGGESTED READINGS AND REFERENCES

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UNIT 4 REFERRALS AND COACHING: FAMILY AND CHILD BEHAVIOUR PROBLEMS

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4.0 INTRODUCTION

In this unit we will be dealing with family and child behaviour problems. We discuss each of the behavioural disorders such as the anxiety disorders, depression,

bipolar disorder etc. in detail. We then discuss the causes of behavioural disorders and in this we discuss about the genetic and environmental influences. There is an emphasis on how to assess the causative factors and how to make the correct diagnosis. This is followed by information on the types of behaviour disorders followed by the treatment and management of behaviour problems in children. Under this we discuss about the treatment and support services and management of children with behaviour disorders. The counseling which is of value to treatment of children is discussed in detail and the 5 steps to be followed by the counsellors are spelt out. The other types of intervention and prevention of children problem behaviour are dealt with in detail. Then we take up how child rearing of varied type brings about varied types of behaviour problems in children. This is followed by how family psychopathology can cause behaviour problems and parent training, sibling training and referrals are discussed.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define behavioural disorders in children;
- Describe each of the behavioural disorders;
- Elucidate the causes of these disorders;
- Explain the treatment and management of behavioural disorders;
- Elucidate the steps to be taken by the counselors in helping children with behaviour problems;
- Describe the various preventive steps to be taken in regard to behaviour problems;
- Analyse the different types of children rearing practices and how behaviour problems are related to the same;
- Elucidate the psychopathology in the family and how it may cause behaviour problems in children; and
- Refer cases to appropriate professionals when needed.

4.2 FAMILY AND CHILD BEHAVIOUR PROBLEMS

The growing years of a child are perhaps the most difficult a family ever has. It is during these years that a child comes to terms with various concepts of life, like family belonging, discipline, social norms etc. These further lead to child behaviour problems.

Child behaviour problems can crop up from anything and everything, and they can be anything. It is necessary to differentiate between mischievous children and child behaviour problems. Child behaviour problems can occur in toddlers as well as teenagers. Needless to say, toddler behaviour problems are a bit simpler as compared to teenage behaviour problems. Child behaviour problems or behaviour disorders are when children show a permanent pattern of hostile, destructive or disruptive behaviour towards self or towards the society.

There are various behavioural symptoms that are signs of behaviour problems in toddlers, children and teenagers. In the case of toddlers, some of the problem

behaviours include the following and invariably these manifest around the age of 4 years.

- A major loss of social and other communication skills. Such children may have difficulty pronouncing words and be unable to understand verbal and other communication.
- No bladder or bowel control.
- No social or self care skills.

There is no known medical treatment for such behavioural problems in children. However, proper therapy at the proper time may help solve this problem to a certain extent.

As for teenage behaviour problems, some of these can include the following:

- The child starts smoking at a very early age.
- Child consistently lies and cheats. Sometimes, the children may lie for no apparent reason.
- In short, fooling others would be a game they play.
- Damaging or destroying property is also one symptom of behaviour problems in these children.
- The child may skip school regularly.
- May show tantrums and arguments frequently.
- May willfully damage and destroy property.
- Consistent refusal to listen to authority is one of the most common symptoms of teenagers.

Even though disciplining the child with punishment is advocated to overcome the behaviour problems in children, research evidences clearly indicate that punishment would only aggravate the problem rather than reducing the same. Harsh discipline or corporal punishment will simply make the child firmer in his ideas about the entire world being out to get him or her, and therefore force the child to take more drastic measures than earlier.

One of the best ways of handling children with behaviour problem is for the parents to show restraint themselves. They should avoid fighting amongst themselves in front of the children. They should not use abusive behaviours in the presence of their children or discuss them and their behaviours in front of outsiders, relatives and friends.

Children do not know what they do not know, and they usually imitate their elders. If children do not know what arguing is, there are chances they may never find out till they learn it from a social group at a later stage.

The best way of combating child behaviour problems is by letting things go on for a while. Sooner the consequences will make the child understand his folly. For example, if the child ignores the parent and has water after having bananas, it is evident that the child will have stomach problems the next day. Rest assured, the child will never drink water now onwards taking bananas. At the same time children must get opportunities to decide for themselves. Parents must give enough choices for their children which should normally be at their level, as for

instance what to wear on a particular day and what they would do with their pocket money on a certain day etc.

Adolescence is the most crucial time for children, as they are going through both physical and mental growth during this time and therefore change considerably in their looks, gait, posture etc., as well as in their thinking and analytical abilities. It is crucial for the parents to be more supportive during these times. If the child rebels at this time, for a while the parents need not give much attention to it as this is part of growing up and will disappear as the child grows up and matures. At this age, the teenagers especially do things sometimes just to get into argument. If the parents do not argue with them in the heat of the moment, chances are that the value of the action will be reduced and the youngster may not be interested in arguing for arguing sake.

4.3 BEHAVIOURAL DISORDERS IN CHILDREN

Early child development can be seriously compromised by social, regulatory and emotional impairments. Indeed, young children are capable of deep and lasting sadness, grief, and disorganisation in response to trauma, loss, and early personal rejection. The preschool years are vital in laying the foundation for emotional development and for future social and cognitive learning. Paying attention to mental health needs in these formative and dynamic years is critically important, and new research sheds light on how to do this well.

Mental health, like physical health, is an essential part of a person's identity. Like physical health, mental health moves back and forth along a continuum throughout life, beginning during prenatal development. Sometimes mental health problems stem from environmental stressors and sometimes they stem from biological factors. For every child, a complex interaction of these two factors exists, combined with the individual process of personality development.

Children affect their environment at the same time the environments also affect them. Environmental factors are the factors people have the most control over, and therefore more information is available about how to make the environmental factors so positive that it can lead to healthy emotional development. Some of these environmental factors are the extended family, child care staff, and others with whom children have regular contact. These profoundly impact their emotional, cognitive, and social development. Attentive care givers learn to watch for the cues babies give to signal their physical needs. Reading the emotional cues of the child and responding in an attentive, caring manner is as important as meeting physical needs.

Many young children, including children with disabilities, engage in behaviour that is labeled by adults as "challenging". Sometimes, the behaviour is short term and decreases with age and use of appropriate guidance strategies. Additionally, what is "challenging" to one person may not be to another. It is critical for professionals to be aware of, and sensitive to how families, cultural groups and communities define appropriate and inappropriate behaviour in young children. It is important to understand what behaviours are typically associated with a particular age group. For example, adults need to understand that young children engage in behaviours that older children do not, such as throwing toys or sitting for only short periods of time. With guidance and instruction most children will learn appropriate behaviour.

Some children's challenging behaviours are not effectively addressed by adult vigilance and use of appropriate guidance. For these children, the behaviours may result in injury to themselves or others, cause damage to physical environment, interfere with the acquisition of new skills, and or socially isolate the child. It is clear that inappropriate behaviours such as these seldom resolve themselves without systematic intervention.

4.3.1 Child Behaviour Disorders

Young people can have mental, emotional, and behavioural problems that are real, painful, and costly. These problems, often called "disorders," are sources of stress for children and their families, schools, and communities.

Mental health disorders in children and adolescents are caused by biological, environmental as well as a combination of these two factors. Examples of biological factors are genetics, chemical imbalances in the body, and damage to the central nervous system, such as head injury. Many environmental factors also can affect mental health, including exposure to violence, extreme stress, and the loss of an important person.

Given below are descriptions of particular mental, emotional, and behavioural disorders that may occur during childhood and adolescence. All can have a serious impact on a child's overall health. Some disorders are more common than others, and conditions range from mild to severe.

4.3.2 Anxiety Disorders

Young people, who experience excessive fear, worry, or uneasiness may have an anxiety disorder. Anxiety disorders are among the most common of childhood disorders and these include:

1) Phobias, which are unrealistic and overwhelming fears of objects or situations.
2) Generalised anxiety disorder, which causes children to demonstrate a pattern of excessive, unrealistic worry that cannot be attributed to any recent experience.
3) Panic disorder, which causes terrifying "panic attacks" that include physical symptoms, such as a rapid heartbeat and disziness.
4) Obsessive-compulsive disorder, which causes children to become "trapped" in a pattern of repeated thoughts and behaviours, such as counting or hand washing.
5) Post-traumatic stress disorder, which causes a pattern of flashbacks and other symptoms and occurs in children who have experienced a psychologically distressing event, such as abuse, being a victim or witness of violence, or exposure to other types of trauma such as wars or natural disasters.

4.3.3 Depression

The disorder is marked by changes in emotions, motivation, physical well being and thoughts. As for emotions, children with depression feel sad, cry and express feelings of worthlessness. In regard to motivation, it is seen that children suffering from depression lose interest in all activities that were of interest to them earlier. There is also a decline in their school performance. Children suffering from

depression also suffer from certain physical ill health as for example, loss of appetite, poor sleep and vague physical complaints etc. Even their thinking gets affected in that they are unable to do anything right. Some are also suicidal and hence one has to be very careful to keep a watch on them and take what theysay about not wanting to live in this world etc., seriously.

4.3.4 Bipolar Disorder

Youngsters suffering from this disorder have mood swings that range from extreme highs (excitedness or manic phases) to extreme lows (depression. Periods of moderate mood occur in between the extreme highs and lows.

During manic phases, children or adolescents may talk nonstop, need very little sleep, and show unusually poor judgment. At the low end of the mood swing, children experience severe depression. Bipolar mood swings can recur throughout life. According to the data published by the National Insitute of health (2001), adults with bipolar disorder (about one in 100) often experienced their first symptoms during their teenage years.

4.3.5 Attention Deficit Hyperactivity Disorder (ADHD)

Young people with attention deficit hyperactivity disorder are unable to focus their attention and are often impulsive and easily distracted. Most children with this disorder have great difficulty remaining still, taking turns, and keeping quiet. Symptoms must be evident in at least two settings, such as home and school, in order for attention deficit hyperactivity disorder to be diagnosed. The characteristics of ADHD include:

- Inattention – difficulty concentrating, forgetting instructions, moving from one task to another without completing anything.
- Impulsivity – talking over the top of others, having a 'short fuse', being accident-prone.
- Overactivity – constant restlessness and fidgeting.

4.3.6 Learning Disorders

Learning disorders can show up as problems with spoken and written language, coordination, attention, or self-control.

4.3.7 Conduct Disorders

Young people with conduct disorder usually have little concern for others and repeatedly violate the basic rights of others and the rules of society. Conduct disorder causes children and adolescents to act out their feelings or impulses in destructive ways. The offenses these children and adolescents commit often grow more serious over time. Such offenses may include lying, theft, aggression, truancy, the setting of fires, and vandalism.

Children with conduct disorder (CD) are often judged as 'bad kids' because of their delinquent behaviour and refusal to accept rules. Around five per cent of 10 year olds are thought to have CD, with boys outnumbering girls by four to one. Around one-third of children with CD also have attention deficit hyperactivity disorder (ADHD).

Some of the typical behaviours of a child with CD may include:

- Frequent refusal to obey parents or other authority figures
- Repeated truancy
- Tendency to use drugs, including cigarettes and alcohol, at a very early age
- Lack of empathy for others
- Being aggressive to animals and other people or showing sadistic behaviours including bullying and physical or sexual abuse
- Keenness to start physical fights
- Using weapons in physical fights
- Frequent lying
- Criminal behaviour such as stealing, deliberately lighting fires, breaking into houses and vandalism
- A tendency to run away from home
- Suicidal tendencies – although these are more rare.

4.3.8 Eating Disorders

Children or adolescents who are intensely afraid of gaining weight and do not believe that they are underweight may have eating disorders. Eating disorders can be life threatening. Young people with anorexia nervosa, for example, have difficulty maintaining a minimum healthy body weight.

Youngsters with bulimia nervosa feel compelled to binge (eat huge amounts of food in one sitting). After a binge, in order to prevent weight gain, they rid their bodies of the food by vomiting, abusing laxatives, taking enemas, or exercising obsessively.

4.3.9 Autism

Children with autism, also called autistic disorder, have problems interacting and communicating with others. Autism appears before the third birthday, causing children to act inappropriately, often repeating behaviours over long periods of time. For example, some children bang their heads, rock, or spin objects. Symptoms of autism range from mild to severe. Children with autism may have a very limited awareness of others and are at increased risk for other mental disorders.

4.3.10 Schizophrenia

Young people with schizophrenia have psychotic periods that may involve hallucinations, withdrawal from others, and loss of contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure.

4.3.11 Oppositional Defiant Disorder

Around one in ten children under the age of 12 years are thought to have oppositional defiant disorder (ODD), with boys outnumbering girls by two to one. Some of the typical behaviours of a child with ODD include:

- Easily angered, annoyed or irritated
- Frequent temper tantrums
- Argues frequently with adults, particularly the most familiar adults in their lives, such as parents
- Refuses to obey rules
- Seems to deliberately try to annoy or aggravate others
- Low self-esteem
- Low frustration threshold
- Seeks to blame others for any misfortunes or misdeeds.

4.4 CAUSES OF BEHAVIORAL DISORDERS

4.4.1 Genetic Influences

Human development is shaped by a continuous interaction between biology and experience. Every child is born with powerful inborn tendencies, and these tendencies can work both for and against a child. When a child is born with a genetically predisposed tendency toward mental health problems, the environment becomes critically important to support and guide the child in a positive, healthy direction. This adds stress to the already difficult job of parenting.

The use of clinical mental health diagnosis is often avoided to prevent labeling children at a young age. However, the importance of identifying problems when they do exist cannot be overemphasised, and often a diagnosis is needed to plan a proper treatment programme for such children. The terms emotional or behavioural problems or disorders are typically used to acknowledge the existence of a problem that needs addressing, without clinically labeling the child.

4.4.2 Assessment of Causative Factors

Family members and professionals should work together to identify the behaviours, assess it in the settings where it occurs, and design interventions that are realistic to implement. Often, families are blamed for a child's problem behaviour. In an extensive review concerning families of preschool children with conduct problems, it was found that certain parental/family factors including depression, substance abuse, aggression, antisocial behaviour, intense marital conflict, insularity, and ineffective parenting skills appear related to the presence of behaviour problems for some children. However, a growing body of evidence was cited in which other factors such as child physiological / neurological / neuropsychological attributes, communication, child social problem solving skills deficiencies, and school setting characteristics also appear directly related to the presence or absence of problem behaviour in children.

While the family may or may not have contributed directly to the onset of the behaviour disorder, family members are almost always significantly affected by the behaviour. Families of children with serious behavioural problems reported the presence of major stressors in their lives two to four times more frequently than did families with typically developing children.

4.4.3 Risk Factors

The causes of ODD, CD and ADHD are unknown but some of the risk factors include:

1) **Gender –** Boys are much more likely than girls to suffer from behavioural disorders. It is unclear if the cause is genetic or linked to socialisation experiences.

2) **Gestation and birth –** Difficult pregnancies, premature birth and low birth weight may contribute in some cases to the child's antisocial behaviour later in life.

3) **Temperament –** Children who are difficult to manage, temperamental or aggressive from an early age are more likely to develop behavioural disorders later in life.

4) **Family life –** Behavioural disorders are more likely in dysfunctional families. For example, a child is at increased risk in families where domestic violence, poverty, poor parenting skills or substance abuse are a problem.

5) **Learning difficulties –** Such as problems with reading and writing.

6) **Intellectual disabilities –** Children with intellectual disabilities are twice as likely to have behavioural disorders.

7) **Brain activity –** Studies have shown that areas of the brain that control attention appear to be less active in children with ADHD.

4.4.4 Diagnosis

Disruptive behavioural disorders are complicated and may include many different factors working in combination. For example, a child who exhibits delinquent behaviours of CD may also have ADHD, anxiety, depression, a drug use problem and a difficult home life.

Diagnostic methods may include:

- Diagnosis by a specialist service, which may include a paediatrician, psychologist or child psychiatrist
- Indepth interviews with the parents, child and teachers
- Behaviour check lists or standardised questionnaires.

A diagnosis is made if the child's behaviour meets the criteria for disruptive behaviour disorders in the *Diagnostic and Statistical Manual of Mental Disorders* from the American Psychiatric Association.

It is important to rule out acute stressors that might be disrupting the child's behaviour. For example, a sick parent at home or being victimised by another child or children in school or neighbourhood may be responsible for sudden changes in a child's typical behaviour and these factors have to be considered initially.

4.5 INFORMATION ON THE TYPES OF BEHAVIOUR DISORDERS AND CAUSES

All children misbehave some times, but behaviour disorders go beyond mischief and rebellion. With behaviour disorders, the child or teen has a pattern of hostile, aggressive or disruptive behaviours for more than 6 months.

Warning signs can include:

- Harming or threatening themselves, other people or pets
- Damaging or destroying property
- Lying or stealing
- Not doing well in school, skipping school
- Early smoking, drinking or drug use
- Early sexual activity
- Frequent tantrums and arguments
- Consistent hostility towards authority figures.

If you see signs of a problem, ask for help. Poor choices can become habits. Kids who have behaviour problems are at higher risk for school failure, mental health problems and even suicide. Family counseling may help parents learn to set and enforce limits.

A young person is said to have a behaviour disorder when he or she demonstrates behaviour that is noticeably different from that expected in the school or community. This can also be stated in simpler terms as a child who is not doing what adults want him to do at a particular time.

Like learning disabilities, behaviour disorders are hard to diagnose. There are no physical symptoms or discrepancies in the body that are observable or measurable. Behaviour disorders are therefore identified by observing behaviour patterns in the child over a period of time. If a child displays some of the following behaviours he may be labeled as having a behaviour disorder:

1) Aggression to people and animals. Some people may say that the child is wicked to others and cruel to animals.
2) Destruction of property including defacing school desks, graffiti, vandalism, etc.
3) Little empathy and concern for others. Shows no feelings when another is in discomfort or pain. He has no remorse for unkind deeds.
4) Takes no responsibility for behaviour. Also lies, cheats and steals easily.
5) Disregards rules and regulations. May be openly defiant.

In addition to these general symptoms of a behaviour disorder, there are other symptoms characteristic of more specific behaviour disorders such as ODD (Oppositional Defiant Disorder, and Obsessive/Compulsive Disorder (OCD).

Young people with ODD appear to have very short tempers. They are quick to argue with others. They are very touchy. They seem to be very angry and resentful.

They display vindictive or spiteful behaviour. Generally they are very difficult to pull on with.

The Obsessive/Compulsive Disorder is manifested in repeated and persistent thought or impulses that are unwanted and cause severe discomfort in the person. For example, a child may constantly imagine that there are monsters lurking everywhere. The behaviour is compulsive when it is repeated persistently without satisfaction, e.g. counting numbers, washing hands all the time.

Behaviour disorders can arise due to brain injury. In quite a few cases child abuse, trauma, etc. can also cause behaviour disorders.

The disorder could also be due to genetic factors. A child with a behaviour disorder will feel bad about himself and that low self esteem will be further worsened by the adults around him who do not treat his condition with understanding and willingness to help. Too often the child is blamed for his unacceptable behaviour and instead of being supported to deal with it he is castigated and alienated. There is, therefore, a thin line between behaviour disorder, emotional disorders and learning disabilities. Or maybe one leads to another.

4.6 TREATMENT AND MANAGEMENT OF BEHAVIOUR DISORDERS

Behaviour disorders are best dealt with by behaviour therapy and psychotherapy. But, as with learning disabilities, accurate diagnosis is important and this must be over a length of time. It is also important in trying to modify the behaviour to be clear about what is the behaviour you are expecting. Make sure it is a rational expectation. For example, expecting a three year old to sit quietly through a long church service may not be reasonable, or demanding that a six year old does extra home work after a long day of school and extra curricular activities may be stretching the child's concentration and attention too far. Since some behaviour disorders stem from traumatic life experiences or brain injury, therapy should include helping the child to resolve and heal emotionally from the experience. The behaviour could be remedied through emotional healing. In other words when a human being is emotionally healthy, that is, can be aware of his intelligence and zest for life and his loving connectedness to other human beings, he automatically "behaves" rationally.

4.6.1 Treatment and Support Services

Now, more than ever before, there is hope for young people with mental, emotional, and behavioural disorders. Most of the symptoms and distress associated with childhood and adolescent mental, emotional, and behavioural disorders can be alleviated with timely and appropriate treatment and supports.

In addition, researchers are working to gain new scientific insights that will lead to better treatments and cures for mental, emotional, and behavioural disorders. Innovative studies also are exploring new ways of delivering services to prevent and treat these disorders. Research efforts are expected to lead to more effective use of existing treatments, so children and their families can live happier, healthier, and more fulfilling lives.

Important Messages about Children's and Adolescents' Mental Health

1) Every child's mental health is important.
2) Many children have mental health problems.
3) These problems are real and painful and can be severe.
4) Mental health problems can be recognised and treated.
5) Caring families and communities working together can help.

4.6.2 Management of Child with Behaviour Disorders

A consistent approach when dealing with children with behavioural concerns most often leads to more productive and positive behaviours. It is highly recommended that counselors plan strategies that can be implemented comfortably and regularly. Whether the child is acting out, involved in conflicts, bullying, or being verbally or physically aggressive, it is important to ensure that counselors have positive interactions with the child. Acceptable and appropriate behaviour is developmental. It happens over time and is greatly influenced by parental support and guidance, peers, previous experiences and the intervention techniques employed by teachers, caregivers and parents. The following needs to be done by the counselors to help children overcome their problem behaviour and these include:

- Promoting self esteem and confidence in the child. Whenever the child does something great, praise him/her. For this one has to be watchful and this is all the more applicable to parents.
- Counsellor and parents should provide opportunities for the child to become responsible. When children do take up responsibility, the counselor and parents must let the child know about the same.
- Counsellors and parents must be objective and understanding of the children. They must be restrained in regard to their emotions and they must be very patient even if they are frustrated.
- Parents and counselors must use their best judgment at all times, remain objective and seek to understand.
- The counselors and parents as well as teachers must communicate their expectations with a minimal number of rules and routines to be followed.
- When the rules and regulations are being made it would be ideal to involve the child also in so that it becomes easier for the child to carry out as he or she was also part of making these rules and regulations.
- When there is an opportunity for the child to succeed the counselor or the parent or the teacher must make sure that this opportunity is made available to the child.
- It would be ideal to encourage the child to participate and monitor the child's own behaviour.
- Discuss with children the appropriate and inappropriate behaviours.
- The counselors, teachers and parents must remember that children with behaviour difficulties benefit from clearly established routines/structure.

- If the child is showing unacceptable behaviour in certain situations, role play that situation and then discuss with them about what is unacceptable and why.
- The children should be specifically taught the skills necessary for appropriate behaviours.

4.6.3 Five Step Plan for Counselors to Change the Undesirable Behaviours

1) Pinpoint the behaviour that is to be changed. Be specific.
2) All the needed information must be gathered from the child, through play, from parents, siblings, peers and school. The focus should be when the unacceptable behaviour occurs, how often it occurs, under what circumstances it occurs, what precedes such a behaviour etc.
3) All the gathered information about the unacceptable behaviours must be interpreted and analysed.
4) Once it is clear why a behaviour occurs and what precedes it and so on, it is easy to plan for a change. The goals should be set clearly as to which behaviour needs to be changed and what changes have to be brought about in the environment etc.
5) Once the goal is set and plans are made and implemented, the next step is to evaluate the implementation as to whether it has brought about the desired results. If not, once again one has to re plan and reinvestigate the failure and make a workable plan to bring about the needed change.

Apart from the above it must be kept in mind by the counselors that treatment and management of many of these problem behaviours is multifaceted and depends on the particular disorder and factors contributing to it. In addition it may include:

- **Parental education:** Teaching parents how to communicate with and manage their children.
- **Functional family therapy:** In this the entire family is helped to improve communication with the child and amongst themselves and also improve their problem solving skills.
- **Cognitive behavioural therapy:** In this the child is helped to control his thoughts and behaviour.
- **Social training:** In this the child is taught important social skills, such as how to have a conversation or play cooperatively with others.
- **Anger management:** This is a very important skill in that the child is taught as to how to recognise the signs of their growing frustration and are given a range of coping skills designed to defuse their anger and aggressive behaviour. Relaxation techniques and stress management skills are also taught to children.
- **Support for associated problems:** In this, the child with a learning difficulty or speech problem is referred to a professional for overcoming certain specific difficulties.

- **Encouragement:** Many children with behavioural disorders experience repeated failures at school and in their interactions with others. Encouraging the child to excel in their particular talents (such as sport) can help to build self-esteem.
- **Medication:** Where needed the children are also given the appropriate medications so as to help in the counseling process s well as in helping the child overcome the problem behaviour.

4.7 INTERVENTION FOR CHILDREN WITH BEHAVIOURAL PROBLEMS

Many families of children with challenging behaviours have astounding stories to tell regarding their journeys through this landscape of conflicting diagnoses, bickering professionals, and expensive mistakes. There are some children whose problematic behaviour is controlled most immediately by physiological factors. There are some individuals who might benefit from appropriate pharmacological treatment in order to respond to complementary environmental, curricular, or behavioural interventions. Finally, families need partners within the working relationship involving families and early intervention professionals. It is not simply a matter of whether family needs are met, but rather the manner in which needs are met that is likely to be both enabling and empowering. Parents of children with problem behaviour are often frustrated with the child, other family members, and themselves. The understanding and support of professionals can have a profound and positive impact. They need effective tools to use, appropriate resources for support, and assurance that they and their child are accepted.

Professionals and families must carefully evaluate a child's behaviour. The focus must be on promoting positive behaviour and preventing problem behaviours. In the appropriate identification of problem behaviours, cultural and community beliefs must also be considered in addition to having developmentally appropriate expectations, and an examination of one's own belief about behaviour. When intervention is needed, such services must be developmentally, individually and culturally appropriate. They should be comprehensive, individualised, positive, multi disciplinary and consider families as integral to all decisions related to the planning and implementation of the strategies and services.

The family provides protection and care to the child and facilitates his/her personality development. Therefore, children feel secure in their families. During early years of life family lays the foundation for later ways of perceiving, thinking and feeling. On the contrary, growing body of psychological literature suggests that psychological disturbances in family members can cause adaptation difficulties leading to various psychological problems in children. For instance poor "mothering" during early childhood may cause general impairment in relationship to people. Such children rarely turn to adults for help, comfort or pleasure, show poor signs of attachment to people. In severe cases of deprivation of parental care and early stimulation it may lead to marked retardation of speech and language, intellectual disability or impaired ability to delay immediate gratification of needs that makes them prone to conduct problems and delinquent behaviour. In view of this, family deserves serious attention for treatment of behaviour problem of children. Therefore, today most programmes of psychological intervention focus on families of children with behavioural problems.

4.8 PREVENTIVE MEASURES

Children may well engage in problem behaviour that quite often can be eliminated by a change in the adult who is looking after the child. It is possible that the child is reacting to adult behaviours such as lack of attention or unrealistic expectations. By changing adult behaviour, we may prevent a child's need to engage in problem behaviour. Prevention is the best form of intervention. It is time and cost efficient, and appears to be a major avenue by which to eliminate, not merely reduce, the incidence of such behaviours.

Prevention means that the important adults in the child's life have to look at their behaviour in the classroom, home or community setting the might be maintaining the child's problem behaviours. For example, are toddlers expected to sit through a 30-minute circle time? Is a child getting a cookie when he screams? Effective prevention strategies that have been applied to the inappropriate behaviours of young children had included systematic efforts to teach parents to use child behaviour management skills and efforts to teach alternative, appropriate behaviours that are coordinated between programs and home.

4.9 CHILD REARING AND BEHAVIOUR PROBLEMS

Family plays a significant role in socialisation and personality development of the child. In this context, family pathologies may also have devastating effects on behavioural development of the child. In spite of presence of family members such as parents, a child may be exposed to 'masked deprivation' if he/she is not cared for and lacks adequate interaction, physical contact, warmth, or encouragement in the family. This may lead to apathy, aggression, and conduct disorders in children. Rejecting, indifferent and punitive mothers may cause anxiety disorders, tense, negativistic behaviours as well as affective disorders such as depression in children. However, such effects are determined by the age of the child during which such deprivation occurs, extent of the duration of deprivation as well as the constitutional make up of the child (Yarrow, 1965).

Apart from actual or masked deprivation, faulty family pattern also influences children's behaviour leading to inappropriate reaction patterns in children. For instance parental rejection, which is manifested in the form of physical neglect such as ignoring basic needs of the child, denial of affection, or harsh punishment, lack of concern for child's achievement or lack of respect to the child's individuality and dignity, may make children feel degraded, insignificant and worthless. These in turn will lead to depression, anxiety and poor self-concept subsequently lead to performance failure in many spheres of academic and professional life of the individual.

On the other hand some parents overprotect and restrict the children from normal interaction with the social and physical environment. Overprotection is manifested in many forms of parental behaviour such as protecting the child from very minor risks, over clothing, overmedication, repeated reminding of things and events of day to day life. Under these circumstances children become over dependent and have considerable difficulty in decision making.

There are parents who use children as scapegoats or use them as objects for ventilating their emotional problems. The satisfaction they should have got from their marriages, they try to derive from their children through excessive physical contact. This kind of eroticized relationship may lead to milder form of anxiety disorders like phobia or grave psychological disorders like schizophrenia, depending on the severity of parental psychopathology. Disciplining of children in family plays a significant role in personality development. Faulty or inconsistent disciplining affects them seriously, making them confused individuals. It affects their decision making process in day to day life, as a result of which they become over dependent on others even for smaller decision making.

Unrealistic demands on children, such as achieving attaining exceptionally high performance in academics and other fields of activities make them feel that they fail to live up to the expectations of their parents. It causes undue stress for them and leads to various forms of anxiety and stress related disorders. On the other hand over permissiveness of parents characterised by lack of restriction or control of wish fulfillment of children, make them egocentric and unconcerned about the needs of others.

They are more driven by their own needs than the social expectations. The "spoiled" children often become selfish, inconsiderate and demanding. They often exhibit conduct problems in schools and social situations.

Negative modeling may of one of the reasons for children developing maladaptive behaviour. Most often children imitate their parents as role models at least at the early years of life and even in later years of life. Parental behaviours are "imprinted" or interjected as 'conscience'. Here, imprinting mean inherent tendency to imitate certain behaviours at the early stage of life and introjections refers to the unconscious process of acquisition of behaviour from the parents.

Learning theorists describe it as modeling. Through modeling (Bandura, et al. 1963), many children acquire problematic behaviours that are exhibited by the parents. For instance aggression, alcoholism, or drug addiction, criminal behaviour, anxiety disorders and so on. In a study, Jenkins (1966) reported that nearly half of the children diagnosed as "over anxious neurotic" had mother with related problems. In another study, Anthony (1969) reported that more children with maladaptive behaviour come from psychotic families than normal and well adjusted ones.

4.9.1 Psychopthology in the Family

There are certain disturbances in the family that may cause behavioural problems in children. Such families are called "pathogenic" families. For example lack of resources in the family, such as poor education, poverty or social skill deficiencies may lead to psychopathology in children. Disturbed families, characterised by enmeshment of children in emotional conflicts of family members, frequent fighting of parents that cause tension in the family frequently affect child's personality development. A number of studies have focused on schizophrenogenic parents, particularly, schizophrenogenic mothers who promote schizophrenic behaviour in children.

These mothers are typically rejecting, dominating, cold and unconcerned about the feelings of their children, although verbally they look to be quite accepting

and understanding. They depend on their children for emotional gratification than on fathers. In many instances they are overtly seductive towards their children.

Similarly antisocial families promote psychopathic behaviour in their children. At the expense of their conformity with the family norms, children ignore the social demands. Broken homes, characterised by death, divorce or prolonged absence of a parents, may lead to a wide variety of behavioural disturbances in children. Therefore, these pathologies are required to be treated or addressed to while conducting intervention programmes for disturbed children.

It is not only that pathological family environment causes stress and behavioural disturbance in children, but also that behavioural disturbances in children do affect the family dynamics causing stress and psychopathology. Therefore, family psychopathology and child behaviour problems are linked with each other.

4.9.2 Parent Training

Training parents of children with behaviour problems is considered to be important as these programmes are required to be implemented in home setting and that parents are considered to be the most responsive members of the family and generally, they have good deal of commitment for their children (Jena, 2009). Therefore, for children, parent training programmes are preferred to institutional programmes. Precisely, the reasons are accountability, transparency and convenience (Jena, 2001). Secondly, presence of the children with maladaptive behaviour do cause stress to the parents (Pershad, et al. 1978; Srivastava, 1990). Parent training programmes are also designed to reduce stress caused by the child with behavioural problems.

Due to their involvement with children, parents act as natural therapists for children. However, professional training makes them very effective as therapist. This is partly because of their clear understanding of the behavioural ecology of the child. In view of this, parents and/or other members of the family are considered as ideal mediators for treatment.

In most cases, the family members create the behavioural ecology or a setting for the behaviour problems to occur and also to sustain it over a long time. In a sense they mediate the behaviour of their children. Such behaviours are heavily reinforced by the family members without knowledge of the child. For instance, even simply watching the temper tantrums of the child, they may selectively reinforce and strengthen this behaviour increasing chances of its future occurrence.

Similarly, severe punishment may lead to a wide range of undesirable behaviours, such as aggressive behaviour, fear or avoidance. Consequently, parents are considered as important ‘mediator’ in treatment programmes as well as in order to make children unlearn inappropriate behaviours and replace them by adaptive ones.

There are two major varieties of training programmes:

i) The first group of training programmes are dynamically-oriented programmes or reflective programes, in which the focus is on teaching communication

skills to parents. They are taught listening techniques as well as how to respond to the emotional needs of their children.

ii) The second groups of training programmes are behavioural training programmes. The focus is primarily on behavioural skills training for the parents. The parents are taught as to how to increase the desirable behaviour of children, while reducing undesirable ones. They are taught, how to reorganise the contingencies of reinforcement and punishment in natural setting.

The parents are taught about:

1) Identification and accurate measurement of problem behaviours of their children,

2) Identification of antecedents and consequences of maladaptive behaviour which influences and maintains the same,

3) Systematic manipulation of reinforcers and punishers in the natural environment,

4) Programme evaluation.

In contrast to the orthodox doctor patient model of treatment of mental diseases, the psychologists and social workers now use a 'triadic' approach, in which the parents act as mediators who transfer the training to the child. The three agents involved in such programmes are the therapist (T), parent (P) and the child (C). The therapist makes use of the parent's understanding about the child behaviour problems and trains them as to how to help the children with behaviour problems.

4.9.3 Sibling Training

Very recently, sibling training has been emphasised for the treatment of child behaviour problems for almost the same reasons for which the parents are involved. Particularly when parents themselves are affected or have little time for their affected children, siblings are involved in treatment programmes. In many cases the siblings are trained as surrogate parents to take over the role of parents for managing their affected siblings. They also compensate the role of their parents whenever required. However, it requires adequate planning and programming, so that the skills can be transferred to them. A number of studies have indicated that the siblings are less affected by the psychopathology of their siblings, therefore, we believe that they are at an advantageous position in working with their affected siblings.

In fact, treatment of a child with behaviour problems has to be family centered involving each family member, so that caregiver's burden or on any one individual family member will be lesser and implementation of the programme will be continuous and successful. Its consequent outcome becomes better than the ones in which only one of the family members is involved.

4.9.4 Referrals and Coaching

Behavioural and mental health problems when occur in milder form can be dealt by educating family members, teachers or caregivers, but when the problem is unmanageable it requires help of a professional counselor or even mental health professionals who are trained and authorised to deal with these problems. These professionals are clinical psychologists, psychiatrists, or psychiatric social

workers. Teaching programmes can be organised by schools to develop specific skills in children to combat with mental health problems. Routine screening and early identification of such problems in school or home setting can prevent serious problems of children, as we believe that prevention is always better than cure.

4.10 LET US SUM UP

In this unit we have dealt with the problem behavious of children and the role of the family. We dealt with in detail the various problem behaviours and the causes thereof. We have drawn certain basic assumptions as rationales for conducting family centered interventions for children with behaviour problems: No matter how the behavioural problem is acquired by the child, it is largely maintained by the family. Family disturbance is one of the most important causes of behaviour problems during childhood. On the other hand, when a child exhibits these behaviour problems, the family is also affected by the same. However, some behaviour problems affect the family dynamics more intensely than others. Training the family members in treatment of children with behaviour disorders is more effective than focusing on the treatment of the child alone. Treatment programmes that are designed to be implemented by the family members are more effective than the ones conducted in the institutional setting. When behaviour problems cannot be handled by the agents in natural setting, should be referred to the mental health professionals. However, effort should be made to prevent than treat such disorders.

4.11 UNIT END QUESTIONS

1) Explain the term child behaviour with reference to its behavioural problems.
2) Differentiate between child behaviour problems and teenagers behaviour problems.
3) Specify the characterstics of conduct disorder and oppositional defiant disorder.
4) Elucidate the causes of behavioural disorders.
5) How can you prevent the child with behavioual disorder, discuss it with reference to five step plan for counselor.

4.12 SUGGESTED READINGS

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UNIT 1 PLAY THERAPY

Structure

1.0 Introduction
1.1 Objectives
1.2 Defining Play Therapy
1.3 Salient Features of Play and Play Therapy
1.4 Basics of Play Therapy
1.5 Characteristics of Play Therapists
1.6 The Effectiveness of Play Therapy
1.7 Let Us Sum Up
1.8 Unit End Questions
1.9 Suggested Readings and References

1.0 INTRODUCTION

We don't stop playing because we grow old; we grow old because we stop playing.
- George Bernard

As we are towards the end of your this course on school psychology, you might have got a very fair idea that this is a very challenging field to work with the school children. The first block has given you sound background knowledge of school psychology as a discipline. In your second block you were acquainted with various development factors where you also read about the assessment of children in schools for various behaviour problems. The behaviour problems were discussed at length in your third unit where you have read not only types of behaviour problems but also why do they appear and how counselling could help. As a school psychologist, you may face problem behaviour in school children like indiscipline, child aggression, bullying, truancy, cheating etc. And, as a school psychologist, you have also read in the section 2.3 of the second unit of your first block, you have to play an important crucial role in the enhancement of the status of children, youth, and adults as learners and productive citizens in schools, families, and communities. To achieve this target, a school psychologist has also to be trained so that he/she could intervene with the help of related therapies whenever some problem behaviour is visible and/or reported there in a school child. Hence is this block. And, we shall start with play therapy.

1.1 OBJECTIVES

By the end of this unit, you will be able to:

- define therapy, psychotherapy, and play therapy;
- illuminate the salient features of play and play therapy;
- describe the basics of play therapy;
- explain the importance of play therapy;
- elucidate the characteristics of play therapists; and
- design play therapy intervention for a hypothetical student.

1.2 DEFINING PLAY THERAPY

As you might have some preconception about the meaning of play, so, let us start with therapy. You might have somewhere come across the term 'therapy'. What general idea do you have about the meaning of therapy? Wikipedia defines therapy as the attempted remediation of a health problem, usually following a diagnosis. Where in medical terminology, it is used a synonym with treatment, in psychology, it generally refers to psychotherapy. Psychotherapy is an English word derived from two Ancient Greek words – *psyche* meaning breath, spirit, and soul, and *therapia* meaning healing, and medical treatment. Wikipedia explains psychotherapy or personal counseling with a psychotherapist as, "an intentional interpersonal relationship used by trained psychotherapists to aid a client or patient in problems of living. It aims to increase the individual's sense of their own well-being. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behaviour change that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family)".

Frank (1988), a psychiatrist, defined psychotherapy as "the relief of distress or disability in one person by another, using an approach based on a particular theory or paradigm, and a requirement that the agent performing the therapy has had some form of training in delivering this. It is these latter two points which distinguish psychotherapy from other forms of counseling or caregiving."

With this background information about therapy and psychotherapy, we can now move on to the meaning and definition of play therapy.

Self Assessment Questions

1) What do you mean by play?

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2) How can play be used as a therapeutic intervention?

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As you have seen in the preceding paragraphs the meaning of therapy and its use for psychological purposes as psychotherapy, you would be trying to develop your own conception about play therapy. First, let us see what experts and psychologists have to say about "play".

Else (2009) writes, "playing children choose the content and purpose of their actions, following their own instincts, ideas and interests, in their own way for their own reasons" (see VanFleet, Sywulak, Sniscak, and Guerney, 2010). Thus, Else considers that play is a process the players choose freely, and direct their actions according to their wish and will, and to attain their perceived rewards.

Clark and Miller (1998, see VanFleet et al., 2010) have also defined the children's play on the basis of the following four parameters:

- It is non-literal.
- It is done for its own reasons and not directed toward an external goal.
- It is associated with positive feelings and is enjoyable.
- It involves flexibility in the use of the play objects as well as in the process.

The views of the above experts reveal the nature of 'play' as it mainly depends on the players to choose their contents and processes. Flexibility in play and leading to rewards and enjoy are another major criteria. If you have seen the children playing, you might have yourself noticed that play is very dynamic group process and depends on various factors like age, sex and personality structure of the players, relationships with other players and rewards associated with winning. And that's why, keeping in view the importance of play in child's psychosocial development, the psychologists are devising and adopting play-based therapeutic approaches to treatment/modification of behaviour of the children in schools. It is also because it is the play which brings out the child's inner world – his/her feelings and perceptions etc. Another important reason of using play as a therapeutic tool is that play helps in discharging the distress and overcoming various problems. Here, let us see how 'play therapy' is defined.

VanFleet (2004) defined play therapy as, "a broad field that uses children's natural inclination to play as a means of creating an emotionally safe therapeutic environment that encourages communication, relationship – building, expression, and problem resolution for the child" (see VanFleet et al., 2010).

Wilson and Ryan (2005) described play therapy as, "a means of creating intense relationship experiences between therapists and children or young people, in which play is the principal medium of communication. In common with adult therapies, the aim of these experiences is to bring about changes in an individual's primary relationships, which have been distorted or impaired during development. The aim is to bring children to a level of emotional and social functioning on par with their developmental stage, so that usual developmental progress is resumed" (see VanFleet et al., 2010).

According to the Association for Play Therapy (APT), United States, the play therapy is, "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (www.a4pt.org, 2011).

Landreth (2002) defined play therapy as: "A dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe environment and a safe relationship for the child (or a person of any

age) to fully express and explore self (feelings, thoughts, experiences, and behaviours) through the play, child's natural medium of communication, for optimum growth and development".

1.3 SALIENT FEATURES OF PLAY AND PLAY THERAPY

The views of experts and psychologists given above might have enlightened you about play therapy and some of its essential features. Let us extract or recapitulate these features for a clearer understanding of this therapeutic intervention.

1) Play is not just any random activity. It is purposeful.
2) It is directly related to the development of a child – be it physical and motor development, social and emotional development.
3) Play gives the children an opportunity to utilise their creativity and develop their imagination.
4) It helps them socialise and learn cooperation as well as competition.
5) It helps boost their physical and emotional strength.
6) Plays help them understand the reality and severity of the loss.
7) It helps them make decisions, negotiating in various situations and finding solutions the various problems.
8) Plays also have binding effects and the child learn attachments which is essential for feelings of safety and security.
9) Plays give them an opportunity to express themselves and their feelings.
10) Play is an integral part of the lives of children.
11) Plays can be used to help children overcome their distress and psychological problems.
12) Play is another type of communication but play therapy does not necessarily require any language or verbalization from the target child.
13) It is one of the most developmentally appropriate therapeutic interventions for the prevention or treatment of many types of child problems (VanFleet et al., 2010).
14) Because play takes place when a child feels security both physically as well as emotionally, play therapy relies on the development of a child-focused relationship as the therapist has to become a part of the world of the target child for minutely but naturally examining his/her behaviour, thoughts and feelings, etc. Through this relationship, the therapist has to provide psychologically and emotionally secure environment to that target child so that he/she could overcome his/her problems, gain mastery over fearful thoughts or anxious feelings, and could achieve psychosocial health as a result of therapist's interventions.

The task of the therapist, this way, is highly challenging as he has to gain the confidence and trust of the child for being a part of his world to understand him/her in order to help him/her through therapeutic interventions.

So, it is clear now that the major purpose of a play therapist is to help the child gain/regain psychological health and smooth functioning in school as well as the peer group or society. As the child uses play to explore his/her world, the therapist has to join the child in that play. He has to play a role of the child and professional. He need not only to observe the behaviour of the target child but also to record. He, being a professional therapist has also to note down his/her own personal reactions towards the observed behaviour of the child/children. He has to take the developmental history of the child by talking to his parents, relatives, teachers and friends. The relationship the child is having with his/her family members, friends, classmates, teachers and others might be a reason of the problem behaviour. So, each bit of information has significance in designing/applying therapeutic interventions for the child.

Self Assessment Question

1) In light of the above features of play and play therapy, how would you design your playroom for therapeutic interventions of the children?

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1.4 BASICS OF PLAY THERAPY

Let us learn the basics of play therapy which might be useful for you to gain the basic understanding of the process. However, you should not "start applying/ using any therapy without the supervision of a trained therapist". For practical experience and know-how to, you should work for a reasonable time under the direct supervision of a trained practitioner.

Suppose you are a trained play therapist. For applying play therapy, now there are two main requirements: (1) a student who is to be benefited from your play therapy, and (2) a well – equipped playroom consisting of items like clays, crayons, toy cars, books, stuffed animals, toy kitchen appliances, puppets, dolls, musical instruments etc. where you would be applying play therapy.

Now, you are required to, first of all, prepare a complete history of the child which is to be followed then by a clinical assessment. Then, in consultation with the caregiver, and depending upon the problem, history and needs of the child, you need to plan/choose a treatment modality appropriate and suitable for the child.

You also need to give due importance to trust-factor by being the friend of the child because in the absence of child's trust in you (play therapist) it would be highly difficult for you to move ahead. Similarly, you will also have to build a good rapport with the child for taking successful play sessions. Depending upon the child's personality, problem and needs, and on the bonding between the child and the therapist, the therapy may range from 12 – 15 sessions to two years or more. The duration of one therapy session may be usually 30 – 60 minutes per day and you may meet the child twice a week or more frequently.

When you meet the child for play therapy session, you should try to make him/her feel safe and comfortable. You may use a directive or non-directive approach. But, the therapy is child-centered and play-based. You should not suggest the child what materials or activities he/she should choose. For the most part, the child is to be allowed to choose the materials. It will help them understand and express their internal feelings. It is the beginning of the healing process. You should be cautious that you should not miss the sessions in unplanned manner as it may disrupt the progress of therapy.

Whenever required, you need to talk to the parents of the child because they are also required to be sensitized about the needs of the child. You may need to counsel not only the parent of the child but also the teachers because they are also in continuous touch with the child (your client) and their behaviour/dealing with the child may negatively affect your efforts. So, to seek their due support, you may need to counsel them too. Sometimes, you may need to call the parents to participate in the therapeutic session.

You are required to minutely observe the progress of your sessions. The child's behaviour is going in which direction and whether moving in the direction of your targets is to be constantly watched and monitored. At the end of the session, you have to tell the child that it is time to stop now and to put the toys back from where they were picked up. If any day, the child wants to go back early, you should allow but, before leaving, inform the child/guardian about the date and time of the next session.

Last but not the least, from the ethical point of view, you are supposed to maintain the confidentiality of the information of the child. You need not to discuss the name, address, problem, etc. of the case where it is not required. It may lessen the child's trust in you and reduce the feelings of safety which in turn would hinder the progress of your therapy.

1.5 CHARACTERISTICS OF PLAY THERAPISTS

This is a general observation that the professionals in their respective fields are expected to have certain specific qualities and characteristics by their academic qualifications or background experiences. This is true for play therapists as well. To be a successful play therapist, there are certain qualities which one need to posses and/or develop. Axline (1947) introduced eight such principles:

First Principle: "The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible".

Second Principle: "The therapist accepts the child exactly as he is".

Third Principle: “The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely”.

Fourth Principle: “The therapist is alert to recognise the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behaviour”.

Fifth Principle: “The therapist maintains a deep respect for the child’s ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child’s ”.

Sixth Principle: “The therapist does not attempt to direct the child’s actions or conversation in any manner. The child leads the way; the therapist follows”.

Seventh Principle: “The therapist foes not attempt to hurry the therapy along. It is a gradual process and is recognised as such by the therapist”.

Eighth Principle: “The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship”.

However, later researchers cautioned the therapists by suggesting that if they possess these qualities to a high degree, they would be considered an “ideal” person and the client/child would not identify themselves with these therapists. So, what should be done then? Depending upon one’s situations, keeping and maintaining the flexibility, one may try to recognise those qualities and characteristics which are going to (a) help develop and maintain the mutual trust between the therapist and the client, and (b) result ultimately in the positive and desired change in the client.

1.6 THE EFFECTIVENESS OF PLAY THERAPY

Play therapy is applied world wide in various settings. Many studies have reported encouraging results that it can be effectively used with children who are suffering from various academic, learning, social, emotional, and behavioural problems. Some of such major problems include anxiety, depression, social developmental problems, anger control/management difficulties, abuse, low self-esteem autism and ADHD etc. Josefi and Ryan (2004) reported a case study of a 6½ year old boy who was suffering from severe autism. The boy was given 16 play therapy sessions and it was found that there was improvement in pretend play, attachment, emotional responses, autonomy, coping with changes, social interaction, and self-regulation of basic needs for nurture. The researchers emphasised that the effectiveness of play therapy for autistic children is noticeable because the child is unconditionally and positively regarded and accepted, and the treatment is planned at the developmental level of the child.

Similarly, it has been found that play therapy has significant positive effect on the children with ADHD as the kids who participated in play therapy sessions were less stressful to their teachers, revealed lesser anxiety, reduced emotional distress, improved self-efficacy, enhanced self-concept and compliance to treatment (Ray, Schottelkorb, and Tsai, 2007). Because the kids might not be able to verbally express themselves through words or language, play therapy is

particularly helpful for them to give an opportunity to express themselves through play. Marvasti (1988) found that the child is able to express his/her emotions through play in a play therapy situation and this emotional expression may be more accurate even than his/her verbal statements.

Drewes (2001), Van Dyke & Wiedis (2001), and Webb (2001) have reported that play therapy has provided an effective treatment for children who were exposed to traumatic events in their lives. As these children were not able to clearly articulate their thoughts and feeling, play provided the most effective approach to trauma resolution. After Hurricane Katrina, the most prominent natural disaster of 2005 in United States, one child under observation during the study used the figures of a child and mother in a dollhouse and acted out those incidents which occurred during the Katrina storm. This child represented that a tree had fell through the roof and she hid the figures of that child and mother under the bed at that time in order to save the terrified child and mother from that falling tree. This way, she played out that terrible episode which had a traumatic impact on her in a safe environment thereby releasing her stressful feelings and thoughts (Hebert & Ballard, 2007).

The results of a study involving 381 elementary school counselors showed that more than 73% of the respondents reported that play therapy is an "effective or highly effective tool" for working with students (Ray, Armstrong, Warren and Balkin, 2005). Ray et a. (2005) further reported that the less use of play therapy by school counselors could be attributed to the lack of time to spend counseling students and inadequate or insufficient training in this field. Although in India also, the use and research on play therapy is very limited, the effectiveness of play therapy has been reported in a 12 – year old girl who was diagnosed for mixed disorder of conduct and emotion (Panicker, Hirisave, and Srinath, 2004). It is also pertinent to mention here that Dutta and Mehta (2006) reported, "child-centered play therapy [along with reflective parent counselling] was effective in children with somatoform disorders as it helped them to systematically address and resolve various emotional issues that they were unable to express verbally". They further remarked that "Play therapy is not a commonly used method in child guidance clinics in India and it is strongly advocated that it should be incorporated in such clinics".

Most of the play therapists quote three major reasons of the effectiveness of play therapy: it is developmentally appropriate, experiential, and child-driven. Being developmentally appropriate means that it gives full freedom to the child to use/speak their own language and to make meaning out of their words with their own language. In very beautiful words, Landreth (1991) said, "Play is to the child what verbalization is to the adult …Toys are used like words by children and play is their language". The second reason is its being experiential (Norton and Norton, 1997). It allows the kids to get their total selves also involved in their own healing. While playing, they trust themselves and use their momentary experiences to manipulate and control the situations. Thus, through play, they catch hold on their life circumstances and by control they heal themselves. Thirdly, the effectiveness of play therapy lies in its being child-driven. Because the child is resilient, he/she also possesses the inner strengths and a natural predisposition for self-healing (Norton and Norton, 1997). Given the opportunity, they help themselves and the playroom supports it. Landreth (1991) rightly explains it, that when properly facilitated, children "take the therapeutic experience where they need to be". These major reasons explain why play therapy works effectively.

1.7 LET US SUM UP

There are growing instances where we are finding that even very young school kids and children are under extreme stress to perform well. It has not only reduced their play time but also has severe effects on their psychosocial and emotional health. They are not finding enough room to express themselves or time with parents to share their feelings and emotions. This is, in the long run, affecting their behaviour. Hence, working on the philosophy of prevention is better than cure, we need to what suggested by Landreth (2002) that play therapy should be integrated into the school-based mental health services in order to enhance the children's potential for learning.

Also, keeping in mind the availability of trained play therapists in India, we need to work on the training of in-service teachers in therapeutic interventions because it is they who directly deal with the students in the class room, interact with them, observe them and may help them. This training may provide them additional skills to promote the well-being and development of the children besides their academic performance.

1.8 UNIT END QUESTIONS

1) Critically evaluate the play therapy in terms of its success in treating children with problem behaviour.
2) Is it essential for the play therapists to posses certain characteristics?
3) "Toys are used like words by children and play is their language". Comment.
4) Write an essay on the effectiveness of play therapy.
5) If you have to develop a treatment strategy for an autistic student, how would you design and implement play therapy?

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UNIT 2 NARRATIVE THERAPY

Structure

2.0 Introduction

2.1 Objectives

2.2 Theoretical Viewpoints Defining Narrative Therapy

2.2.1 Psychodynamic Approaches to Narrative Therapy

2.2.2 Cognitive/Constructivist Approaches to Narrative Therapy

2.2.3 Social Constructionist Narrative Therapy

2.3 Therapeutic Process

2.3.1 Assumptions of Narrative Therapy

2.3.2 Assessment

2.3.3 Goals of Narrative Therapy

2.3.4 Therapeutic Outline: Process of Therapy

2.4 Let Us Sum Up

2.5 Unit End Questions

2.6 Suggested Readings and References

2.7 Answers to Self Assessment Questions

2.0 INTRODUCTION

Narrative therapy is a form of psychotherapy used when working with adolescents on the tensions or problems of living. "Psychotherapy involves the psychological treatment of problems of living, by a trained person, within the context of a professional relationship, involving either removing, reducing, or modifying specific emotional, cognitive, or behavioural problems; and/or promoting social adaptation, personality development and/or personal growth" (Barker, 1999). Narrative therapy specifically involves working with a person to examine and edit the stories the person tells himself or herself about the world to promote social adaptation while working on specific problems of living. These complex stories include those related to who they are as a person and their interpretation of events that signal to them where they fit into the world. It is very much about re-ordering parts or in some cases the whole of the personal in head filing cabinet. This occurs around specific and concrete incidents. In this unit you will learn about theories of narrative therapy, assumptions, assessment and goals of narrative therapy and we give you an idea of therapeutic process in terms of an outline.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Define narrative therapy;
- Elucidate the theoretical viewpoints;
- Explain the psychodynamic approaches to narrative therapy;
- Describe the cognitive/constructivist approaches to narrative therapy;
- Elucidate the social constructionist narrative therapy;

- Discuss the therapeutic process of narrative therapy; and
- Explain the therapeutic outline of narrative therapy.

2.2 THEORETICAL VIEWPOINTS DEFINING NARRATIVE THERAPY

Freedman and Combs (1996) in their text *Narrative Therapy* notes,

Using the narrative metaphor leads us to think about people's lives as stories and to work with them to experience their life stories in ways that are meaningful and fulfilling. Using the metaphor of social construction leads us to consider the ways in which every person's social, interpersonal reality has been constructed through interaction with other human beings and human institutions and to focus on the influence of social realities on the meaning of people's lives.

The central assumption of the narrative approach is that personal experience is fundamentally ambiguous. This doesn't mean that experience isn't real or that it's necessarily mysterious or opaque but rather that understanding human experience, including one's own, is never simply a process of seeing or analysing it. The elements of experience are understood only through a process that organises those elements, puts them together, assigns meaning, and prioritizes them. To say that experience is fundamentally ambiguous is to say that its meaning isn't inherent or apparent but that it leads itself to multiple interpretations.

To illustrate how experience is shaped by the language we use to describe it, consider the difference between calling heart-racing tension most people feel before specking in public "stage-fright" or "excitement". The first description makes this agitation a problem, something to overcome. The second suggests it's natural, an almost inevitable and not necessarily problematic response to standing up in front of people whose approval you hope to win.

Whether people experience stage fright or excitement depends upon how they are interpreting their arousal. Strategic therapists gave clients reframes—new interpretation—for their experience. "The next time you are speaking in front of others, just think of yourself as excited rather than nervous". Narrative therapists recognise that such interpretations are useless unless these interpretations fit in the stories people create about themselves. For example if someone does not have a positive view of self, he will have great difficulty believing that his hands are trembling because of excitement instead of anxiety. Therefore, therapist first needs to work on his life story (He is intelligent and people like to listen to him) and then the situation story (Hand trembling when on stage). Narrative therapy focuses on self-defeating cognitions—stories people tell themselves about their problem. Narrative therapy aims to expand client's thinking to allow them to consider alternative ways of looking at themselves and their problems.

Stories don't just mirror life, they shape it. That's why people have the interesting habit of becoming the stories they tell about their experience. It is also why therapist's eagerness to impose their interpretation often fail—and why, by delving into people's stories, narratives therapists are able to understand and influence what makes them act as they do.

Narrative has become an enormously popular topic. There is a vast literature on narrative, written by anthropologists, sociologists, historians and scholars in

linguistics, cultural studies and literary criticism, as well as by psychologists and therapists. Partly this reflects the ubiquity of narratives: stories are everywhere. But partly, too, it reflects an important aspect of what has become known as the postmodern era in which we live. The industrialised, scientific, mass society that most of us live in is dominated by the values of modernity: belief in progress, rationality, science.

These are some of the reasons why the literature on narrative is large and complex, and potentially confusing. For instance, it is possible to find several different definitions of 'narrative' and 'story'. A story is taken to be an account of a past event that is structured with a beginning, middle and end, and communicates information about a sequence of intended actions undertaken by a person or group. A story is therefore different from a mere chronicle of events. A well constructed story has some degree of dramatic quality, and conveys suspense and feeling and something about the personality of both the teller of the story and the characters within it. A story will also usually have some evaluative element. There is often a 'moral' to a story. A story is told to 'make a point'.

A narrative, by contrast, is a more inclusive term that is used to describe a general process of creating an account of what has happened. A narrative may include several discrete stories, but may also include commentaries on these stories, linking passages and explanations. The whole of what a client says in a counselling session can therefore be seen as his or her 'narrative', which may be built around the telling of three or four discrete 'stories' over the course of the hour. The concept of narrative has been used in quite different ways by representatives of competing theoretical approaches to counselling and psychotherapy. There have been three quite distinct lines of development in relation to the evolution of a 'narrative-informed' or 'narrative-oriented' model of therapy. The three theoretical orientations that have been most involved in this area are the psychodynamic, constructivist and social constructionist approaches (McLeod 1997). Most of the remainder of this topic concentrates on the contribution of a social constructionist approach to narrative therapy, because that is the approach that has most fully exploited narrative ideas. However, before we move on to a fuller exploration of that set of ideas, it is necessary to review briefly the way that psychodynamic and cognitive/constructivist counselors and therapists have looked at story and narrative.

2.2.1 Psychodynamic Approaches to Narrative Therapy

Psychoanalytic and psychodynamic therapists and counsellors have shown a lot of interest in narrative, and have looked at this phenomenon in two main ways. First, the stories told by clients or patients have been seen as conveying information about the person's habitual ways of relating to others. Second, the role of the therapist has been viewed as that of helping the client to arrive at an alternative, and more satisfactory, way of telling their life story.

The first of these topics, the value of the client's story as a source of information about recurring patterns of conflict within their relationships, has been explored by Strupp and Binder (1984) and by Luborsky and Crits-Christoph (1990). Although Strupp and Luborsky have taken broadly similar approaches to this issue, the work of Luborsky's research group, based at the University of Pennsylvania, is better known and more extensive. The key source for these

studies is Luborsky and Crits-Christoph (1990), although Luborsky et al. (1992, 1994) have compiled excellent short reviews of their research programme and its clinical implications.

The Luborsky group has observed that although clients in therapy tell stories about their relationships with many different people (for instance, their spouse/ partner, family members, friends, the therapist), it is nevertheless possible to detect consistent themes and conflicts running through all, or most, of the stories produced by an individual. Luborsky labels this the core conflictual relationship theme (CCRT). Moreover, Luborsky suggests that these stories are structured in a particular way, around three structural elements. The story expresses the wish of the person in relation to others, the response of the other and finally the response of self. This model allows the meaning of what might be a convoluted and complex story told by a client to be summarized in a relatively simple form.

In general, the most frequently reported client wishes are ‘to be close and accepted’, ‘to be loved and understood’ and ‘to assert self and be independent’. The most common responses from others are ‘rejecting and opposing’ and ‘controlling’, and the most frequent responses of self are ‘disappointed and depressed’, ‘unreceptive’ and ‘helpless’ (Luborsky et al. 1994). In their research studies, Luborsky and his colleagues have found that clients tell an average of four stories in each session, usually about events that have taken place in the last two weeks, and that around 80 per cent of the responses from others and of self are clearly negative, but become more positive as therapy progresses.

The research carried out by Luborsky and his collaborators has established the importance of the CCRT as a unit for analysing therapy process. However, their model also has many implications for practice. Luborsky’s main aim has been to provide therapists with a straighforward and easy-to-use method of both making interpretations and analysing transference. It has been shown (Luborsky and Crits-Christoph 1990) that interpretations accurately based on CCRT elements are highly effective in promoting insight, although overall the accuracy of therapist interpretations assessed by this technique tends to be low, and the relationship with the therapist (the transference) tends to correspond to the CCRT pattern found in stories about other people. The CCRT model therefore serves as a highly practical method for improving the effectiveness of psychodynamic counselling, by acting as a conceptual tool that counsellor and psychotherapists can use to enhance the accuracy of their interpretations.

Several other psychoanalytic theorists have made important contributions to an understanding of the role of narrative in therapy. Spence (1982) has argued for a distinction between narrative truth and historical truth. Whereas Freud and other early psychoanalytic therapists believed that free association and dream analysis were unearthing evidence about early childhood conflicts that actually occurred, Spence points out that it is seldom possible to verify in an objective sense whether or not these childhood events took place. He suggests that what therapists do is to help the client to arrive at a narrative truth, a story that makes sense and has sufficient correspondence with the historical data that are available. Another significant psychoanalytic writer on narrative has been Schafer (1992), who regards the interpretations made by the therapist over a period of time as comprising a ‘re-telling’ of the client’s story in the form of a psychoanalytic narrative. Eventually, the client comes to see his or her life in psychoanalytic

terms. In similar fashion, Schafer would argue, a client of person-centred counselling would develop a Rogerian narrative account of their life, and a cognitive–behavioural client would acquire a cognitive–behavioural story. Finally, McAdams (1985, 1993) has explored the underlying or unconscious narrative structures, such as myths, that people use to give shape to their life as a whole.

The psychoanalytic or psychodynamic tradition has generated a wealth of powerful and applicable ideas about the role of narrative in therapy. However, for psychodynamic writers and practitioners an interest in narrative is only an adjunct to the real business of identifying unconscious material, interpreting the transference and so on. Luborsky, Schafer and others have aimed not to create a narrative therapy, but to practise psychodynamic therapy in a narrative-informed fashion.

2.2.2 Cognitive/Constructivist Approaches to Narrative Therapy

The constructivist approach to counselling has been associated with many significant advances in the use of narrative in counselling and psychotherapy. The basic goal of constructivist therapy is to work with the ways that the person constructs meaning in their life. These meanings are understood as comprising cognitive schemas, and the stories that the person tells reflect the underlying structure of the cognitive schemas through which reality is interpreted. Following the roots of constructivism in the cognitive–behavioural tradition, there is a strong tendency in this approach to work very actively with the story, and to adopt techniques for bringing about change within a limited period of time.

Two aspects of constructivist narrative counselling are of particular importance: identifying conflicting stories, and the use of metaphor. The work of Russell has been influential in drawing attention to the role of cognitive conflict in therapeutic change (Russell and van den Boek 1992; Russell et al. 1993). Russell suggests that, in the course of therapy, a client will almost certainly tell different types of story about the same situation or relationship. For example, a client may usually refer to his inability to cope with stress at work, but may occasionally let slip some stories of how he has managed to deal with his work demands without becoming stressed. Russell suggests that at this point the client can be seen to have activated two quite different schemas relating to the same set of events. And, just as Piaget and other developmental psychologists have shown that cognitive development in childhood is triggered by the requirement to integrate competing schemas, the client may arrive at a higher level of understanding as a result of reflecting (with the help of the therapist) on the difference between these two stories. To return to the example of the stressed worker, this client may become able to construct a 'higher-order' story, which encompasses both the 'stressed at work' and 'not stressed at work stories'. A story along the lines of 'when I make sure I ask for the support and help I need, I can avoid becoming too stressed' would subsume both the previous stories, and also serve as a guide for coping better in future. Behind this new story is a new underlying schema that might feature a definition of self as worthy of support from others, in contrast to the previous underlying self-schema that centred on a sense of self as undeserving.

Another version of this theory is the solution-focused therapy of de Shazer (1985). In this approach, little attention is paid to the contrast between alternative narrative accounts of the same events. Instead, the client is invited to talk exclusively about solution stories, or positive outcome stories, and to use these stories to learn more about how they can achieve their goals in life. In some respects the solution-focused approach can appear to operate as a kind of version of behaviourism in which the client is reinforced for 'positive' behaviour, and 'negative' behaviour is ignored and therefore is extinguished. Certainly, little time is spent examining any conflicts between problem-saturated stories and solution stories.

However, in the end the effect on the client is probably the same as envisaged by Russell. The energetic and unremitting pursuit by the therapist of solutions has the effect of producing a kind of cognitive crisis in the client, a realisation that their problem story or stories are no longer tenable. In the aftermath of this crisis, the client is eager to find another story to tell.

The constructivist model of narrative change proposed by Goncalves (1995: 158) defines its goal as empowering the client to use narrative techniques to 'develop a continuous sense of actorship and authorship in his/her life'. What is particularly striking about Goncalves's work is his continuing effort to introduce incongruity and conflict into the client's way of construing the world. Over and over again, the client is invited to retell the story of key events in different ways: objectively, subjectively, metaphorically. The Goncalves (1995) model of constructivist narrative therapy takes the client through a five-stage programme:

Phase 1: Recalling Narratives

Identification of memories of important life events, using guided imagery exercises to facilitate recall. Homework assignment involving writing key stories from each year of life. Review of collected life stories to select a 'prototype' narrative.

Phase 2: Objectifying Narratives

Retelling important narratives in ways that 'bring the reader into the text': for example, through giving greater attention to sensory cues – visual, auditory, olfactory, gustatory, tactile. Collecting documents and artefacts (e.g. photographs, music, letters) that will further 'objectify' the story by defining its external referents.

Phase 3: Subjectifying Narratives

The aim of this stage is to increase the client's awareness of his or her inner experience of the narrative. Exercises are used in which the therapist triggers recall of a significant story and then asks the client to focus on the inner experience of the event through instructions such as 'Allow yourself to be aware only of what you are experiencing now.'

Phase 4: Metaphorizing Narratives

The client is trained in methods of generating metaphoric associations to stories, and then the origins of these images in his or her life are explored.

Phase 5: Projecting Narratives

The client is given practice in constructing alternative metaphors, drawn from literature and art. These new root metaphors are implemented within sessions and then in everyday life.

The work of Goncalves (1993, 1994, and 1995) is representative of other constructivist approaches to working with narrative and metaphor. The therapist or counsellor takes an active role in suggesting exercises and encouraging consideration of new, alternative storylines and images. The client is guided in the direction of getting in touch with the direct experiential referents of the story. The aim is to experience the emotions and physical sensations that are associated with a story, since there are more possibilities for change generated by specific, detailed narratives than by vague and general accounts of events. The focus is on a change process occurring at the individual level. The goal is to facilitate change in how the person makes sense of the world, how they think, perceive and feel.

2.2.3 Social Constructionist Narrative Therapy

Social constructionism is a philosophical position that regards personal experience and meaning as being not created merely by the individual (the constructivist position) but something embedded in a culture and shaped by that culture. People are social beings. Personal identity is a product of the history of the culture, the position of the person in society and the linguistic resources available to the individual. Social constructionism is mainly associated with the writings of Gergen (1985, 1994); although in fact it is more accurately understood as a broad movement within philosophy, humanities and the social sciences. From a social constructionist perspective, narrative represents an essential bridge between individual experience and the cultural system. We are born into a world of stories. A culture is structured around myths, legends, family tales and other stories that have existed since long before we are born, and will continue long after we die. We construct a personal identity by aligning ourselves with some of these stories, by 'dwelling within' them.

Applied to therapy, social constructionism does not look for answers in terms of change in internal psychological processes. Indeed, the whole notion that an inner psychological reality exists is questionable from a social constructionist stance.

Self Assessment Questions

1) Fill in the blanks:

   a) According to Psychodynamic view on the most frequently reported client wishes are

      1) ....

      2) ....

      3) ....

   b) According to cognitive Approach to Narrative Therapy there are four stages, these are:

      Phase 1: ....

Phase 2: ....

Phase 3: ....

Phase 4: ....

c) Social constructionism is a philosophical position that regards personal experience and meaning as being not created merely by the individual.

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2.3 THERAPEUTIC PROCESS

Narrative therapists aren't problem solvers. Instead they help people separate themselves from problem-saturated stories (and destructive cultural assumptions) to open space for new and more constructive views of themselves. Narrative therapy transforms identities from flawed to heroic. Despite being a widely used approach, particularly when combined with other therapeutic approaches, Narrative Therapy has certain boundaries or limitations. In many occasions, diverse clients may expect the therapist to act as the expert, instead of having to 'conduct' the conversation themselves. For this reason, Narrative Therapy can be challenging when the individual is not articulate. Lack of confidence, intellectual capacity and other issues such as reality testing impairment (psychotic disorders) could also undermine the expression of the individual through a narrative and they might not be suited for this kind of therapy, nevertheless Narrative therapy has been extensively applied to family medicine and relationship issues in neurotic population.

Another common boundary of Narrative Therapy is the lack of recipe, agenda or formula. This approach is grounded in a philosophical framework, and sometimes can become a particularly subjective or widely interpretative process.

2.3.1 Assumptions of Narrative Therapy

The assumptions of narrative therapy are:

1) Realities are socially constructed

2) Realities are constituted through language

3) Realities are organised and maintained through language

4) There are no essential truths

(Adapted from Freedman and Combs, 1996)

With these assumptions it is intended that stories an individual narrates is culturally loaded and the language is also contributory element to the issue at hand. The language individual uses maintain the problem strength, and make it difficult to resolve. But, these languages and ideas are amiable to deconstruction, and if and when deconstructed a new reality has space to germinate and grow.

2.3.2 Assessment

Narrative practitioners are not very likely to use formal assessment; the assumptions behind such systems are generally inconsistent with narrative therapies philosophy. First, traditional models of assessment assume a single reality to which the therapist has access. Second, these processes tend to be pathology-oriented and may ignore cultural or other contextual factors. Narrative therapy works by helping clients deconstruct unproductive stories in order to reconstruct new and more productive ones. The two main assessments in therapy are thus, assess what is client's current story (Unproductive and Problematic) and what could be client's possible story (Positive and Productive).

2.3.3 Goals of Narrative Therapy

There are four main goals of narrative therapy:

1) To separate the problem from the client,
2) To empower the client and restore his integrity,
3) To co-create a revitalized story that includes an evolving cultural identity, and
4) To witness the emergence and reclamation of the new story—reconnecting the client to a base of support.

In this process, a skilled therapist will work with the client to develop a thick description of the situation, recognising the influence of personal and dominant culture in her stories, creating safe ways to externalise the problem, supporting the client's agency in defining the problem and solutions, demonstrating times when the problem did not exist or have power, and working with the client for an appropriate audience to honour the transformation.

2.3.4 Therapeutic Outline: Process of Therapy

The strategies of narrative therapy fall into three stages:

1) **The Problem Narrative Stage**

Through listening to the story of the problem, it is recast as an affliction of the client. To do this, the therapist and client concentrate on the effects rather than the causes of the problem. These efforts help in the process of externalising the problem; to understand it more concretely it involves the following processes:

A) Narrative Expression: Problem Saturated Story,

B) Externalisation and Deconstruction.

A) **Narrative Expression: Problem Saturated Story**

A narrative therapist is interested in helping others fully describe their rich stories and trajectories, modes of living, and possibilities associated with them, also known as 'Problem Saturated Stories'. For most clients, the problem saturated story is the dominant story of their lives at that time—it is what prompts them to come to counselling. Knowing this story is important but, at the same time, the therapist is interested in co-investigating a problem's many influences, including on the person himself and on their chief relationships.

There is a need to understand that a personal narrative process is involved in a person's sense of personal or cultural identity, and in the creation and construction of memories; it is thought by some to be the fundamental nature of the self. On the other hand, illness narratives are a way for a person affected by an illness to make sense of his or her experiences. They typically follow one of several set patterns: restitution, chaos, or quest narratives. In the restitution narrative, the person sees the illness as a temporary detour. The primary goal is to return permanently to normal life and normal health. These may also be called cure narratives. In the chaos narrative, the person sees the illness as a permanent state that will inexorably get worse, with no redeeming virtues. This is typical of diseases like Alzheimer's disease: the patient gets worse and worse, and there is no hope of returning to normal life. The third major type, the quest narrative, positions the illness experience as an opportunity to transform oneself into a better person through overcoming adversity and re-learning what is most important in life; the physical outcome of the illness is less important than the spiritual and psychological transformation. This is typical of the triumphant view of cancer survivorship in the breast cancer culture.

Generally patients would have a restitution or chaos story to begin with. Both these stories are problem saturated, where in the central theme remains the illness and surrounding phenomena. These also helps them to express and acknowledge what he had been experiencing and how he views and shapes his reality, this also induces awareness and builds insight.

B) **Externalisation and Deconstruction**

Externalisation is a process used in Narrative therapy by which the therapist helps a client to see that they are separate from their perceived character traits.

This is useful in solving problems as it is easier to offer assistance in changing an attribute when a client stops believing that that attribute is an inseparable aspect of his/her core self. The client will learn that symptoms such as depression, low self esteem, or lack of ambition etc. are separate entities that can be altered with the self as opposed to being altered by altering the self.

The therapist will suggest that a client is 'with depression' or 'holds depression' as opposed to promoting that a client 'is depressed'. If a client is depressed then the therapist must change the actual client… if the client is with depression then the therapist can help to change the client's relationship with depression… depression is removable without asking a client to change their core self.

Therapist suggest that all of perception can be externalised – 'this is a perception I hold of reality' as opposed to 'this is reality'. There is a Deconstruction of the earlier held reality starts to take place.

Deconstruction starts when there is exploring of meaning by taking apart and examining taken-for-granted categories and assumptions, making possible newer and sounder constructions of meaning. For example, a depressed person may think of herself as worthless and consider it as her characteristic that she is good for nothing, she may be asked to deconstruct

the concept that is she actually good for nothing or is she feeling as good for nothing, where there any time when she was able to do something worthwhile. Is this an assumption or a truth? How did she come to the conclusion of being worthless? These questions would aim at examining this assumption of being worthless.

White (2004), while acknowledging the value of these conversations, maintains that they are not always present in his work with clients. Externalising is only the beginning of the journey—the focus must next turn to the exploration of unique outcomes. Dominant stories are often supported by lots of plot and don't go away easily. They are therefore sometimes difficult to deconstruct. This perspective is one way in which narrative therapist would view "resistance" on the part of the client. In social constructivist approaches, client resistance is also seen as the client's attempt to protect the view of self and world if these are threatened by the prospect of change.

2) **Finding Exceptions**

Alternatives to the problem are explored, and an alternate story is created through focusing on unique outcomes or times when the problem was not manifest, this leads to reauthoring the problem-saturated story.

A) **Unique Outcome: Re-authoring**

Unique outcomes are events that are not part of the dominant, problem-saturated story (White & Epston, 1990). They are the exceptions to the problem's rule and are very important in helping clients escape the tyranny of the problem. Often found in alternate stories, unique outcomes usually become part of the preferred story (here read "therapy goals") for the client. The client is asked to decide if this story is the preferred story, if her actions or situation are more consistent with her experiences and more acceptable to her than was the problem-saturated story. The Narrative therapist is very interested in unique outcomes and spends a lot of time asking detailed questions about them, getting the client to expand upon her description. As it begins to develop, this story will include plans and strategies to strengthen the story line, and details opportunities for the new story to take place. The preferred story characterises the client as capable, rather than downtrodden, as able to stand up to the problem. This process is sometimes called re-authoring, re-storying or re-membering (Monk, 1997; Morgan, 2000; White & Epston, 1990) and is described as "relocating a person/family's experience in new narratives, such that the previously dominant story becomes obsolete. In the course of these activities, people's own lives, relationships, and relationships to their problems are redescribed" (White & Epston, 1990).

3) **The Recruitment of Support**

The therapist and client build a support group to help the client continue the new story. The support group is chosen by the client and can be family, friends, or entire communities. These are also known as Outsider Witnesses. Sometimes written artifacts are also used by the therapist to keep the preferred story afresh and strong.

A) **Outsider Witnesses**

The final question in narrative therapy is about how to extend the new story into future; this is generally done by creating outsiders as witnesses. White (2004) describes this technique as rooted in the tradition of acknowledgement. Its primary purpose is to develop a rich, thick story line for the client, often about the preferred story. In this process, values become clearly identified and negative perceptions can be diminished or defeated.

This technique involves the client(s) and an outsider-witness group. The witness(es) can be the other partner in a couple, family members, friends—anyone who is deemed relevant by the client(s). The ceremony begins with the client telling a story of her choosing and the witnesses listening carefully. At some point (determined by the therapist) the witnesses are invited to recount what was most salient for them in the client's story. They are encouraged to explain why they were drawn to aspects of the client's story, what they mean to them, and what images they evoked.

Following the witnesses' retelling, the therapist then interviews the client, asking some of the same questions: what stood out in the witnesses' retelling, what images emerged for the client about her life in this process, and what meanings were salient for the client. Sometimes outsider witness practices are used to help further establish the preferred story. People who are identified by the client as the most likely to believe in the client's ability to change can be invited to hear the client tell the preferred story and react to it. They might also become allies of the client in establishing the preferred story. Another way of encouraging and supporting the client is by written artifacts.

B) **Written Artifacts**

Therapist often uses written documents as ways of reinforcing or celebrating the accomplishments of their clients. Because the written word is considered more powerful than the spoken, these artifacts are important evidence for the client and others of the client's new story. These artifacts can be letters, certificates, memos, lists; virtually anything that is dreamed up by the therapist and client (Payne, 2000). For example, White and Epston (1990) describe the "Certificate of Concentration" and the "Escape from Tantrums Certificate" given to commemorate therapeutic success stories.

Self Assessment Questions

1) The three stages of Narrative Therapy are:

   1) ....

   2) ....

   3) ....

2) State *True* or *False*:

   a) Narrative therapists are problem solvers ( )

   b) Narrative therapy follows the pathology model ( )

   c) Narrative therapist deals with client's problem saturated stories ( )

   d) Narrative therapist aims at externalising client's problem and eliminates external emotional invading ( ) ( )

   e) Narrative therapy makes use of formal assessment procedures

2.4 LET US SUM UP

Narrative Therapy is a constructivist approach in which counsellor and clients collaborate to create new life stories. Narrative therapists recognise that we create our realities through our language, and further, that cultures have dominant discourses that determine who gets power and control and who doesn't. Thus, Narrative therapists are very attuned to issues of social justice and power. People and problems are always viewed with an awareness of the cultural context in which they are embedded.

Clients come to counseling because the stories that are dominant in their lives do not fit some aspects of their experiences. The Narrative therapist listens closely to the client's story, attempting to understand the dominant themes but also looking for alternative stories or unique outcomes, cases in which the problem-saturated story does not hold. The goal of Narrative Therapy is to help the client deconstruct the problem-saturated dominant story and to thereby create opportunities to choose among other, more preferred outcomes.

2.5 UNIT END QUESTIONS

1) What you understand by Narrative Therapy? Explain briefly.
2) Explain what Luborsky labels as the core conflictual relationship theme.
3) Explain stages of Narrative therapy from the cognitive school of thought.
4) How is the social constructive approach of narrative therapy different from other approaches?
5) Taking a hypothetical example explain stages of narrative therapeutic process.
6) What are the goals of narrative therapy?
7) What is the difference between externalisation and deconstruction?
8) Why is there need for an outsider witness in narrative therapy?
9) State the importance of re-authoring.
10) How can written artifacts help clients? Give some examples.

2.6 SUGGESTED READINGS AND REFERENCES

Morgan, A. (2000). *What is Narrative Therapy? An Easy to-read Introduction.* Adelaide: Dulwich.

Payne, M. (2006). *Narrative Therapy: An Introduction for Counsellors*. London, England: Sage.

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White, M. (2001). Narrative practice and the unpacking of identity conclusions. *Gecko: A Journal of Deconstruction and Narrative Practice 1*, 1-17.

White, M. (1995). *Re-authoring lives.* Adelaide, AU: Dulwich Centre Publications.

White, M. (1992). Deconstruction and therapy: In D. Epston, & M. White (Eds.), *Experience, contridiction, narrative and imagination* (pp. 109-47). South Australia, Dulwhich Centre Publications.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton.

2.7 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) Fill in the Blanks

   a) 1) 'To be close and accepted',

      2) 'To be loved and understood' and

      3) 'To assert self and be independent'.

   b) Phase 1: Recalling narratives.

      Phase 2: Objectifying narratives.

      Phase 3: Subjectifying narratives.

      Phase 4: Metaphorizing narratives.

      Phase 5: Projecting narratives.

   c) Is embedded in a culture and shaped by that culture

2) Fill in the blanks

   The problem narrative stage

   Finding exceptions stage

   The recruitment of support stage

3) True or False

   a) False, b) False, c) True, d) True, e) False

UNIT 3 SOLUTION FOCUSED THERAPY

Structure

3.0 Introduction

3.1 Objectives

3.2 Definition of Solution Focused Therapy

3.3 Theoretical Foundation

3.4 Difference between Problem Focused Psychotherapy and Solution Focused Therapy

3.5 Assumptions of Solution Focused Therapy

3.6 Therapeutic Process

- 3.6.1 Assessment
- 3.6.2 Goal Setting
- 3.6.3 Therapeutic Relationship
- 3.6.4 Levels of Therapeutic Relationship

3.7 Therapeutic Techniques

- 3.7.1 Problem Free Talk
- 3.7.2 Pre session Change
- 3.7.3 Exception Questions
- 3.7.4 Present and Future Focussed Questions vs. Past Oriented Focus
- 3.7.5 Compliments
- 3.7.6 Miracle Questions
- 3.7.7 Miracle Questions: Variations on a Theme
- 3.7.8 Scaling Questions
- 3.7.9 Coping Questions
- 3.7.10 Take a Break and Reconvening

3.8 Indication and Contraindication of Solution Focused Therapy

3.9 Let Us Sum Up

3.10 Unit End Questions

3.11 Suggested Readings and Refences

3.0 INTRODUCTION

Within psychotherapy there is an evolution from lengthy to short forms of treatment and from cure to prevention. There is a process of patients becoming clients and of using facilitators rather than traditional practitioners. The focus shifts from mental illness to mental health. Seligman, the founding father of *positive psychology*, introduced the term *learned optimism* (Seligman, 2002). Positive psychology emphasises the client's strengths and the supposition that happiness is not the result of having the right genes or mere chance, but is to be found through identifying and using the strong points that the client already possesses, such as friendliness, originality, humor, optimism and generosity. Clients become increasingly emancipated. The therapist adopts an enabling role, coaching the client in exploring his own way of solving the problems experienced, thereby using his own competence to the greatest extent possible. Solution-Focused Therapy (SFT) supports this evolution and represents a dramatic shift

in focus from previous approaches that seek to identify and explain problems and their origins. In this unit we will be dealing with the definition of solution focussed therapy, its theoretical foundation, assumptions of solution focused therapy, the therapeutic process, etc. We will then take up assessment in SFT, the goals of SFT, and the typical therapeutic relationship. Then we deal with levels of therapeutic relationship, and then take up therapeutic techniques within which we will discuss the SFT techniques.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Define solution focused therapy;
- Explain the theoretical foundation;
- Analyse the difference between problem focused psychotherapy and solution focused therapy;
- Elucidate the assumptions of solution focused therapy;
- Discuss the therapeutic process;
- Explain the therapeutic techniques of SFT; and
- Analyse the indication and contraindication of solution focused therapy.

3.2 DEFINITION OF SOLUTION FOCUSED THERAPY

It is a competency-based model, which minimizes emphasis on past failings and problems, and instead focuses on clients' strengths, abilities, and resources thereby creating a counselling atmosphere that is flavoured with hope and optimism. It focuses on working from the client's understandings of their concern or situation and what the client might want different and places responsibility for change in the hands of clients by using empowering language and recognising them as skilled in matters of self-care. In this way it is deeply respectful of clients as individuals and takes a more balanced approach to finding solutions.

Use of basic counselling skills, such as attending and listening, genuineness, empathy, positive regard, and reflection, provide the foundation upon which SFT is practised Solution-focused therapy emerged in the United States in the late 1970s and early 1980s under the umbrella of brief therapy. It was pioneered by Steve de Shazer (1940-2005), and Insoo Kim Berg (1934-2007) and their colleagues in Milwaukee, Wisconsin.

The entire solution-focused approach was developed inductively in an inner city outpatient mental health service setting in which clients were accepted without previous screening. The developers of SFT spent hundreds of hours observing therapy sessions over the course of several years, carefully noting the therapists' questions, behaviours, and emotions that occurred during the session and how the various activities of the therapists affected the clients and the therapeutic outcome of the sessions. Questions and activities related to clients' report of progress were preserved and incorporated into the SFT approach.

3.3 THEORETICAL FOUNDATION

The theoretical underpinning of SFT comes from social constructionism and Wittgenstein's philosophy of language.

Social constructionism maintains that the individual's idea about what is real—including the idea of the nature of his or her problems, competences and possible solutions—is being construed through social interaction and use of language.

SFT asserts that problems occur in interactions between individuals and do not rest within any one individual. People define and create their sense of what is real through interaction and conversation with others, a form of negotiation carried out within the context of language. SFT helps clients do something different by changing their interactive behaviours or the interpretations of behaviours. This approach makes no assumptions about the "true" nature of problems. SFT has a strong orientation toward the present and future and further believes that everyone's future is negotiated and created.

Language is a resource that is vital to all therapists' practices and relationships with their clients. The importance of language in SFT is crucial. Gail Miller and Steve de Shazer in 1998 wrote about how meanings of words are inseparable from the ways in which people use them within concrete social contexts. Problem-focused language emphasises what is wrong with people's lives, and frequently portrays the sources of the problems as powerful forces that are largely beyond one's control or understanding. In contrast, solution-focused language focuses on finding ways of managing one's problems. Solution-focused therapists ask, "Since we talk ourselves into problems and solutions anyway, why not emphasise solutions." This is not to deny the deprivations and injustices in clients' lives, but to help get through and beyond them. This model uses postmodern assumptions that problems and solutions are talked into being, and meaning is changeable based on the use of language.

3.4 DIFFERENCE BETWEEN PROBLEM FOCUSED PSYCHOTHRAPY AND SOLUTION FOCUSED THERAPY

The model of SFT is a clear departure from any problem focused approach of psychotherapy which either requires "working through" or intensive focus on a problem to resolve it, or which primarily focuses on the past rather than the present or future. These therapies emphasises on exploring problematic feelings, cognitions, behaviours, and/or interaction, providing interpretations, confrontation, and client education.

In contrast, SFT minimizes emphasis on past failings and problems, and instead focuses on clients' strengths and previous successes. It helps clients to develop a desired vision of the future wherein the problem is solved, and client's exceptions, strengths, and resources are explored and enhanced to co-construct a client-specific pathway to making the vision of future a reality. Thus each client finds his or her own way to a solution based on his or her emerging definitions of goals, strategies, strengths, and resources. Even in cases where the client comes to use outside resources to create solutions, it is the client who

takes the lead in defining the nature of those resources and how they would be useful.

The time frames of problem focused therapies may range from weeks or months to even years encompassing as many as fifty or more sessions. On the other hand in SFT an average of six conversations seems to be sufficient.

3.5 ASSUMPTIONS OF SOLUTION FOCUSED THERAPY

The following core assumptions are at the root of SFT and provide key ideas that drive the practice and techniques of this counseling model.

1) The therapeutic focus should be on the client's desired future rather than on past problems or current conflicts.
2) Patients are experts on their lives. Therapist's job is to support and amplify this expertise.
3) Change is constant, inevitable, and contagious. Solution-building conversations identify, elaborate, and reinforce change behaviour.
4) Even small increments of change lead to large increments of change.
5) Presuppositional language emphasises the presumption that change *will* occur, creating an atmosphere of "when," not "if."
6) Clients have strengths, resources, and coping skills that drive change while generating optimism and hope.
7) Extensive information about a problem is rarely necessary to bring about change.
8) Clients' solutions are not necessarily *directly* related to any identified problem by either the client or the therapist.
9) Exceptions (that is, times when the problem could have happened but didn't) to the identified problem are often undervalue and since exceptions are part of solution behaviour, solution-building conversations explore them in considerable detail.

3.6 THERAPEUTIC PROCESS

3.6.1 Assessment

Therapists using this approach of therapy avoid any assessment of how problems develop; neither the patterns of behaviour that might be perpetuating those problems are evaluated. Instead therapists are concerned with identifying those patterns of behaviour that existed when the problem wasn't operative. Since solution focused therapists are interested in listening to clients' constructions of their problems first hand and without any preconceptions, a detailed history intake is not considered important.

3.6.2 Goal Setting

In solution focused therapy the setting of specific, concrete, and realistic goals is very important. Goals are formulated and amplified through Solution Focused

conversation about what clients want different in the future. As a result in SFT clients set the goals. Goals need to be small so that several small goals can be met quickly. Once a beginning formulation is in place, therapy focuses on exceptions related to goals, regularly scaling how close clients are to their goals or a solution, and co-constructing useful next steps to reaching their preferred futures.

3.6.3 Therapeutic Relationship

In solution focused therapy both the therapist and the client work in a close and collaborative partnership, in which the therapist conveys respect to a competent, resourceful problem solver. The clients do more of the talking, and what they talk about is considered the cornerstone of the resolution of their complaints. The therapist uses more indirect methods such as the use of extensive questioning about previous solutions and exceptions to help the client reach to a solution.

The client is considered the expert, and the therapist takes a stance of "not knowing" and of "leading from one step behind" through solution-focused questioning and responding. It requires a more positive and egalitarian stance from the therapist than the conventional "expert" position.

3.6.4 Levels of Therapeutic Relationship

Solution Focused Therapy conceptualises the process of change by categorising types of client counsellor relationships. Identifying the type of client-counsellor relationship has two main benefits.

First, it reminds the counsellor that treatment outcome depends on teamwork with the client. Second, it helps determine which therapeutic intervention is most likely to result in increased client participation in changing.

Solution Focused Therapy proposes three different types of client: the visitor, the complainant and the customer.

1) **Visitors** are the clients who has been sent or referred by others. These types of clients do not come forward in search of help and is not suffering emotionally. The therapists usually asks what the client thinks the person referring would like to see changed in his behaviour and to what extent he is prepared to cooperate.

2) **Complainants:** These kinds of clients do have a problem and suffers emotionally, but does not (yet) see oneself as part of the problem and/or the solution. They believe that other person or the world needs to change, rather than oneself. The therapist acknowledges the client's suffering and gives suggestions for observing the moments when the problem is not present or exists to a lesser extent, or the moments when part of the miracle is already taking place. These clients are not (yet) ready to carry out a behaviour assignment, in which he or she should do something differently, but may undertake an observation assignment, which does not yet involve a change in behaviour. This can be interpreted as a paradoxical intervention

3) **Customers:** These are ideal clients who see themselves as part of the problem and/or solution and are motivated to change their behaviour. This client may be given a corresponding behaviour assignment ('continue with what works,' 'do something different,' 'act as if the miracle has happened') etc.

3.7 THERAPEUTIC TECHNIQUES

Solution Focused Therapy utilises the same process regardless of the concern that the individual client brings to therapy. It directs the conversation towards developing and achieving the client's vision of solutions using various questions as questions are the basic tools of solution-focused therapy. The signature questions used in solution-focused interviews are intended to set up a therapeutic process wherein practitioners listen for and absorb clients' words and meanings (regarding what is important to clients, what they want, and related successes), then formulate and ask the next question by connecting to clients' key words and phrases. Therapists continue to listen and absorb as clients again answer from their frames of reference, and once again the therapist formulate and ask the next question by similarly connecting to the client's responses.

It is through this continuing process of listening, absorbing, connecting, and client responding that practitioners and clients together co-construct new and altered meanings that build toward solutions.

3.7.1 Problem-Free Talk

Though most of the solution focused sessions comprises of problem free talk, the therapist usually at the beginning of a session engages the client in a discussion, completely unrelated to the problem. Solution focused therapists talk about seemingly irrelevant life experiences of the client such as leisure activities, meeting with friends, relaxing and managing conflict. The therapist also gathers information on the client's values and beliefs and their strengths.

Problem free talk conveys the message that there is more to a person than the problems and also reveals potentially transferable strategies, beliefs, values and skills. For example; if a client wants to be more assertive it may be that under certain life situations he/she may be assertive. This strength from one part of their life can then be transferred to the area with the current problem.

Dan Jones, in his *Becoming a Brief Therapist* book writes:

'...it is in the problem free areas you find most of the resources to help the client. It also relaxes them and helps build rapport, and it can give you ideas to use for treatment...Everybody has natural resources that can be utilised. These might be events...or talk about friends or family...The idea behind accessing resources is that it gives you something to work with that you can use to help the client to achieve their goal...Even negative beliefs and opinions can be utilised as resources'

3.7.2 Pre-Session Change

There is a core solution-focused belief that clients are engaged in constructive action when they seek help. Some of these actions are helpful and others prevent the situation from getting worse.

Therefore at the beginning or early in the first therapy session, solution focused therapist typically asks, "What changes have you noticed that have happened or started to happen since you called to make the appointment for this session?" This question might have three possible answers.

First, the client may say that nothing has happened. In this case, the therapist may simply begin the session by asking something like: "How can I be helpful to you today," or "What would need to happen today to make this a really useful session?" or "What needs to be different in your life after this session for you to be able to say that it was a good idea you came in and talked with me?"

The *second* possible response may be that things have started to change or get better. In this case, the therapist asks many questions about the changes that have started, requesting a lot of detail. This starts the process of "solution-talk," emphasising the client's strengths and resiliencies from the beginning, and allows the therapist to ask, "So, if these changes were to continue in this direction, would this be what you would like?" thus offering the beginning of a concrete and positive goal.

The *third* possible answer may be that things are about the same. The therapist might be able to ask something like, "Is this unusual, that things have not gotten worse?" or "How have you managed to keep things from getting worse?" These questions may lead to information about previous solutions and exceptions, and may lead the client into a solution-talk mode.

Overall by acknowledging pre-session change, the therapist underlines that the client and not the therapist, is the agent for change.

3.7.3 Exception Questions

The clients usually give an account of how "the problem" is affecting their life. However proponents of SFBT believe that there are *always* times when the identified problem is less severe or absent for the client. While listening and acknowledging the difficulties the solution-focused therapist encourages the client to describe what different circumstances existed when the problem was not present or was being managed better. This includes searching for transferable solutions from other parts of the client's life or past. There are always exceptions waiting to be found. If the clients experienced difficulties 40 percent of the time it means remaining 60 per cent was problem free. What happened during those times? What they did that was helpful? How did they do it? Could they do it again?

Self Assessment Questions

1) Are there times now that a little piece of the miracle happens?

....

....

....

....

2) Tell me about these times. How do you get that to happen?

....

....

....

....

3) What will you do to make that happen again?

....

....

....

....

....

4) What will your husband (for example) say you need to do to increase the likelihood of that (exception) happening more often?

....

....

....

....

....

5) What is different about the times when the problem does not happen, or when it is less severe or less frequent?

....

....

....

....

....

3.7.4 Present- and Future-Focused Questions Vs. Past-Oriented Focus

The questions that are asked by SF therapists are almost always focused on the present or on the future, and the focus is almost exclusively on what the client wants to have happen in their life. This reflects the basic belief that problems are best solved by focusing on what is already working and how clients would like their lives to be, rather than focusing on the past and the origin of problems.

3.7.5 Compliments

Compliments are another essential part of solution focused brief therapy. They are Integral to solution-building conversations, and have multiple effects: it validates any progress that clients make; it encourages clients by reminding them of personal power over their well-being; it emphasises strengths and abilities; it sets up the expectation that past success is an excellent indicator of future possibilities; it fosters confidence; and it facilitates relationship building and maintains rapport.

In solution focused therapy, compliments are often conveyed in the form of appreciatively toned questions of “How did you do that?” that invite the client to self-compliment by virtue of answering the question.

Compliments

1) How did you manage to do that?
2) How did you know it was a good idea to try that?
3) How did you know it was a good time to do that?
4) How did you start?
5) How did you keep that going?

3.7.6 Miracle Questions

The miracle question is a central intervention in solution focused therapy. After meeting with thorpatients and getting a brief description of presenting problems, posing the miracle question signals the onset of solution talk. It is a way to ask for a client's goal in a manner that communicates respect for the immensity of the problem, and at the same time leads the client's to come up with smaller and more manageable goals. It is also a way for many clients to do a "virtual rehearsal" of their preferred future. The precise language of the intervention may vary, but the basic wording is,

"I am going to ask you a question that is different from those you might have heard before. It is going to require that you do some pretending. Suppose that tonight, after our meeting, you go home, go to bed, and fall asleep. While you are sleeping, a miracle happens, and the miracle is that the problem that brought you here is solved. But, because you are asleep, you do not know that the miracle has happened.

When you wake up tomorrow morning, what will be the first thing you notice that will tell you the miracle has happened?"

Clients have a number of reactions to the question. They may seem puzzled. They may say they don't understand the question or that they "don't know." They may smile. Usually, however, given enough time to ponder it and with persistence on the part of the therapist, they start to come up with some things that would be different when their problem is solved

This and all other related questions encourage patients to construct a vision of the future that could usually be taken as the goal of the therapy.

With a detailed description of how they would like their lives to be, clients often can turn more easily to building enhanced meanings about exceptions and past solution behaviours that could be useful in realising their preferred futures.

3.7.7 Miracle QuestionS: Variations on a Theme

Imagine that, while you are sleeping tonight, a miracle happens. You wake up tomorrow, and you sense that you are on track toward making a decision. What will you be doing differently that will tell you that you are on track?

Imagine six months into the future, after you have successfully solved the problem that brings you here today. What will be different in your life that will tell you the problem is solved?

Pretend the problem is solved. What are you doing differently?

If I have a video camera and follow you around when you have solved this problem, what will I see that will tell me this?

What will be the first sign that a piece of the miracle is happening?

- Who will be the first to notice this is happening?
- What will others notice about you that will tell them this is happening?

3.7.8 Scaling Questions

Whether the client gives specific goals directly or via the miracle question, an important next intervention in SFBT is the use of scaling questions. Scaling questions are useful for making vague clients perceptions concrete and definable. They measure problem severity, progress toward a goal, confidence, and commitment to a goal.

Normally the therapist uses a scale of 0 to 10, where 0 means the" worst the problem has ever been" or perhaps how the client felt before contacting the therapist and 10 representing "the best things could ever possibly be". Asking a patient to "scale" items transforms a description of something important into an accessible and measurable entity. This then becomes a starting point from which future progress is assessed. If a patient scales a problem at 1 or 2, therapist might ask, "How will you know when you reach 2.5?" This question requires the patient to identify the next step and to begin solving the problem. If confidence is scaled at 1, asking, "How did you manage to come in today?" encourages a patient to recognise that action is possible even with low confidence. If confidence is scaled at 3, a question like, "What do you need to do in order for your confidence to move to 3.5?" will encourage thinking in concrete terms of strategies needed to sustain and increase confidence. When clients have trouble thinking in terms of forward movement, a question like, "What do you need to do to maintain the progress at 3?" frees up both patients and therapist to recognise that sometimes, treading water is an accomplishment in and of itself.

Examples of Scaling Questions

1) On a scale of 1 to 10, where 10 is the problem solved and 1 is the worst it has ever been, where is the problem today?

2) On a scale of 1 to 10, with 10 meaning you have every confidence this problem can be solved and 1 meaning no confidence at all, where are you today?

3) If 10 means you are prepared to do anything to find a solution and 0 means that you are prepared to do nothing, how would you rate yourself today?

4) What will you need to do to go from a (for example) 3 to a 3.5?

3.7.9 Coping Questions

Coping Questions helps to elicit information about client resources that they use in times of overwhelming difficulties but remains unaware of it. Even in the midst of despair, many clients do manage to do many things that require major effort. Therapists try to find out the examples of coping: *"I can see that things have been really difficult for you, yet I am struck by the fact that, even so, you*

manage to get up each morning and do everything necessary to get the kids off to school. How do you do that?"

Genuine curiosity and admiration on the part of therapist helps to highlight strengths without appearing to contradict the client's view of reality. The initial summary *"I can see that things have been really difficult for you"* validates the clients feeling for their problems. The second part *"you manage to get up each morning etc."* also remains a fact, but it counters the problem focused narrative and open up a different way of looking at client's resiliency and determination.Coping questions start to gently and supportively challenge the problem-focused narrative and provide a foundation upon which to build solutions.

Examples of Coping Questions

1) How did you manage to get yourself up this morning?
2) How are you preventing things from getting worse?
3) That sounds nearly overwhelming. How do you manage to cope?
4) I understand how hard this is for you. How did you manage to get to the office today?

3.7.10 Take a Break and Reconvening

In SFT, therapists are encouraged to take a break near the end of a session. Taking a break allows both clients and therapist to reflect on conversations they had concluded in the session. The therapist uses this opportunity to compose the message-a form of feedback to the clients. In some setting therapist actually leaves the room for a few minutes to do this but if it is not feasible a short pause is required for the therapist to consult his or her notes and compose the short message for the client. The feedback consists of the following:

- compliments of how the client participated in the session and the therapist's feelings about it;
- a short summary of what the client is already doing that is helpful;
- a bridging statement linking the client's actions with the stated goal or goals;

Homework Assignments: In SFT therapists frequently end the session by suggesting a possible homework task for the client to try between sessions if they so choose. Usually the following generic assignments are given as part of homework:

- think about the times when an exception occurs and note differences; observe for positive changes;
- do more of the exceptions and pay attention to the consequences;
- pretend to do a small piece of the miracle picture;
- pretend you know what to do to start solving the problem and try it out; and
- finally, think about what you are doing to prevent the situation from worsening.

So, what is better, even a little bit, since last time we meet? At the start of each session after the first session, the therapist usually asks about progress, about what has been better during the interval. Clients who report that there have been some noticeable improvements, the therapist help the client to describe these changes in as much detail as possible.

On the other hand clients who report that things have remained the same or have become worse, therapists explore how the clients have maintained things without things getting worse; or, if worse, what did the client do to prevent things from getting much worse. Whatever the client has done to prevent things from worsening then becomes the focus and a source for compliments and perhaps for an experiment since whatever the client did, should continue doing.

3.8 INDICATION AND CONTRAINDICATION OF SOLUTION FOCUSED THERAPY

Solution-Focused Brief Therapy is an effective way of helping people with diverse problems varying from alcohol abuse, posttraumatic stress disorder, personality disorders depression, eating disorders, relationship problems. It is applied to children and adolescents, to groups, in education in management & coaching. It is suitable for a wide variety of clients, whereby it is of importance that the client has a goal (or is able to formulate one during psychotherapy).

Contraindications are minimal, and can generally be described as any situation where it is impossible to establish a dialogue with the client: emergencies, life-threatening situations, threats of suicide, or psychotic episodes (medication might be indicated in the case of acute psychosis or deep depression). At a later stage medication often helps a client undertake solution-focused conversations.

3.9 LET US SUM UP

Solution-focused therapy is a brief counselling model that was developed by Steve de Shazer and Insoo Kim Berg and their colleagues beginning in the late 1970's in Milwaukee, Wisconsin.

It originated from social constructionism and Wittgenstein's philosophy of language. Social constructionism maintains that people develop their sense of what is real through conversation with and observation of others. Social constructionism holds that reality, as each individual perceives it, is by definition subjective and created through the process of social interaction and the use of language. SFBT asserts that problems occur in interactions between individuals and do not rest within any one individual. People define and create their sense of what is real through interaction and conversation with others, a form of negotiation carried out within the context of language.

SFT is most dissimilar in terms of underlying philosophy and assumptions with any approach which requires "working through" or intensive focus on a problem to resolve it, or any approach which is primarily focused on the past rather than the present or future.

Solution Focused Therapy identifies three different types of therapist -client relationship which determines the outcome of the therapy: the visitor, the complainant and the customer.

Solution focused therapists believe that change is constant. By helping clients identify the things that they wish to have changed in their life and by attending to those things that are currently happening and they wish that it continues, SFBT therapists help their clients to construct a concrete vision of a *preferred future* for themselves. The SFBT therapist then helps the client to identify times in their current life that are closer to the preferred future, and examines what is different on these occasions. By bringing these small successes to their awareness, and helping them to repeat these successful things they do when the problem is not there or less severe, the therapists helps the client move towards the preferred future they have identified.

Therapists uses the following techniques and questions as a means of helping clients to achieve their goals :problem-free talk, pre –session change, exceptions, compliments, miracle questions, scaling, coping questions, homework assignments etc.

3.10 UNIT END QUESTIONS

1) What are the assumptions of Solution Focused Therapy?
2) Elaborate the theoretical background of Solution Focused Therapy.
3) Differentiate between problems focused psychotherapy and SFT.
4) Explain briefly the relevance of problem free talk, pre-session change exceptions and compliments in identifying the client's strengths and resources necessary for therapeutic change.
5) What are the major questioning techniques used by solution focused therapists to achieve the goals co-constructed with clients?
6) Briefly discuss the indications and contraindications of SFT.

3.11 SUGGESTED READINGS AND REFERENCES

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UNIT 4 ART THERAPY

Structure

4.0 Introduction
4.1 Objectives
4.2 History of Art Therapy
4.3 Multiple Approaches to Art Therapy
4.3.1 Psychodynamic Approaches
4.3.2 Humanistic Approaches to Art Therapy
4.3.3 Behavioural and Cognitive Approaches
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4.0 INTRODUCTION

Like any psychotherapy, art therapy aims to assist the patient to resolve internal conflicts and gain greater self-awareness through the development and exploration of the relationship between the individual and therapist, and the issues which arise in therapy. The inclusion of art making in therapy is the vital difference between psychotherapy and art therapy. Whilst this may appear obvious, it is easy to become lost in the similarities of the two therapies and confuse about the differences. Although some art therapists still choose to use varying degrees of verbal interaction with their patients, the role of the image and the process of art making are the key factors in art therapy.

To an onlooker there may appear little difference between art therapy and an art activity conducted by another health professional, teacher or artist. The distinguishing components are the purpose for which the art is being created and the thinking and understanding on the part of the therapist. To be considered art therapy, the primary goal of the art making must be therapeutic. If the goal of art making is for recreation or learning, then it is not art therapy. This is not to undervalue the magnificent work of many artists and teachers working with children, as there is no doubt that this work are incredibly valuable. It is meant simply to help define the differing roles of each profession. Art therapists must have an understanding of both art *and* therapy. Of art they must know; the materials, the creative processes, the language and nature of art and symbols. Of therapy they must know psychodynamics, development, the nature and mechanisms of treatment and the therapeutic relationship.

4.1 OBJECTIVES

After reading this unit, you will be able to:

- Define the history of art therapy;
- Understanding the multiple approaches to art therapy;
- Aim and purpose of art therapy;
- Understanding about art as a therapy and art in therapy;
- Application of art therapy;
- Indications and contraindications of art therapy; and
- Advantages of art therapy.

4.2 HISTORY OF ART THERAPY

The roots of art therapy reach into prehistory, "to a time when people fist began to make images and objects intended to influence, make sense of, or express their experiences. Throughout time and across the globe, countless examples can be found of the use of visual arts in healing rituals". Archaeology is littered with examples of artistic objects used in rituals for healing, religious practices, the desire to be immortalised and many other such examples, from ancient Egypt, Greek and Roman Mythology to the Golden Calf mentioned in the Christian Bible. Indian mythologies and religion also reflect art and artistic objects in various ways, from traditions like making a Rangoli to creating handprints to folk arts like Madhubani. It is not difficult to grasp that the significance of art has never been merely aesthetic pleasure.

Even though art has for aeons been used in rituals, religions and many other practises, hints of its first uses in the area of psychiatry emerged in the first half of the nineteenth century. One of the most influential figures during this period was the German psychiatrist Johan Reil, who outlined an elaborate programme for the treatment of mental illness, which included the use of art therapy.

Also, during the late nineteenth and early twentieth centuries, some psychiatrists became fascinated by the spontaneous art of the mentally ill. Around the turn of the century a few psychiatrists began collecting the spontaneous artwork of their patients, although "…most regarded them as mere curiosities". There were notable exceptions though, and from 1876 to 1888 Paul-Max Simon, a French psychiatrist, published the first serious studies of drawings of the mentally ill, with several other psychiatrists following suit.

"However as psychiatry moved closer to medicine, the view that mental illness was a result of brain abnormality gradually came to assert itself. Henceforth, the structure and workings of the brain became the focus of psychiatric investigation and treatment. Among the many consequences of this were the increasing emphasis placed on physical, rather than psychological forms of treatment and the isolation of the mentally ill in vast asylums". During this period the therapeutic use of art therapy was largely reduced in importance to a supplementary role, often in the form of diversional, recreational or educational activities.

Nevertheless, it was against this backdrop and within these psychiatric institutions that art therapy began to emerge as a distinct paradigm from the 1940's.

The triumph of medical psychiatry did little to foster greater understanding of the symbolic and therapeutic value of art produced by the mentally ill. The belief that brain abnormality might be revealed through drawing and painting did, however, result in a renewed interest in the diagnostic potential of art. An early pioneer in this area was the German psychiatrist Fritz Mohr, who devised an experimental procedure for the study of drawings of mentally ill patients, with the intention of relating these to specific types of neurological dysfunction. The patient had to copy certain drawings, complete others and draw anything that occurred to them. In this way Mohr anticipated many of the visual and projective based psychological tests that are still in use today, such as the Draw-A-Person-Test. Though questions remain regarding the validity of many of these tests, they still played a significant role in the development of art therapy. Another individual who contributed to this area is Ruth Shaw, who invented the use of finger-painting, which was thought to be both diagnostic and therapeutic.

From the late 1930’s a group of psychiatrists, “…known as the émigré psychiatrists, collaborated on a series of research projects in London, concerned with visual and self-perception in depersonalisation and manic depressive psychosis…”. As with so many other inquiries of this kind, the meaning attached to these images by the individuals who had created them were of lesser concern. “The visual image was essentially regarded as a depiction of psychopathology…”

Another important influence of art therapy is that which has been exerted by psychoanalysis. Since Freud founded the profession, psychoanalysis has had much to say about the creative process, aesthetics and the interpretation of art. Indeed, all the major psychoanalytic schools have, from time to time drawn from the arts to support or substantiate their theories. For many leading psychoanalysts, including Carl Jung (1969), Melanie Klein (1975) and Donald Winnicott (1971), painting and drawing often played an important role in their clinical work.

Even Freud himself was interested in art to some extent. His interest in art arose from his belief that neurotic symptoms developed as a consequence of the conflict between the pleasure and reality principles. For Freud the unconscious mental processes operative in neuroses, dreams, and the creation of works of art, functioned in similar ways. According to Freud what distinguishes the artist from the neurotic is that the artist “…understands how to work over his daydreams in such a way as to make them lose what is too personal about them, and to make it possible for others to share in the enjoyment of them. The artist also understands how to tone them down so they do not easily betray their origin from proscribed sources”.

One important consequence of Freud’s approach to art has been “…to view it like a dream or symptom, and as the symbolic expression of the neurotic and conflicted inner world of the artist”. Furthermore, although Freud acknowledged that the experience of dreaming was predominantly visual, he was primarily concerned with translating dream imagery into words. He did however acknowledge the difficulty of this. “Part of the difficulty of giving an account of dreams is due to having to translate these images into words. ‘I could draw it’, a dreamer often says to us, ‘but I don’t know how to say it’…”.

This was probably what encouraged Freud to ask some of his patients to paint, particularly dreams that had no form or shape to describe.

It is clear that even though Freud didn’t use art therapy as we see it today, he had a substantial influence in the development of art therapy. Just Freud’s dream

interpretation alone, a technique to explore the unconscious, eventually contributed substantially to the evolution of art therapy techniques.

Eisdell (2005) regards Carl Jung as the forerunner of art therapy. While Jung broke away from the psychoanalytic movement and founded 'Analytical Psychology', his approaches had much in common with Freud's. Both approaches are grounded in the belief that our inner (subjective) life is determined by feelings, thoughts and impulses beyond conscious awareness, but which may find expression in symbolic form.

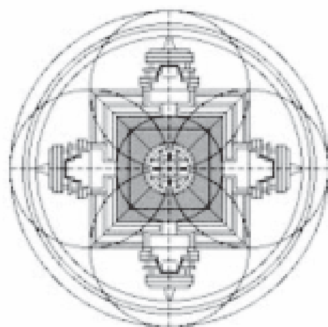
However, in a number of marked respects Jung's approach to art and the imagination stand in marked contrast to that traditionally found in psychoanalysis. Unlike Freud for whom psychoanalysis was a talking culture, Jung arrived at the view that it was through images that the most fundamental human experiences and psychological life found expression. As a consequence, Jung frequently encouraged his clients to paint or draw as part of their analysis.

These pictures were seen as "of therapeutic value by Jung because of two reasons: Firstly, Jung believed they played a mediation role between the patient and his or her problem; Secondly, image making provided the patient with the opportunity to externalise their problem, and thus establish some psychological distance from their difficulties". Therefore thoughts and feelings experienced as unmanageable could through painting or drawing be given form and expression.

"Jung's way of working with images was primarily aimed at encouraging an active relationship between the artist/patient and his or her imagery, rather than the production of further unconscious material for interpretation".

For Jung, symbolism has what he termed a 'transcendent function'. It is by means of symbolic forms that the transition from one psychological attitude or condition to another is effected. Through drawing on the archetypal patterns that Jung believed structured the human mind, each individual is regarded as having access to images and narratives through which expression to conflicting aspects of the psyche can be given. In Jungian theory archetypes are, like the instincts, an inherited part of the psyche and belong to the collective unconscious.

Archetypes were said by Jung to cluster around the most fundamental and universal life experiences – birth, parenthood, death and separation – and to reflect the psyche itself; revealing themselves by way of such inner figures such as the 'anima', 'shadow' and 'persona'. As such, our dreams, fantasies and images all derive in part from a collective reservoir of symbols and myths that repeat themselves universally. An example of one such symbolic form frequently cited in Jungian literature is the mandala. Mandala is an ancient Sanskrit word meaning magic circle. Mandalas assume many forms but a basic mandala is a geometric figure in which a circle is squared or a square is encircled.



Mandalas are found in the art of many religious traditions where they are employed in the service of personal growth and spiritual transformation. Jung considered the mandala to be an expression of the self and an archetypal symbol of wholeness. Jung used the mandala as a therapeutic tool and believed creating Mandalas helped patients make the unconscious, conscious.

The importance Jung attached to images in psychological healing has had a marked influence on the development of art therapy. Maclagan (2001) states "what made Jung a reference for later development of art therapy was not just his insistence on the primacy of the image, and the phantasy (fantasy) thinking depending on it, nor the enormous importance he attached to archetypal symbolism, but his pioneering promotion of art making as an important path to psychological awareness".

In the United Kingdom the artist Adrian Hill is generally recognised as the first person to have used the term 'art therapy' to describe the therapeutic application of image making. For Hill the value of art therapy lay in completely engrossing the mind and releasing the creative energy of the frequently inhibited patient. This, Hill suggested enabled the patient "…to build up a strong defence against his misfortunes".

At approximately the same time, Margaret Naumburg, an American Psychologist, also started using the term 'art therapy' to describe her work (Edwards, 2004). According to Naumburg, her model of art therapy based its methods on "…releasing the unconscious by means of spontaneous art expression. It has its roots in the transference relation between patient and therapist and on the encouragement of free association, and is closely allied to psychoanalytic theory. Treatment depends on the development of the transference relation and on a continuous effort to obtain the patient's own interpretation of his symbolic designs. The images produced are a form of communication between patient and therapist, constituting symbolic speech".

Although the approaches to art therapy adopted by Hill and Naumburg were very different, and have subsequently progressed to other approaches and definitions, their pioneering work has exerted a significant influence.

Numerous and often conflicting definitions of art therapy have been advanced since the term first emerged in the late 1940's. With the subsequent global growth and recognition of the discipline, definitions have become more established.

The British Association of Art Therapists (BAAT)(2005) defines art therapy as: "The use of art materials for self-expression and reflection in the presence of a trained therapist. Clients who are referred for art therapy need not have previous experience or skill in art, as the art therapist is not primarily concerned with making an aesthetic or diagnostic assessment of the client's image. The overall aim of its practitioners is to enable a client to effect change and growth on a personal level through the use of art materials in a safe and facilitating environment".

The American Art Therapy Association (AATA)(2005) defines art therapy as: "The therapeutic use of art making, within a professional relationship, by people who experience illness, trauma or challenges in living, and by people who seek personal development. Through creating art and reflecting on the art products

and processes, people can create awareness of self and others, cope with symptoms, stress, and traumatic experiences, enhance cognitive abilities, and enjoy the life-affirming pleasures of making art".

Art therapy, as defined by these international associations, is thus therapy enabled by the encouragement of self expression through art and reflection on the image produced, in a professional, safe and facilitating environment that is not dependent on language, but does in general utilise it, all of which is directed towards effecting positive, personal and psychological growth within the client.

4.3 MULTIPLE APPROACHES TO ART THERAPY

Anthony Storr (1999) states that "as a psychotherapist I found it particularly heartening that the use of art in therapy seems to have the effect of reducing the differences between Freudians, Jungians, Kleinians, and adherents of other schools…Art not only bridges the gap between the inner and outer worlds but also seems to span the gulf between different theoretical positions"

Art in therapy is an ideal medium that can be used across different theoretical frameworks. Just like practitioners of verbal therapy, art therapists have grounded their work in a variety of theoretical frameworks. These multiple perspectives define the discipline as much as its common underpinnings.

Here follows a brief description of many of the dominant theoretical approaches currently in use with art therapy:

4.3.1 Psychodynamic Approaches

The advent of psychoanalysis early in the 20th century provided a natural catalyst for the emergence of the idea of art therapy and offered a conceptual framework complementary to the potential of art expression in psychotherapy. Equally, Jung's belief in the inherent healing power of images and art making fuelled the analytic approach to art therapy and techniques such as amplification and active imagination, providing ways to work with and understand images created in therapy. Object relations, a more contemporary development of psychoanalytic theory, has provided a way of thinking about client's responses in art therapy, reflecting early attachments and current relationship issues. Although most contemporary practitioners do not take a strictly psychoanalytic, analytic, or object relations approach to art therapy, elements of these philosophies are present in many contemporary art therapy approaches to treatment. Together, these theories have formed the bedrock for the subsequent development and advances of art therapy as a method of client communication and therapeutic change.

4.3.2 Humanistic Approaches to Art Therapy

Humanistic approaches to art therapy range from examining life's existential meaning through the metaphor of art to more active, experiential techniques of Gestalt art therapy to the more contemplative methods such as those employed in transpersonal work. Unconditional regard, human potential, free will, self-actualisation, and self-transcendence are concepts that complement the application of art expression in therapy because each underscores an element of the creative process. The common ground that connects these approaches is a respect for the person's central role in the therapeutic process, an acceptance of all artistic expression as a will to meaning, and the belief in the individual's ability to find wellness through creative exploration.

4.3.3 Behavioural and Cognitive Approaches

Combining cognitive-behavioural therapy with image making interweaves linguistic and imaging techniques to help clients reduce or eliminate negative cognitions and self-talk. While cognitive-behavioural therapy has traditionally used verbal modalities as agents for change, image making actually complements cognitive-behavioural approaches, providing therapists with an opportunity to capitalise on visual communication to enhance therapy. The infusion of image making within treatment offers the client an opportunity to collaborate with the therapist on developing creative visual strategies to achieve change. The benefits of therapy continue after the session in the form of imagery-related homework and encourage the client to be an active partici pant in the process of recovery through hands-on strategies. In summary, a cognitive-behavioural approach to art therapy offers a viable way to reframe dysfunctional patterns of behaviour and provides a unique supplement to cognitive techniques that restructure negative patterns and support a positive sense of self.

4.3.4 Developmental and Adaptive Approaches

Art has cognitive development component inherent in itself. This approach is a particularly popular approach among therapists who work with individuals with developmental delays; cognitive, visual, or auditory impairments; and physical handicaps. Although it is applicable to specific populations, developmental approaches can serve as a basis for all art therapy approaches with children and adults. It provides therapists not only a method of evaluating development but also norms for establishing goals for treatment based on the rich foundation of artistic development.

4.3.5 Family Systems Approaches to Art Therapy

The integration of art expression within the context of family treatment not only enhances client–therapist communication but also offers the opportunity to explore family-related issues through visual means. Therapists can capitalise on this quality through the use of metaphor; both visual and verbal, to help clients and families achieve change, and can infuse art experiential with strategic techniques such as reframing, unbalancing, restraining, and other approaches. Most important, family art therapy allows the individual or family to “see” the presenting problem and take advantage of visual symbols for problem solving, personal change, insight, and understanding the family dynamics which brought them to treatment.

4.3.6 Expressive Art Therapy

The theoretical orientation of the ego psychologists emphasises the belief that ‘personality issues’ interfering with the client’s creative expression should be the subject of treatment in art therapy. They believe that facilitating creativity improves the client’s psychological health. This view gave rise to ‘expressive art therapy’, which holds that any form of creativity that stretches the boundaries of the client’s creativity is beneficial. Again, the underlying core idea amongst these therapists is that the creative process is healing of itself.

4.4 AIM AND PURPOSE OF ART THERAPY

The aim of art therapy often varies according to the particular needs of the individuals with whom the art therapist works. These needs may change as the therapeutic relationship develops. For one person the process of art therapy might involve the art therapist encouraging them to share and explore an emotional difficulty through the creation of images and discussion; whereas for another it may be directed towards enabling them to hold a crayon and make a mark, thereby developing new ways of giving form to previously unexpressed feelings. While it is often assumed to be so, it is not the case that only those individuals who are technically proficient in the visual arts are able to make use of art therapy in a beneficial way. Indeed an emphasis on artistic ability – as might be the case when art is used primarily for recreational or educational purposes – is likely to obscure that with which art therapy is most concerned. That is to say, with the symbolic expression of feeling and human experience through the medium of art.

The purpose of art therapy can be three major categories: assessment, catharsis and growth. All three permeate the therapy from beginning to end and will be discussed here:

Assessment: Assessment in art therapy allows the following process:

- Gives diagnostic information that aids conceptualisation of issue at hand
- Gives diagnostic information that aids treatment planning
- Presents dynamic and interpersonal information
- Recognises conflicts and problems
- Recognises mood changes and unconscious needs
- Determination of change that implies progress
- Determination of readiness for termination

Catharsis: Art therapy allows a cathartic process which helps in the following ways:

- It allows free expression of affects and needs,
- Allows uninhibited processing of past occurrences
- Expression and recreation of current events
- Expression and recreation of anticipated events
- Release and mastery of affects and conflicts

Growth: Another important purpose of art in therapy is that it provides opportunities for growth in numerous ways:

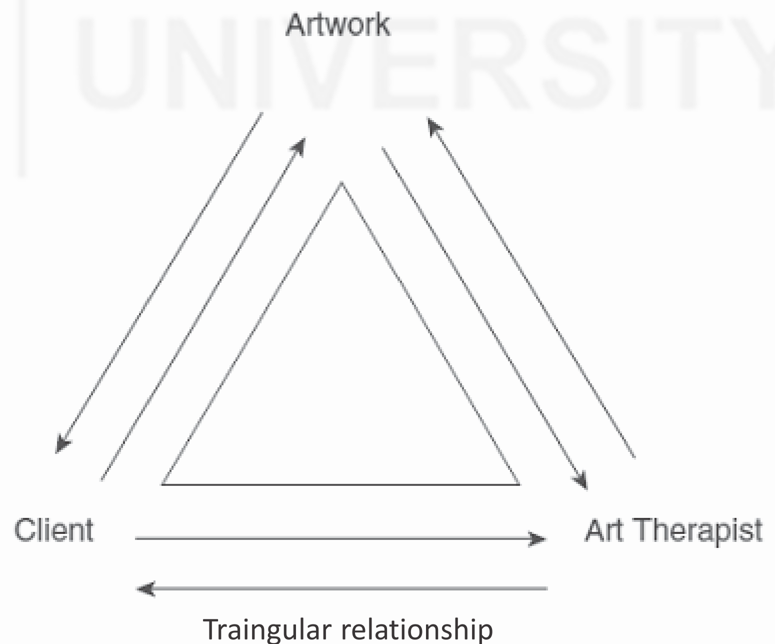
- Establishment of therapeutic rapport
- Exploration of alternative problem solving techniques
- Fostering of creative problem solving
- Fostering creativity in approach and solution to problem situations
- Skill learning and talent development
- Increased self esteem and self confidence
- Increased goal-directedness

4.5 ART AS THERAPY AND ART IN THERAPY

Art therapy has developed along *'two parallel strands: art as therapy and art psychotherapy'*. The first involves a belief in the inherent healing power of the creative process of art making. This view embraces the idea that the process of making art is therapeutic; this process is sometimes referred to as art as therapy. Art making is seen as an opportunity to express oneself imaginatively, authentically, and spontaneously, an experience that, over time, can lead to personal fulfilment, emotional reparation, and transformation. This view also holds that the creative process, in and of itself, can be a health-enhancing and growth-producing experience.

The second definition of art therapy is based on the idea that art is a means of symbolic communication. This approach, often referred to as art psychotherapy, emphasises the products—drawings, paintings, and other art expressions—as helpful in communicating issues, emotions, and conflicts. Psychotherapy is essential to this approach, and the art image becomes significant in enhancing verbal exchange between the person and the therapist and in achieving insight. With therapeutic guidance and support, art can facilitate new understandings and insights. It can help resolve conflicts, solve problems, and formulate new perceptions that in turn lead to positive changes, growth, and healing.

In reality, most therapists who practice art therapy integrate both art as therapy and art psychotherapy into their work in varying degrees. In other words, both the idea that art making can be a healing process and that art products communicate information relevant to therapy are important. Therapists may emphasise one area over another, depending on their own philosophy and the person's needs and goals in art therapy.



Traingular relationship

In art therapy this dynamic is often referred to as the triangular relationship. Within this triangular relationship greater or lesser emphasis may be placed on each axis (between, for example, the client and their art work or between the client and the art therapist) during a single session or over time.

4.6 APPLICATION OF ART THERAPY

"Art therapy offers the opportunity to work with many different client groups" This is one of its main advantages as a treatment process, as it can be made available to a wide variety of people with a multitude of different problems, needs and expectations. All people are at least able to make a mark and therefore can use art therapy in some way. The range of settings in which art therapists now work is extensive and constantly developing. These include hospitals, schools, community-based centres, therapeutic communities and prisons. Art therapy is also often included as part of the services provided to particular client groups such as children, adolescents, families, older adults and individuals with learning difficulties. Within these broad areas art therapists may work with individuals on a one-to-one basis or with groups. Art therapists are also to be found practicing in a number of specialist fields including work with offenders, clients who have autism, eating disorders, addictions or who have experienced physical or sexual abuse, psychosis and physical illnesses.

Art in therapy has been used within many areas of therapy and in numerous settings, including:

- HIV/AIDS (Bien, 2005; Estes, 1990; Jansen, 1995; Weiser, 1996);
- Trauma (Anderson, 1995; Appleton, 1993; Bien, 2005; Brooke, 1997; Chapman, Appleton, Gussman, & Anderson, 1997; Cohen, Barnes, & Rankin, 1995; Cohen & Cox, 1995; Malchiodi, 1998; Powel & Faherty, 1990; Prager, 1991; Ruben, 1999; Sanderson, 1995; Spring, 1993; Taylor, 1990);
- Sexual Abuse (Landgarten, 1987; Malchiodi, 1998);
- Separation and Loss (Doyle & Jones, 1993; Fehlner, 1994; Gonick & Gold, 1992; Lyons, 1993; Shostak, 1985);
- Divorce (Landgarten, 1987);
- Marital or Couple problems (Ruben, 1999);
- Bereavement (Councill, 1993; Zambelli, Johns Clark & Jong Hodgson, 1994);
- Psychopathology (Cohen, Barnes & Rankin, 1995; Cohen & Cox, 1995; Dick, 2001; Killkick & Schaverien, 1997; Robbins, 1994; Ruben, 1999);
- Neurological Disorders (Robbins, 1994);
- Depression (Edwards, 2004, Landgarten, 1987; Robins, 1994);
- Eating Disorders (Dalley, 1984; Edwards, 2004; Robbins, 1994; Schaverien, 1989);
- Self Mutilation (Milia, 1996);
- The Mentally Handicapped, Autism and other related problems (Dalley, 1984; Edwards, 2004; Evans & Dubowski, 2001; Robins, 1994; Ruben, 1999; Toburen & Atkins, 1882);
- Disabled (Lewis & Langer, 1994);
- The Elderly and Terminally Ill (Dalley, 1984; Landgarten, 1987; Ferguson & Goosman, 1991; Ruben, 1999);

- Alzheimer's Disease (Toshimitsu, Shin, Ken-Ichi, Kiyoko & Kazuo, 2000);
- Physical Illness (Edwards, 2004; Knight, 1997; Ruben, 1999; Skaife, 1993; Sundaram, 1995);
- Prison Inmates (Baillie, 1994; Bradford, 2005; Dalley, 1984; McCourt, 1994; Ruben, 1999);
- Addiction (Edwards, 2004; Ruben, 1999; Shostak, 1985);
- Abuse (Brooke, 1997; Powel & Faherty, 1990; Shostak, 1985; Van der Kolk & Van der Hart, 1989); and
- Self Image Problems (Cameron, Juszczak & Wallace, 1984; Cochran, 1996; De Chiara, 1982).

While not an overly extensive listing, it is clear that art therapy can and has been used in the treatment of a broad myriad of problems, as well as within a variety of settings and circumstances.

4.7 INDICATIONS AND CONTRAINDICATIONS

It might be assumed that those who are good at art or who have attended a fine art program would be the most suitable candidates for art therapy. However, this is not always the case as such a person might be too skilled at concealing to benefit from the process. It is partly the unexpected nature of what is produced that makes art therapy so effective and lack of skill or previous ability contribute to this. When there is a need for the unconscious material to press to the fore through visual expression previously unskilled people may find themselves surprisingly visually articulate. It is as if, when the unconscious needs to express itself, the ability is there.

It has sometimes been thought that art therapy should be restricted and not applied with patients in psychotic states. However, this has been widely challenged by research in art therapy where it has become clear that this client group, if appropriately understood and monitored, benefits from the experience of nonverbal expression in a contained setting more than the traditional psychotherapy.

4.8 ADVANTAGES OF ART THERAPY

The following are some of the advantages of art therapy that may be relevant in different circumstances:

Almost everyone has used art as a child and can still do so if encouraged to forget about images having to be 'artistically correct'.

It can be used as a means of non-verbal communication. This can be important for those who do not have a good mastery of verbal communication for whatever reason. For those who cannot stop talking, it can sometimes be a good way of cutting through 'tangled verbosity'.

It can be used as a means of self-expression and self-exploration. A picture is often a more precise description of feelings than words and can be used to depict experiences which are 'hard to put into words'. Sometimes 'words are hard to

find', as in dementia. The spatial character of pictures can describe many aspects of experience simultaneously.

The process of doing art can sometimes help people become more aware of feelings previously hidden from them, or of which they were only partly aware. It can help people become clearer about confused feelings.

Using art can sometimes help people release feelings, e.g. anger and aggression, and can provide a safe and acceptable way of dealing with unacceptable feelings.

It can help such people to look at their current situations and at ways of making changes. The 'framed experience' (an experience within a boundary, like a picture in a frame) can provide a context to try out or fantasise about possible futures without the commitment of reality.

It can be used to help adults play and 'let go'. Recapturing the ability to play can lead to creativity and health.

The concreteness of the products makes it easier to develop discussion from them. The pictures are there to return to at a later date and it is possible to look back over pictures from a series of sessions and note developments.

The existence of a picture as a separate entity means that therapist and client can relate to each other through looking at the picture together. This is sometimes a less threatening way of confronting issues or relating. This is also referred to as the 'triangular relationship of art therapy'.

Discussion of the products can lead to explorations of important issues.

'Interpretation' of a reductive kind is not widely used as pictures are often ambiguous and the most important thing is for the creator to find his or her own meanings.

Using art requires active participation, which can help to mobilise people who have become accustomed to doing very little. In a group setting, it is one way of equalising participation. Everyone can join in at the same time and at their own level.

It can be enjoyable and this may lead to shared pleasure and to individuals developing a sense of their own creativity. Many people who start art therapy in a very tentative way go on to develop a real interest in art.

4.9 LET US SUM UP

Art therapy, though similar to psychotherapy in its goals and principles is very different in its approach. It draws its roots from psychoanalysis and schools of psychology, but in current scenario its viewpoint is eclectic and global. It is more client centred approach and flows with the clients framework rather than the therapists psychological viewpoints. The inherent healing capacity of art is explored in this form of therapy. It has recently become widely applicable in all most all types of disorders clinically and with growing body of research in this field it is gaining its status as a highly effective modality especially when other modalities have fallen short.

4.10 UNIT END QUESTIONS

1) Who was the pioneers of art therapy and how has art therapy evolved over years?
2) State any 5 major advantages of art therapy
3) What are the three main purpose of art therapy? Explain.
4) Elucidate the triangular relationship of art therapy
5) Where all can art therapy be applicable?

4.11 SUGGESTED READINGS

Edwards, M. (1987). Jungian Analytic Art Therapy. In Rubin (Ed.). *Approaches to Art Therapy: Theory and Technique.* New York: Bruner/Mazel

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